

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106116	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2025
NAME OF PROVIDER OR SUPPLIER Aviata at Bryan Dairy		STREET ADDRESS, CITY, STATE, ZIP CODE 9035 Bryan Dairy Rd Largo, FL 33777	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility policy, interviews and record review, the facility failed to ensure advanced directives were implemented in a timely manner and failed to ensure the residents' wishes were honored related to full code status for one resident (#5) of three residents sampled. On [DATE] at 1:09 a.m., Staff B, Licensed Practical Nurse (LPN) obtained Resident #5's oxygen saturation level (SpO2) which was 84% with supplemental oxygen by nasal cannula. According to emedicinehealth oxygen saturation levels below 95% are considered abnormal, and the brain may be affected when SpO2 levels drop below 80 to 85 percent. https://www.emedicinehealth.com/what_is_a_good_oxygen_rate_by_age/article_em.htm retrieved on [DATE]. Staff B, LPN did not notify the medical provider or document interventions regarding the change in condition. At approximately 3:15 a.m., Staff B, LPN found Resident #5 pulseless and not breathing. The staff member summoned Staff I, Certified Nursing Assistant (CNA) and Staff C, LPN to the resident's room. Staff C, LPN assessed Resident #5 and confirmed the resident did not have a pulse or respirations. Staff B, LPN and Staff I, LPN reviewed Resident #5's electronic health record (EHR) for resuscitation orders and the paper chart for a Do Not Resuscitate (DNR) form. Staff C, LPN stated Resident #5 had an order for full code and confirmed there was no DNR form in the chart. Staff B, LPN reviewed the full code order and failed to act on it. Staff B, LPN said he was confused because on [DATE], when Resident #5 was readmitted from the hospital, the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form Agency for Healthcare Administration (AHCA) form, 3008), documented DNR status for the resident. Staff B, LPN called the administration, hospice, and Resident #5's medical team, which delayed chest compressions and ventilation for approximately 45-60 minutes. This failure created a situation in which Resident #5's wishes for cardiopulmonary resuscitation (CPR) were not honored, resulting in death, which resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D after verification of removal of immediacy of harm. Findings included: A review of Resident #5's admission record showed an initial admission date of [DATE], and a readmission of [DATE], with diagnoses including metabolic encephalopathy, multiple sclerosis, sepsis, dysphagia, acute respiratory failure with hypoxia, diabetes type 2, pneumonia, acute kidney failure, myocardial infarct, and hypertension. A review of Resident #5's order summary report showed, as of [DATE], Full Code order, dated [DATE]. A review of Resident #5's annual minimum data set (MDS), dated [DATE], section C- cognitive pattern, showed a brief interview for mental status (BIMS) score of 15, indicating cognitively intact. Section B- hearing, speech, and vision shows the resident can express ideas and wants. Section Q- participation in assessment and goal setting showed active participation in the assessment process. A review of Resident #5's care plan showed a focus area of advanced directive full code, initiated on [DATE], created by the Social Worker. The intervention for this care plan focus is to, Discuss [Resident #5's] advanced directives with his or her representative as needed. A review of Resident #5's care conference participation record and summary, dated [DATE], showed advance directives: full code. A review of Resident #5's social service progress note dated [DATE] showed .patient wishes to continue with full code status . A review of Resident #5's progress notes showed the following:- On [DATE] at 5:35 a.m. authored by Staff B, LPN showed, The resident was coded, resuscitation was performed on her as protocol demands, 911 was called and all needed medical attention was given. At 0500 [5:00 a.m.] the resident was pronounced dead. MD [medical doctor] was notified. - On [DATE] at 7:30 p.m. authored by Staff A, LPN, [Resident #5] was seen and admitted to hospice today. Code changed to DNR waiting for paperwork . - On [DATE], showed a BIMS summary score of 15 During a telephone interview on [DATE] at 3:08 p.m., Staff C, LPN said Staff B, LPN, called her to Resident #5's room to check for a pulse and respirations. Staff C, LPN, said she used her stethoscope to confirm Resident #5 did not have a pulse. She checked the resident's electronic health record (EHR) for full code orders and the paper chart for a DNR form. Staff C, LPN, found Resident #5 had an order for full code and did not find a DNR form in the chart. Staff C, LPN told Staff B, LPN, We need to run a code, I kept saying we need to run a code. Staff