STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105366	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vivo Healthcare University	3648 University Blvd S Jacksonville, FL 32216

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28892 Based on observations, interviews, and record reviews, the facility failed to ensure that residents who were unable to carry out activities of daily living (ADLs) received necessary services to maintain good grooming and personal hygiene for two (Residents #48 and #19) of three residents reviewed for ADL care from a total survey sample of 46 residents. The findings include: 1. A review of Resident #48's medical record revealed an admitted [DATE] with diagnoses including Type 2 diabetes mellitus (T2DM), acute chronic diastolic (congestive) hear failure, muscle weakness (generalized), pleural effusion, legal blindness, end stage renal disease (ESRD), hyperthyroidism, arteriosclerotic heart disease of native coronary artery, major depressive disorder, generalized anxiety disorder, and hypertension. On 11/05/24 at 10:20 AM, an observation was made of Resident #48's fingernails which were long with brown matter underneath. (photographic evidence obtained) On 11/07/24 at 8:56 AM, an observation was made of Resident #48's fingernails which remained long with brown matter underneath. (photographic evidence obtained) A review of Resident #48's annual minimum data set (MDS) assessment, dated 08/05/24, revealed that he had a brief interview for mental status (BIMS) score of 15 out of 15 possible points, indicating intact cognition. No hallucinations or delusions were documented, no physical or verbal behavioral symptoms directed towards others, and no rejection of care or wandering behaviors were documented. An interview with the resident for daily preferences or daily activities was not documented. The resident had no impairment of the upper or lower extremities; required supervision or touching assistance with eating and oral hygiene; required substantial/maximum assistance with toileting, shower/bathing, upper and lower body dressing, and putting on/taking off footwear and personal hygiene. He required substantial/maximum assistance with mobility. He did not receive scheduled or as needed (prn) pain medications. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #48's care plan documented a focus area for Activities of Daily Living (ADL) Performance Deficit related to activity intolerance and end-stage renal disease (ESRD). The care plan goal was to improve the current level of function in at least one of the resident's ADLs by the next review date. The care plan interventions included provision of personal hygiene and oral care. The resident required staff participation with personal hygiene and oral care. The date the intervention was created was documented as 9/13/2022. On 11/07/24 at 9:02 AM, Certified Nursing Assistant (CNA) A was interviewed and reported that she had worked at the facility for two months. She explained that she made care rounds every two hours. During care rounds, she would make a visual head-to-toe check of residents assigned to her. The visual head-to-toe check included looking at fingernail length and condition. The process for completing her rounds began with checking the resident's vital signs and providing breakfast. After breakfast, she provided ADL care, gave her assigned residents a shower, and got them ready for therapy. She explained that she was familiar with Resident #48 and his care needs. He was blind and received eye drops. She stated she had not clipped the resident's fingernails because there had been no access to nail clippers for some time. The nail clippers were usually located in the clean utility room and the person in charge of supplies said nail clippers were on backorder. She stated nails extending approximately a half a centimeter beyond the nail bed were considered too long and could be considered a scratching hazard. At 9:11 AM, CNA A was accompanied to the resident's room. She observed the resident's fingernails and reported that they were too long and looked like weapons. On 11/07/24 at 9:12 AM, Licensed Practical Nurse (LPN) B was interviewed and reported that he had worked at the facility for three months. He explained that nurses were responsible for conducting a head-to-toe skin assessment of residents once a week, which included looking at fingernail length. Residents also received a skin assessment when they received either a bed bath or shower two times per week, which included looking at fingernail length. He stated he always carried fingernail clippers in his pocket, kept a supply of clippers in a drawer at the nurses' station, and also in his personal work desk. Fingernail clippers could also be found in the clean utility room. If CNAs could not locate fingernail clippers in those areas, they could ask their nurse or go to the central supply room to obtain a pair. He also instructed CNAs to take fingernail clippers with them when they provided bed baths and showers. LPN B stated nail length that was considered as excessive was subjective. He made sure to first ask the resident of the fingernail length they preferred. Some male and female residents did not mind long fingernails. For his non-verbal residents, he ensured fingernail length was short enough to prevent them from scratching themselves. On 11/07/24 at 9:19 AM, LPN B was accompanied to Resident #48's room. He observed the length of the resident's fingernails and stated Resident #48's fingernails were excessively long. LPN B reviewed a nursing progress note dated 10/28/24 (10 days prior to this interview), which documented that a skin check was completed and the resident's nails were cleaned and clipped. LPN B stated the resident's fingernails could not have been cleaned and clipped on the documented date because the fingernails could not have grown to their present length within 10 days. On 11/07/24 at 9:24 AM, an observation was made of two pairs of fingernail clippers in a desk drawer at the east nursing station. