STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105491	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vivo Healthcare Gandy	4610 S Manhattan Ave Tampa, FL 33611

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, interviews, and record reviews, the facility failed to provide staff with adequate training on issues regarding language barriers reported through grievances via the resident council and residents in seven of seven grievances sampled for review.Findings include: On 1/28/26 at 2:20 pm, an interview with Resident #7 revealed language is still a big barrier at the facility. Resident #7 stated Resident Council has been discussing this issue for months, and no resolution has been made. Resident #7 stated staff will just shove their phone in the resident's faces and try to make them use a translator application. Resident #7 refuses to use the translator for communication. Resident #7 believes they should be able to communicate with staff without having to use a translator. Resident #7 said they hear staff speak Spanish while caring for other residents who are also only English speaking. A review of Resident #7's admission record revealed an original admission date of 11/28/22, with a readmission date of 1/14/25, with diagnoses to includer respiratory failure, seizures, and difficulty walking. A review of Resident #7's Quarterly Minimum Data Set (MDS) assessment, dated 12/3/25, revealed a Brief Interview Mental Score (BIMS) of 15, meaning resident is cognitively intact. A review of the facility's grievances revealed the following: 5/13/25 a grievance from a resident residing on Unit Three at the facility CNA providing care could not answer a question for [resident's name] because she could not speak English. She did not understand what [resident's name] was asking herResolution: Blank 5/23/25 a grievance from a resident residing on Unit Two at the facility Resident and [family member] complained to social worker that resident has difficult time communicating with [Care Staff Member], language barrier, and has poor response timeResolution: Employee was counseledNo follow up documented 6/2/25 a grievance from the Resident Council meeting Residents state the staff speak Spanish to each other during mealtimes in the dining room in front of non-Spanish speaking residents.Resolution: Staff inserviced 6/6/25In-service on 6/6/25-English (Primary Language in Facility): English is the primary language to be spoken in the facility unless you are speaking with a resident in their primary language. All employees must speak English at all times in the facility. 6/2/25 a grievance from the Resident Council meeting Residents state the CNAs on station three do not speak/know very little EnglishResolution: Staff inservice 6/6/25In-service on 6/6/25-English (Primary Language in Facility): English is the primary language to be spoken in the facility unless you are speaking with a resident in their primary language. All employees must speak English at all times in the facility. 7/1/25 a grievance from the Resident Council meeting Residents state the staff speak Spanish to each other during mealtimes in the dining room in front of non-Spanish speaking residents.Resolution: Already educating on this areaIn-service on 6/30/25-Primary Language in Facility: English is the primary language to be spoken in the facility unless you are speaking with a resident in their primary language. All employees must speak English at all times in the facility. 7/1/25 a grievance from the Resident Council meeting Residents state the CNAs on station three do not speak/know very (continued on next page)

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

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	little EnglishResolution: Already education in this area 7/4/25In-service on 6/30/25-Primary Language in Facility: English is the primary language to be spoken in the facility unless you are speaking with a resident in their primary language. All employees must speak English at all times in the facility. 7/21/25 a grievance from a resident residing on Unit Three at the facility States that aide today didn't understand him.Resolution: Aide moved off assignment. 7/23/25No follow up documented. A review of the facility's resident council minutes revealed the following: On 6/2/25 Residents state the CNAs on station three do not speak English/know very little English.Not Resolved-Action Needed Residents state the staff speak Spanish to each other during mealtimes in the dining room in front on non-Spanish speaking residentsNot Resolved-Action Needed On 7/1/25 Residents state the CNAs on station three do not speak English/know very little English. Residents feel uncomfortable with staff using phone to translateNot Resolved-Action Needed Residents state the staff speak a language other than English to each other during mealtimes in the dining room in front of English-speaking residents.Not Resolved-Action NeededCompliments/Notes of Appreciation: Residents stated last month grievances regarding nursing have not been resolved and would like action taken. On 9/1/25 Residents state the CNAs on station three do not speak English/know very little English. Residents feel uncomfortable with staff using phone to translate from Spanish to EnglishNot Resolved-Action Needed On 1/28/26 at 9:46 am, an interview with Staff H, Certified Nursing Assistant (CNA), was attempted. The interview did not occur due to a language barrier of