B, LPN told her Resident #5 was a DNR. Staff C, LPN, told Staff B, LPN to call the Director of Nursing (DON) about the situation as, I could not find any paperwork to show Resident #5 was a DNR. After contacting the DON, Staff B, LPN paged hospice and the doctor. Staff B, LPN stated they were waiting for hospice to return their call. Staff C, LPN told Staff B, LPN to call Staff H, LPN/ Init Manager (IIM) because She will know Resident #5's</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to protect the resident's right to be free from deprivation of goods and services by failing to ensure timely Cardiopulmonary Resuscitation (CPR) was provided, per the resident's wishes, and failed to notify the physician of a change in condition for one resident (#5) out of three residents sampled for advance directives. On [DATE] at 1:09 a.m., Staff B, Licensed Practical Nurse (LPN) obtained Resident #5's oxygen saturation level (SpO2) which was 84% with supplemental oxygen by nasal cannula. According to emedicinehealth oxygen saturation levels below 95% are considered abnormal, and the brain may be affected when SpO2 levels drop below 80 to 85 percent. https://www.emedicinehealth.com/what_is_a_good_oxygen_rate_by_age/article_em.htm retrieved on [DATE]. Staff B, LPN did not notify the medical provider or document interventions regarding the change in condition. At approximately 3:15 a.m., Staff B, LPN found Resident #5 pulseless and not breathing. The staff member summoned Staff I, Certified Nursing Assistant (CNA) and Staff C, LPN to the resident's room. Staff C, LPN assessed Resident #5 and confirmed the resident did not have a pulse or respirations. Staff B, LPN and Staff I, LPN reviewed Resident #5's electronic health record (EHR) for resuscitation orders and the paper chart for a Do Not Resuscitate (DNR) form. Staff C, LPN stated Resident #5 had an order for full code and confirmed there was no DNR form in the chart. Staff B, LPN reviewed the full code order and failed to act on it. Staff B, LPN said he was confused because on [DATE], when Resident #5 was readmitted from the hospital, the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form Agency for Healthcare Administration (AHCA) form, 3008), documented DNR status for the resident. Staff B, LPN called the administration, hospice, and Resident #5's medical team, which delayed chest compressions and ventilation for approximately 45-60 minutes. This failure created a situation in which Resident #5's wishes for CPR were not honored, resulting in death, which resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the severity and scope was reduced to a D after verification of removal of immediacy of harm. Findings included: A review of Resident #5's admission record showed an initial admission date of [DATE], and a readmission of [DATE], with diagnoses including metabolic encephalopathy, multiple sclerosis, sepsis, dysphagia, acute respiratory failure with hypoxia, diabetes type 2, pneumonia, acute kidney failure, myocardial infarct, and hypertension. A review of Resident #5's order summary report showed the following:- As of [DATE] Full Code order, dated [DATE].- Pulse oximetry (ox) every shift for monitoring, dated [DATE].- Respiratory: Oxygen-via Nasal Canula (NC) continuous every shift for (oxygen) O2 dated [DATE]. A review of Resident #5's care plan showed a focus area of advanced directive full code, initiated on [DATE], created by the Social Worker. The intervention for this care plan focus is to, Discuss [Resident #5's] advanced directives with his or her representative as needed. A review of Resident #5's annual minimum data set (MDS), dated [DATE], section C-cognitive pattern, showed a brief interview for mental status (BIMS) score of 15, indicating cognitively intact. Section B- hearing, speech, and vision shows the resident can express ideas and wants. Section Q- participation in assessment and goal setting showed active participation in the assessment process. A review of Resident #5's progress notes showed the following:- On [DATE] at 5:35 a.m. authored by Staff B, LPN showed, The resident was coded, resuscitation was performed on her as protocol demands, 911 was called and all needed medical attention was given. At 0500 [5:00 a.m.] the resident was pronounced dead. MD [medical doctor] was notified.- On [DATE] at 7:30 p.m. authored by Staff A, LPN, [Resident #5] was seen and admitted to hospice today. Code changed to DNR waiting for paperwork.- On [DATE], showed a BIMS summary score of 15.- On [DATE] showed Resident #5 was admitted to the facility from a local hospital.