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/07/24 at 9:26 AM, CNA C was interviewed and reported that she had worked at the facility for [AGE] years. She was responsible for stocking the main central supply room and the east and west wing clean utility rooms. She displayed five boxes of small, medium and large nail clippers in the main central supply room, each box containing 24 clippers. The main supply room also had a large plastic bag full of various sizes of fingernail clippers. She said that she stocked the clean utility rooms with various items, including fingernail clippers two or three times a week and reported that CNAs could not say that they could not clip fingernails because they did not have supplies. 48947 2. A review of Resident #19's medical record revealed an admitted [DATE] with diagnoses including a contracted right hand, need for assistance with personal care, cognitive communication disorder, other symptoms involving the musculoskeletal system, other cervical disc displacement, tremors, unspecified dementia, psychotic disturbance, mood disturbance, and anxiety. Further review of Resident #19's medical record revealed a Quarterly Minimum Date Set (MDS) assessment with a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15 points, indicating moderate cognitive impairment. No behaviors were indicated, and the need for partial/moderate staff assistance with personal hygiene, transfers and bed mobility, and substantial/maximal staff assistance with transfers was documented. A review of Resident # 19's active care plan revealed the following focus areas: FOCUS: ADL self-care performance deficit related to Dementia. Goal: Resident will maintain current level of function in ADLs through the review date. Intervention: Bathing/Showering: Check nail length and trim and clean on bath schedule and as necessary. FOCUS: Resident at risk for loss of range of motion related to existing contractures of right hand. Goal: He will have no loss of skin integrity related to contractures. Interventions: Assist in keeping fingernails short and trimmed. A review of Resident #19's progress notes revealed that skin checks dated 11/1/2024 at 3:41 PM revealed: Resident skin is clear no impairment. Resident nails cleaned and trimmed. On 11/04/24 at 10:54 AM, Resident #19's right and left hands were observed and revealed fingers contracted on both hands with long fingernails and brown matter underneath. On 11/05/24 at 10:37 AM, Resident #19 was observed resting in bed. A carrot/splint was observed on his overbed table. The fingernails on his right and left hands were long with brown matter underneath. On 11/06/24 at 3:26 PM, Resident #19 was observed resting in bed. He was asked if staff had trimmed or cleaned his fingernails today and he answered, No. The fingernails on his right and left hands were long with brown matter underneath. (photographic evidence obtained) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/07/24 at 9:13 AM, an interview was conducted with Registered Nurse (RN) E. She stated, Nursing is responsible for nail care and nail care is performed during showers or anytime it's needed. A review of the facility's policy titaled Nail Care, Clinical services (implemented 9/1/2023), revealed: Policy Explanation and Compliance Guidelines: 3. Routine cleaning and inspection of nails will be provided during ADL care and on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48947 Based on observations, record reviews, interviews, and a review of facility policy, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible for one (Resident #72) of one resident reviewed for accident hazards out of 46 residents in the total survey sample. Medicated ointments in plastic medication cups were left at the resident's bedside. Resident #72 had not been assessed for capability of self-administering/applying medicated ointments. No self-administration assessment was found in the record or provided by the facility during the survey. No care plan was located in the record indicating that the resident was capable of safely self-administering medications/medicated ointments. The findings include: On 11/04/24 at 10:43 AM, two medication cups were observed on the resident's bedside table. (photographic evidence obtained) An interview was conducted with the resident at the time of this observation, who reported that the cups contained her medications, which were the two creams she applied to both her hands for psoriasis. She stated, The nurse brought them in here and left them over there. I usually put them on myself. On 11/05/24 at 10:28 AM, two medications cups were observed on the bedside table. (photographic evidence obtained) An interview was conducted with the resident at the time of the observation, who confirmed that the cups contained creams she applied to her hands and they were not the same ones from the previous day. On 11/07/24 9:33 AM, two medication cups were observed on the bedside table (photographic evidence obtained) An interview was conducted with the resident at the time of the observation, who confirmed that the two cups containing medicated creams were left over from the previous day. A review of Resident #72's medical record revealed an admitted [DATE] with diagoses including encephalopathy, need for