Staff H, CNA not being able to understand the questions being asked in English. On 1/30/26 at 10:14 am, an interview with Staff A, Licensed Practical Nurse (LPN)/Unit Manager (UM), said communicating with staff on Unit 3 is easier for her due to being able to communicate in Spanglish. Staff A, LPN/UM stated it is hard for the CNAs on the unit to understand clinical questions if you don't speak slowly and clearly. Staff A, LPN/UM said resident council brings up hearing staff speaking Spanish in the hallways every month. Staff A, LPN/UM said she tries to encourage staff to speak English as much as possible. Staff A, LPN/UM stated staff will use a translator application on their phones to communicate between residents and English-speaking staff members. On 1/30/26 at 11:43 am, an interview with the Social Services Director (SSD) said there are grievances related to language barriers regarding residents and the care staff. The SSD stated in-services have occurred with staff reminding them not to speak other languages while caring for residents. The SSD said giving a verbal reminder is not being effective in correcting the issue and the care staff knows better. The SSD said grievances related to language barriers were handled by the Director of Nursing (DON). The SSD said the grievance should be completed to include the resolution. On 1/20/26 at 12:11 pm, an interview with the Social Worker (SW), said there is a potential issue with Spanish speaking staff and residents. The SW stated care staff is not allowed to use translators to communicate with the residents. The SW said being able to communicate and read English is a requirement for staff. The SW said they do not specifically document resolutions to grievances presented to them. On 1/30/26 at 12:52 pm, an interview with the Regional Director of Operations (RDO) said the facility must go beyond verbal communication to resolve a repeating issue. The RDO stated something more should have been done by the facility to provide the staff with resources, and residents with resolution to their grievances, and communication in a language they understand. The RDO said the expectation for staff is to speak the primary language of the residents, which is primarily English.A review of the facility's Culturally Competent Care policy revealed the following: It is the policy of this facility to provide culturally competent care in accordance with professional standards of practice. The facility has established a culture that treats each resident with respect and dignity as an individual, as well as address, supports and/or enhances his/her feelings of self-worth including (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	personal control over choices and cultural preference. 'Culture' is the conceptual system that structures the way that people view the world-it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize the world. 'Cultural Competency' is defined as a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Cultural competence involves valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, and acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communication. 'Effective communication' describes a process of dialogue between individuals. The skills include speaking to others in a way they can understand and active listening and observation of verbal and non-verbal cues. Understanding what the resident is trying to communicate is essential to giving a response. Additionally, effective communication ensures that information provided to the resident is provided in a form and manner that the resident can access and understand, including a language that the resident can understand. The facility will provide sufficient guidance for staff, including temporary staff, on how to communicate and deliver care for the resident. Direct care staff will be trained on effective communication that reflects the needs of the resident population and needs of the staff and will correspond with the Facility Assessment. A review of the facility's Resident and Family grievances policy dated revised 01/2026, revealed: . 'Prompt efforts to resolve' include the facility acknowledgment of a complaint/grievance and actively working toward resolution of that complaint/grievance. The facility Social Services Director has been designated as the Grievance Official and can be reached at [SSD Contact Number]. The facility will make prompt efforts to resolve grievances.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and review of the facility policy, the facility failed to ensure allegations of abuse and neglect were reported in a timely manner for four (#3, #4, #5 and #6) of five residents reviewed.Findings include: Review of a facility policy titled, Abuse, Neglect and Exploitation, revised 1/2026, showed it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.Definitions: . Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.VII. Reporting/ResponseA. The facility will have written procedures that include:1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, orb. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.2. Assuring that reporters are free from retaliation or reprisal;3. Promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports a suspicion of a crime. This facility will post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if the employee believes the facility has retaliated against him/her for reporting a suspected crime and how to file such a complaint.4. Reporting to the state nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service;5. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following:a. Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences;b. Defining how care provision will be changed and/or improved to protect residents receiving services;c. Training of staff on changes made and demonstration of staff competency after training is implemented;d. Identification of staff responsible for implementation of corrective actions;e. The expected date for implementation; andf. Identification of staff responsible for monitoring the implementation of the plan.B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. 1.Review of the admission record revealed Resident #3 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses to include metabolic encephalopathy, major depressive disorder, antineoplastic chemotherapy, secondary malignant neoplasm of unspecified lung, Malignant neoplasm of the brain, severe calorie malnutrition, Cachexia, COPD, personal history of pneumonia, Acute history respiratory failure with hypoxia. Review of a witness statement dated [DATE] revealed, Security camera footage of the smoking patio from [DATE], shows a resident [Resident #3] assigned to (Staff B, Certified Nursing Assistant- (CNA)) for care entering the smoking patio in the afternoon, where he remained for the duration of the afternoon. Resident #3 is seen on the video footage remaining on the smoking patio without receiving any visits or care from staff nor assigned CNA. At 5 p.m., Resident #3 was found unresponsive by another staff member (not identified). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3 was assisted indoors, and a code blue was called. Video shows that Resident #3 did not receive care from [Staff B, CNA] for over 4.5 hours. The statement was signed by Staff A, Licensed Practical Nurse (LPN), and dated [DATE]. Review of the facility's abuse logs dated [DATE] through [DATE] did not reveal the incident with Resident #3. On [DATE] at 11:32 a.m. an interview was conducted with the Nursing Home Administrator (NHA) and the Regional Director of Clinical Services (RDCS). The NHA stated there was no allegation of neglect and there would not have been a reason to report/investigate. She stated at the time the patio was not supervised but staff in the dining room had clear view of the patio. During an interview on [DATE] at 6:16 p.m. with the RDCS and the NHA they stated they did not investigate/report Resident #3's sudden death at the patio despite the allegation of the resident being unattended for 4.5 hours. The NHA stated they did not see it as needed to be investigated or reported. On [DATE] at 1:13 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated the incident was, just a regular code, we did not investigate or report. The DON stated at the time there was no hydration cart and there was no supervision of the patio. The DON stated this was not a reportable event. It was not an abuse or neglect issue. She said, We would report a death that would be questionable in the facility. If they were not expected to die. The DON stated Resident #3 had a lot of terminal diagnoses, and the prognosis was not good. She stated she was surprised he died that day. The DON said regarding the sudden death, It did not raise an alarm for me. On [DATE] at 4:55 p.m. an interview was conducted with Staff C, Licensed Practical Nurse (LPN) and evening supervisor. Staff C stated there was no sign the resident was going to die. She stated the resident had an appointment the day before and there was, nothing obviously concerning. Staff C said she did not think to investigate/report as Resident #3 was alert and pushed himself out to the patio. Staff C said, I was not supervising him. There was no clear view of him while out there. The incident was not witnessed by staff. We don't know what happened. Staff C stated the resident was suddenly found unresponsive. On [DATE] at 5:11 p.m., a telephone interview was conducted with Staff B, CNA. Staff B, CNA said not remembering Resident #3, nor an incident occurring on [DATE]. Staff B, CNA said, No, I don't have the memory of an elephant. When asked if he recalled the resident sitting outside for four or more hours, he said he did not leave a resident outside for four hours, but also said he did not remember the resident. On [DATE] at 9:15 a.m. an interview with the RDCS and the facility's Chief Nursing Officer (CNO) revealed, We became aware last night of the witness statement of the resident left outside for 4.5 hours and have now reported neglected. We suspended the DON, unit manager and the NHA, pending investigation. The CNO said they interviewed [Staff A, LPN] and asked why the statement did not go anywhere. The CNO said, She was essentially focusing on the caregiver not the resident. We know the way it looks; it is not good, she said the CNA was not good, so she wanted to school the CNA and get back at him. The RDCS stated Staff A, LPN did not review the video for four and half hours of video. She stated the administration was not forthcoming at all. She stated they had an unsupervised smoking patio which they corrected in [DATE]. The RDCS said, I wanted to be transparent. I have integrity. I did not know about the 4.5 hours. I would have investigated it further. The RDCS stated they took immediate action last night and have several staff members who will not be returning. The RDCS said, We have now