- On [DATE] social service progress note showed, .patient wishes to continue with full code status .A review of Resident #5's AHCA form, 3008, section H, advanced care planning section showed Resident #5's had DNR status. Review of Resident #5's orders did not show physician orders for DNR status. A review of Resident #5's care conference participation record and summary, dated [DATE], showed advance directives: full code. A review of Resident #5's hospice patient care notes, dated [DATE], showed, Bedside visit with patient, [family member] on speaker phone. Pt [patient] is unresponsive s/s [signs and symptoms] [of] imminence per [doctor]. A review of Resident #5's hospice protocol for, Patients Enrolled in Hospice Medicare Benefit form, showed the following, .please notify [name] Hospice if .changes occur in the patient's physical or mental status During an interview on [DATE] at 12:25 p.m. Staff A LPN said on [DATE] at approximately 7:00 p.m.</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>(continued on next page)</p>		

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According to emedicinehealth oxygen saturation levels below 95% are considered abnormal, and the brain may be affected when SpO2 levels drop below 80 to 85 percent. https://www.emedicinehealth.com/what_is_a_good_oxygen_rate_by_age/article_em.htm retrieved on [DATE]. Staff B, LPN did not notify the medical provider or document interventions regarding the change in condition. At approximately 3:15 a.m., Staff B, LPN found Resident #5 pulseless and not breathing. The staff member summoned Staff I, Certified Nursing Assistant (CNA) and Staff C, LPN to the resident's room. Staff C, LPN assessed Resident #5 and confirmed the resident did not have a pulse or respirations. Staff B, LPN and Staff I, LPN reviewed Resident #5's electronic health record (EHR) for resuscitation orders and the paper chart for a Do Not Resuscitate (DNR) form. Staff C, LPN stated Resident #5 had an order for full code and confirmed there was no DNR form in the chart. 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The intervention for this care plan focus is to, Discuss [Resident #5's] advanced directives with his or her representative as needed. A review of Resident #5's care conference participation record and summary, dated [DATE], showed advance directives: full code. A review of Resident #5's social service progress note dated [DATE] showed .patient wishes to continue with full code status . A review of Resident #5's progress notes showed the following: - On [DATE] at 5:35 a.m. authored by Staff B, LPN showed, The resident was coded, resuscitation was performed on her as protocol demands, 911 was called and all needed medical attention was given. At 0500 [5:00 a.m.] the resident was pronounced dead. MD [medical doctor] was notified. During a telephone interview on [DATE] at 11:00 a.m. Staff I, CNA said, I always start preparing water to pass out at 3:00 a.m. On [DATE] at approximately 3:15 a.m. Staff B, LPN told her Resident #5 had expired and called her to the resident's room. Staff I, CNA said, Everyone was scrambling, and she asked if she needed to call a code blue. She there was, Confusion about the code status. During an interview on [DATE] at 11:46 a.m. Staff H, LPN/Unit Manager (UM), said on [DATE] at 4:05 a.m. Staff B, LPN, called and told her Resident #5, Expired 45 to 50 minutes ago. Staff H, LPN/UM, said two nurses are expected to review the residents' orders and check the chart for a DNR form and if there was a discrepancy, staff are expected to follow physician's orders. She said the Code Blue Documentation Tool [form] should be completed and signed by all the staff members who participated. Staff H, LPN/UM said nurses have been instructed to complete a progress and/or a change in condition note. During an interview on [DATE] at 12:08 n m the Nursing Home Administrator (NHA) said she contacted the Emergency Medical Services (EMS)</p>		

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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>(continued on next page)</p>		

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A review of Resident #5's Treatment Administration Record (TAR), dated [DATE], showed the pulse ox reading was documented for two out of five opportunities.A review of Resident #5's annual minimum data set (MDS), dated [DATE], section C-cognitive pattern, showed a brief interview for mental status (BIMS) score of 15, indicating cognitively intact. Section B- hearing, speech, and vision shows the resident can express ideas and wants. Section Q- participation in assessment and goal setting showed active participation in the assessment process. A review of Resident #5's progress notes showed the following:- On [DATE] at 5:35 a.m. authored by Staff B, LPN showed, The resident was coded, resuscitation was performed on her as protocol demands, 911 was called and all needed medical attention was given. At 0500 [5:00 a.m.] the resident was pronounced dead. MD [medical doctor] was notified.- On [DATE] at 7:30 p.m. authored by Staff A, LPN, [Resident #5] was seen and admitted to hospice today. 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