assistance with personal care, other signs and symptoms involving cognitive function and awareness, and psoriasis. No Medication Self-Administration Assessment form was located in the resident's record. A review of Resident #72's Quarterly minimum data set (MDS) assessment, dated 07/23/24, revealed she had a brief interview for mental status (BIMS) score of 13 out of 15 possible points, indicating intact cognition. She required substantial/maximal staff assistance with toileting, transfers, and personal hygiene. A review of Resident #72's active physician's orders revealed: Clobetasol Propionate External Cream 0.05%, apply to both hands topically twice daily for psoriasis of hands. Calcitrene External Ointment 0.005%, apply to both palms topically twice daily until resolved. (ordered 9/11/2024) A review of Resident #72's baseline care plan, dated 02/04/2023 (Admission), revealed in Section 3. Health Conditions, B: Level of Consciousness, 2. a. cognitively intact and b. cognitively impaired/forgetful, D. Medications, 2. Self-administer medications, a. No. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #72's active Care Plan revealed the following focus areas: FOCUS: Cognitive-Communication deficit as evidenced by impaired safety awareness and insight (initiated 2/28/2023, revised 2/28/2023) FOCUS: Resident has an ADL (Activities of daily living) self-care performance deficit related to encephalopathy. (initiated 3/15/2024, revised 3/15/2024). No care plans were found in the record indicating that Resident #72 had been assessed and was capable of self-administering medications or medicated ointments. On 11/07/24 at 9:21 AM, an interview was conducted with Licensed Practical Nurse (LPN) D. She stated there were no residents on her unit who self-administered their medications or treatments. She was asked to explain the facility's process for allowing a resident to self-administer medications or treatments. She explained that the facility had an assessment that was completed by a nurse or the Unit Manager to determine whether or not the residents were capable of self-administering medications. She was asked if the nurse was required to observe the resident during self-administration of the medication or treatments. She replied, Yes. She was asked where the medications were stored if the resident self-administered. She stated, I need to check the policy. She was asked if the nurse was permitted to leave medications or treatments at the bedside for the resident to administer for themselves. She replied, If they have an assessment that confirmed they can self administer, but it must be care planned. On 11/07/24 at 9:38 AM, an interview was conducted with LPN B, the Unit Manager for the East unit. He stated he was familiar with Resident #72 and the condition of the skin on both her hands. He was aware that she received creams for the treatment of her hands. He stated, Yes, she has creams she gets three times daily that she puts on. He was asked if she ever refused her treatments. He replied, No. He was asked to explain the process for allowing a resident to self-administer medications or treatments. He stated, The care plan must reflect the self-administration of medications and the resident has to have a BIMS of 13 or above. That's all as far as I know. He was asked if the nurse was required to observe when the resident self-administered medications or treatments. He stated, Yes, the nurse must be there. On 11/07/24 at 12:20 PM, the completed Medication Self-Administration Assessment Form for Resident #72 was requested from the Director of Nursing (DON). It was never provided. On 11/07/24 at 2:21 PM, the DON was asked to provide any additional documentation as evidence that Resident #72 had been assessed for self-administration of medications/treatments. No further evidence was provided. A review of the facility's policy titled Resident Self-Administration of Medication, Clinical Services (implemented 9/1/2023), revealed: Policy Explanation and Compliance Guidelines: 4. The results of the interdisciplinary team assessment are recorded on the Medication Self-administration Assessment Form, which is placed in the resident's medical record. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into other residents' rooms or to confused roomates of the resident who self-administers medication. The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider. 13. The care plan must reflect self-administration and storage arrangements for such medications.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45153 Based on observations, interviews, record review, and facility policy and procedure review, the facility failed to ensure that residents who needed respiratory care, were provided such care, consistent with professional standards of practice, for one (Resident #34) of one resident reviewed for respiratory care, from a total survey sample of 46 residents. Resident #34 was not receiving oxygen at the flow rate ordered by her physician. The findings include: On 11/04/24 at 11:20 AM, Resident #34 was observed fully dressed sitting in her wheelchair inside her room wearing a nasal cannula with an oxygen tank on the back of her wheelchair. She reported receiving oxygen at a flow rate of 1.5 liters per minute (L/min) when she was in her wheelchair and 3.0 L/min when in bed and sleeping. Resident #34's oxygen concentrator located at bedside was observed to be set at 3.0 L/min. On 11/07/24 at 10:11 AM, Resident #34 was observed fully dressed in the main dining room sitting in her wheelchair wearing her nasal cannula with the portable oxygen tank located on the back of her wheelchair turned off. When the resident was