reported the neglect allegation. The CNO stated they became aware the NHA had a culture of hiding everything. She said, She is not returning. She hid stuff from us. The CNO stated they would not have an unethical culture. On [DATE] at 9:54 a.m. a follow-up interview was conducted with Staff A, LPN. Staff A, LPN stated the statement previously written regarding [Resident #3] remained on the patio for 4.5 hours unattended was false. Staff A said, I do not believe he was toileted, but other staff cared for him. When Resident #3 coded I did not see (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he was soiled. I do not think he [Staff B, CNA] changed him. Staff A said, The administration was aware of the statement. They did not report it. They could have investigated and reported it if they wanted to. Staff A stated the statement was written about the staff's performance. She stated she did not think about the resident at the time. Staff A stated to her knowledge, Resident #3 was not toileted during the 4.5 hours. 2.Resident #4 was admitted to the facility on [DATE] with a primary diagnosis of hemiplegia and hemiparesis. A review of the facility's abuse log revealed an abuse allegation was filed for Resident #4 dated [DATE]. Review of a psychology progress note treatment plan dated [DATE] revealed, [Resident #4] is seen today at the request of the facility relative to his allegation of harm at the hands of a professional. [Resident #4] is alert and oriented. He is easily engaged and provides information relative to his allegation of the assault. He maintains eye contact and is attentive. He is not animated, his affect is flat. He repeats words to seemingly emphasize their relevance to him. [Resident #4] reports that a person by the name of [Staff D, title unknown) comes to his room and violates his space by patting him on the head and pinching his cheek asking, how is my guy today. He comes to his room at dusk. [Resident #4] feels demeaned by the interaction. He emphasizes the word violates several times in his conversation. [Resident #4] is not sure of [Staff D's] role. He does not want [Staff D] returning to his room. This happened in the last several days prior to the session. During an interview conducted with the NHA on [DATE] at 5:54 p.m., the NHA stated Resident #4 alleged a short haired man, slapped him and he reported it to the nurse, two days prior. The NHA stated Resident #4 was assessed and there were no injuries. The NHA said, He could not give a name, contrary to the note above. The NHA stated the resident had a similar incident occur in [DATE], at which he alleged a violation that occurred in his room. The NHA stated the incidents were not substantiated. She stated she did not have a name to go by. The NHA did not identify who [Staff D] was and did not reveal the person was part of the investigation. The NHA stated she reported the incident which occurred on [DATE] at 4:29 p.m. She stated she reported the abuse the next day, notified DCF (Department of Children and Families) on [DATE] at 10:08 a.m. and AHCA (Agency for Health Care Administration) on [DATE] at 10:05 a.m. The NHA acknowledged the reporting did not meet their policy standards. She stated, I was educated on the reporting requirements. It should have been within two hours. She confirmed she could have investigated further to confirm who Staff D was. 3.Resident #5 was admitted to the facility on [DATE] with a primary diagnosis of Hemiplegia and Hemiparesis. Review of the facility's abuse log revealed the resident had an incident on [DATE]. During an interview conducted with the NHA on [DATE] at 5:54 p.m., the NHA stated on [DATE] at 2:00 p.m. Resident #5 reported an incident which occurred the night before on 11 p.m. - 7 a.m. shift. The NHA stated the resident reported a female came into her room and refused to give her the call light which was not within reach. The resident reported the staff member said she was not her assigned CNA and that she did not have a CNA and left. The resident stated she needed to be changed, and this CNA did not change her. The NHA stated she reviewed Resident #5's chart and did not see any documentation of the resident being changed, but once at 8:17 p.m. She stated she interviewed the CNA who was assigned and they said they were attending to another resident but eventually came back to Resident #5. The NHA stated they did not have an exact time when this occurred. She stated they could not get to the bottom of it because, the resident has glaucoma, she could not see clearly to tell us who it was. The NHA stated the resident was seen by psych and denied being abused. The NHA said the resident said, it was probably a misunderstanding. She stated having witness statements that were not reviewed during this investigation process. The NHA stated she treated this as a neglect incident and did not see it as abuse. She said it was not abuse because there was no physical injury. The NHA said she was notified (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on [DATE] at 2:30 p.m. and reported to AHCA on [DATE] at 7:48 p.m. The NHA said, To my knowledge we have 24 hours if there is no injury. The NHA confirmed abuse allegations should be reported within 2 hours. She stated they reviewed the abuse policy. Reviewed policy showed abuse also includes the deprivation by an individual, including a caretaker of goods or services. 4.Review of the admission record for Resident #6 revealed an admission date of [DATE] with diagnoses to include muscle wasting and atrophy, cognitive communication deficit disorder, and unspecified dementia. Review of the facility's abuse log revealed an allegation of abuse was filed on [DATE]. Review of a psychology progress note dated [DATE] revealed, client reported that three people (1 male and 2 females) were in her room. The male was asleep with her in her bed when one of the females began hitting her. She stated the female began to feed others in the room before they all left. During an interview conducted with the NHA on [DATE] at 5:54 p.m., the NHA stated a family member alleged on [DATE] at 1:05 p.m. the resident was beat up by staff. The NHA stated she was notified of the incident when it happened. She stated she notified DCF on [DATE] at 2:50 p.m. She stated she notified AHCA on [DATE] at 3:59 p.m. The NHA stated, I know it was not within the two hours. I was with the police. I was not able to do it. The NHA stated reporting of abuse incidents should be within two hours. She stated their investigation was on-going. On [DATE] at 11:30 a.m. an interview was conducted with the RDCS. She confirmed there were no reports filed or investigated for Resident #3. The RDCS stated they were reviewing their reportable events. She stated the NHA should have filed reports in the required timeframes. She stated if the NHA could not do it for one reason or another, another staff member could submit the report.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and review of the facility policy, the facility failed to thoroughly investigate allegations of abuse and neglect in a timely manner for four residents (#3, #4, #5 and #8) of five residents reviewed.Findings include: Review of a facility policy titled, Abuse, Neglect and Exploitation, revised 1/2026, showed it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.Definitions: . Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur.B. Written procedures for investigations include:1. Identifying staff responsible for the investigation;2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence);3. Investigating different types of alleged violations;4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and6. Providing complete and thorough documentation of the investigation. 1.Review of the admission record revealed Resident #3 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses to include metabolic encephalopathy, major depressive disorder, antineoplastic chemotherapy, secondary malignant neoplasm of unspecified lung, malignant neoplasm of the brain, severe calorie malnutrition, Cachexia, COPD, personal history of pneumonia, Acute history respiratory failure with hypoxia. Review of a witness statement dated [DATE] revealed, Security camera footage of the smoking patio from [DATE], shows a resident [Resident #3] assigned to (Staff B, Certified Nursing Assistant- (CNA)) for care entering the smoking patio in the afternoon. He [Resident #3] is seen on the video footage remaining on the smoking patio in the afternoon. He is seen on the video footage remaining on the smoking patio without receiving any visits or care from his assigned CNA. At 5 p.m. the resident was found by other staff to be unresponsive. He was assisted indoors and subsequently a code blue was called. Video shows that the resident received no care of kind from [Staff B, CNA] for over 4.5 hours. The statement was signed by Staff A, Licensed Practical Nurse (LPN), and dated [DATE]. Review of the facility's abuse logs dated [DATE] through [DATE] showed the incident above was not listed. On [DATE] at 11:32 a.m. an interview was conducted with the Nursing Home Administrator (NHA) and the Regional Director of Clinical Services (RDCS). The NHA stated there was no allegation of neglect and there would not have been a reason to report/investigate. She stated at the time the patio was not supervised but staff in the dining room had clear view of the patio. During an interview on [DATE] at 6:16 p.m. with the RDCS and the NHA stated they did not investigate/report Resident #3's sudden death near the patio despite the allegation of the resident being unattended for 4.5 hours. The NHA stated they did not see it as needed to be investigated or reported. On [DATE] at 1:13 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated the incident was, just a regular code, we did not investigate or report. The DON stated at the time there was no hydration cart and there was no supervision of the patio. The DON stated this was not a reportable event. It was not an abuse or neglect issue. She said, We would report a (continued on next page)

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	105491	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vivo Healthcare Gandy	4610 S Manhattan Ave Tampa, FL 33611