asked for permission to observe her oxygen tank settings, she replied, I have not had the opportunity to turn the machine on. Resident #34 asked Activities Assistant M to turn on her oxygen. Activities Assistant M turned on the portable oxygen tank that was located at the back of the resident's wheelchair. The flow rate was set at 1.5 L/min. On 11/07/24 at 11:33 AM, Resident #34 was observed transferring herself from her wheelchair to her bed. She was not wearing her nasal cannula but her oxygen concentrator was observed in the on position with a flow rate set at 3L/min. (Photographic evidence obtained) A review of the resident's active physician's orders revealed: Oxygen at 4 L/min via Nasal Cannula, continuously, every day and night shift for oxygen management dated 9/3/24; (copy obtained) A review of Resident #34's medical record revealed an admitted [DATE] with a previous admitted [DATE]. Her diagnoses included chronic respiratory failure with hypoxia; acute respiratory failure with hypoxia, unspecified asthma, respiratory syncytial virus (RSV - contagious virus that causes infections of the respiratory tract) as the cause of diseases classified elsewhere; dependence on supplemental oxygen; major depressive disorder, generalized anxiety disorder, chronic obstructive pulmonary disease (COPD) with (acute) exacerbation, anxiety disorder, and major depressive disorder. A review of the Quarterly minimum data set (MDS) assessment dated [DATE], revealed that the resident was assessed with shortness of breath or trouble breathing while lying flat and required oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the active Care Plan revealed focuses and goals including oxygen therapy related to ineffective gas exchange and use of antipsychotic medication. Interventions included administration of medication as ordered, monitoring for and documenting side effects and effectiveness of medications, and oxygen as ordered. A review of the resident's Medication Administration Records (MARs) for October and November 2024 revealed that oxygen was provided as ordered by the resident's physician. (copy obtained) On 11/7/24 at 11:21 AM, Registered Nurse (RN) E reported that the facility's portable oxygen tanks could hold 10 - 15 liters of oxygen. Staff were expected to check oxygen tanks frequently. On 11/07/24 at 11:36 AM, RN E verified that Resident #34's oxygen concentrator, located at her bedside, had a flow rate set at 3L/min, and stated the oxygen concentrator should have been set at 4L/min. Nursing staff provided ongoing monitoring of the resident's oxygen therapy. Nursing was responsible for ensuring that the resident was receiving the correct oxygen flow rate per the physician's order. Correct oxygen flow rate settings were identified by checking the physician's orders. Nursing staff on the 11-7 PM shift were responsible for changing the resident's oxygen tubing. Correct flow rate settings were communicated from one nurse to another via shift change reports and reviewing orders in the computer. Resident #34 did not refuse oxygen therapy, but she would sometimes rush to leave her room and nursing then had to track her down. On 11/07/24 at 12:33 PM, the Director of Nursing (DON) confirmed that correct oxygen settings were identified by verifying the order in the computer or by calling the physician. On 11/07/24 at 1:03 PM, the DON stated nursing was responsible for changing the oxygen settings on the concentrator and on the portable oxygen tank located on the back of Resident #34's wheelchair. When asked whether anyone else could or did change the settings, the DON replied, No, nursing. A review of the facility's policy and procedure titled Oxygen Administration (implemented on 03/2024), revealed: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences. Policy Explanation and Compliance Guidelines: 1. Oxygen is administered under orders of a physician, except in the case of an emergency . 2. Personnel authorized to initiate oxygen therapy include physicians, RNs, LPNs, and respiratory therapists. (copy obtained)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45153 Based on kitchen food service observations, staff interviews, facility document review, and facility policy and procedure review, the facility failed to follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness with the potential to affect all residents who consumed foods from the facility's kitchen. The facility failed to 1) Date mark open packages of croutons and tea bags, 2) Clean grease build-up inside and around the door area of the convection oven, 3) Clean grease and food substances from the inside door area and oven floor, 4) Clean grease and food debris from the oven tray, 5) Clean food debris stuck on and around the safety guard of the mixer, 6) Clean food debris stuck on the meat slicer, 7) Clean one of two microwaves located in the east unit nourishment room, 8) Clean the ice machine dispenser tray located in the west unit nourishment room, and 9) Address condensation build-up in the walk-in freezer. Food handling and sanitation are important in health care settings serving nursing home residents. Unsafe food handling practices represent a potential source of pathogen exposure. The findings include: A tour of the kitchen was conducted on 11/04/24 at 9:40 AM. During the tour, no date markings were observed on one open package of croutons or one open package of tea bags located on the rack in the dry storage room. Condensation build-up was observed in the walk-in freezer and water leaks were observed on the floor coming from the walk-in freezer. Observation of the open package of croutons and tea bags, water on the floor around the walk-in freezer area, and condensation build-up in the walk-in freezer were made again on 11/05/24 at 8:51 AM. (photographic evidence obtained) A follow-up tour of the kitchen was conducted on 11/06/24 at 10:45 AM. During the tour, the convection oven next to the oven was covered with food grime and grease build-up. The inside oven door area and oven floor next to the convection oven were covered with grease and food substances. The oven tray was filled with grease and dried food debris. The mixer located across from the meat slicer had food debris stuck on and around the safety guard. Food debris was stuck on the meat slicer. The inside top area of the microwave, located in the east unit nourishment room, was filled with food debris, and the west unit nourishment room's ice machine's dispenser tray was covered with a white substance. (photographic evidence obtained) On 11/7/24 at 1:23 PM, another observation was made of the open package of croutons and tea bags in the dry storage room, condensation build-up in the walk-in freezer, the convection oven remained covered with food grime and grease build-up, and the inside oven door area and oven floor were covered with grease and food substances. The oven tray was filled with grease and dried food debris, and the mixer located across from the meat slicer had food debris stuck on and around the safety guard. (photographic evidence obtained) On 11/07/24 at 12:10 PM, Dietary Aide J reported that dietary aides and cooks were responsible for stocking the dry storeroom. The facility's policy around date marking food was to date and discard after three days. Cooks were responsible for cleaning kitchen and food service equipment daily or after each use. Dietary aides were responsible for cleaning the microwaves and ice machines in the nourishment rooms. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/07/24 at 12:19 PM, [NAME] K reported that the dietary aides were responsible for stocking dry foods in the dry storage room, and the cooks were responsible for stocking frozen and produce foods. The facility's policy around date marking food was to add the open date, use by date, and discard after three days. Cooks were responsible for cleaning the meat slicer and mixer. [NAME] K stated the menu had not required kitchen staff to use the mixer. Kitchen equipment was cleaned each Wednesday. Dietary aides were responsible for cleaning the microwaves and ice machines in the nourishment rooms. When asked to explain the condensation build-up in the freezer, [NAME] K replied, It was reported to the Certified Dietary Manager (CDM). The freezer shields would get stuck and the door will open itself if you're not paying attention. On 11/07/24 at 12:51 PM, Maintenance Director L reported that Maintenance requests were received from staff verbally and through the computer. He added verbal requests to the computer. He was aware of the condensation build-up in the walk-in freezer. He said the gasket was replaced twice and Maintenance was currently monitoring. He reported the freezer issue to the vendor on 10/29/24 via a verbal conversation. The vendor stated they would stop by the next day. There was no documented evidence of the request for service. There had been no follow-up with the vendor since 10/29/24. A review of the facility's policy and procedure titled Food Safety Requirements (undated), revealed: Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state and local authorities. Food will also be stored, prepared, distributed and served in accordance with professional standards for food service safety. Policy Explanation and Compliance Guidelines: 1. Food safety practices shall be followed throughout the facility's entire food handing process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include the following: . b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms . e. Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food . 3ci. Monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation . iv. Labeling, dating, and monitoring refrigerated foods, including, but not limited to leftovers, so it is used by its use-by date, or frozen (where applicable)/discarded; and v. keeping foods covered or in tight containers . 8e. Cleaning and sanitizing the internal components of the ice machine according to manufacturer's guidelines. (copy obtained) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105366	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vivo Healthcare University	3648 University Blvd S Jacksonville, FL 32216

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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Reference: FDA Food Code 2022 Annex 5. Conducting Risk-Based Inspections Annex 5 - C. Intervention Strategies for Achieving Long-term Compliance. 4. Establish First-In-First-Out (FIFO) Procedures. Page 31. https://www.fda.gov/media/164194/download (Accessed on 5/24/2024): Product rotation is important for both quality and safety reasons. First-In-First Out (FIFO) means that the first batch of product prepared and placed in storage should be the first one sold or used. Date marking foods as required by the Food Code facilitates the use of a FIFO procedure in refrigerated, ready-to-eat, TCS foods. The FIFO concept limits the potential for pathogen growth, encourages product rotation, and documents compliance with time/temperature requirements. Equipment, Utensils, and Linens. 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. 4-6 Cleaning of Equipment and Utensils, 4-601 Objective, Equipment Food-Contact Surfaces and Utensils. (A) Equipment Food Contact Surfaces and Utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.