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	death that would be questionable in the facility. If they were not expected to die. The DON stated Resident #3 had a lot of terminal diagnoses, and the prognosis was not good. She stated she was surprised he died that day. The DON said regarding the sudden death, It did not raise an alarm for me. On [DATE] at 4:55 p.m. an interview was conducted with Staff C, Licensed Practical Nurse (LPN) and evening supervisor. Staff C stated there was no sign the resident was going to die. She stated the resident had an appointment the day before and there was, nothing obviously concerning. Staff C said she did not think to investigate/report as Resident #3 was alert and pushed himself out to the patio. Staff C said, I was not supervising him. There was no clear view of him while out there [on the patio]. The incident was not witnessed by staff. We don't know what happened. Staff C stated the resident was suddenly found unresponsive. On [DATE] at 5:11 p.m., a telephone interview was conducted with Staff B, Certified Nursing Assistant (CNA). Staff B, CNA said he did not remember Resident #3. He said he did not remember an incident that occurred on [DATE]. Staff B, CNA said, No, I don't have the memory of an elephant. When asked if he recalled the resident sitting outside for four or more hours, he said he did not leave a resident outside for four hours. On [DATE] at 9:15 a.m. an interview with the RDCS and the facility's Chief Nursing Officer (CNO) revealed, We became aware last night of the witness statement of the resident left outside for 4.5 hours and have now reported neglected. We suspended the DON, unit manager and the NHA, pending investigation. The CNO said they interviewed [Staff A,LPN] and asked why the statement did not go anywhere. The CNO said, She was essentially focusing on the caregiver not the resident. We know the way it looks; it is not good, she said the CNA was not good, so she wanted to school the CNA and get back at him. The RDCS stated Staff A, LPN did not review the video for four and half hours of video. She stated the administration was not forthcoming at all. She stated they had an unsupervised smoking patio which they corrected in [DATE]. The RDCS said, I wanted to be transparent. I have integrity. I did not know about the 4.5 hours. I would have investigated it further. The RDCS stated they took immediate action last night and have several staff members who will not be returning. The RDCS said, We have now reported the neglect allegation. The CNO stated they became aware the NHA had a culture of hiding everything. She said, She is not returning. She hid stuff from us. The CNO stated they could not have an unethical culture. On [DATE] at 9:54 a.m. a follow-up interview was conducted with Staff A, LPN. She stated the statement she wrote that [Resident #3] remained on the patio for 4.5 hours unattended was false. Staff A said, I do not believe he was toileted, but other staff cared for him. When he coded, I did not see that he was soiled. I do not think he [Staff B, CNA] changed him. Staff A said, The administration was aware of the statement. They did not report it. They could have investigated and reported it if they wanted to. Staff A stated the statement was written about the staff's performance. She stated she did not think about the resident at the time. Staff A stated to her knowledge, Resident #3 was not toileted during the 4.5 hours. 2.Resident #4 was admitted to the facility on [DATE] with a primary diagnosis of hemiplegia and hemiparesis. A review of the facility's abuse log dates [DATE] -[DATE] revealed an abuse allegation was filed for Resident #4 dated [DATE]. Review of a psychology progress note treatment plan dated [DATE] revealed, [Resident #4] is seen today at the request of the facility relative to his allegation of harm at the hands of a professional. [Resident #4] is alert and oriented. He is easily engaged and provides information relative to his allegation of the assault. He maintains eye contact and is attentive. He is not animated, his affect is flat. He repeats words to seemingly emphasize their relevance to him. [Resident #4] reports that a person by the name of [Staff D, title unknown) comes to his room and violates his space by patting him on the head and pinching his cheek asking, how is my guy today. He comes to his room at dusk. [Resident #4] feels demeaned by the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interaction. He emphasizes the word violates several times in his conversation. [Resident #4] is not sure of [Staff D's] role. He does not want [Staff D] returning to his room. This happened in the last several days prior to the session. During an interview conducted with the NHA on [DATE] at 5:54 p.m., the NHA stated Resident #4 alleged a short haired man, slapped him and he reported it to the nurse, two days prior. The NHA stated Resident #4 was assessed and there were no injuries. The NHA said, He could not give a name, contrary to the note above. The NHA stated the resident had a similar incident occur in [DATE], at which he alleged a violation that occurred in his room. The NHA stated the incidents were not substantiated. She stated she did not have a name to go by. The NHA did not identify who [Staff D] was and did not reveal the person was part of her investigation. The NHA stated she reported the incident which occurred on [DATE] at 4:29 p.m. She stated she reported the abuse the next day, notified DCF (Department of Children and Families) on [DATE] at 10:08 a.m. and AHCA (Agency for Health Care Administration) on [DATE] at 10:05 a.m. The NHA acknowledged the reporting did not meet their policy standards. She stated, I was educated on the reporting requirements. It should have been within two hours. 3.Resident #5 was admitted to the facility on [DATE] with a primary diagnosis of Hemiplegia and Hemiparesis. Review of the facility's abuse log dates [DATE] -[DATE] revealed the resident had an incident on [DATE]. During an interview conducted with the NHA on [DATE] at 5:54 p.m., the NHA stated on [DATE] at 2 p.m. Resident #5 reported an incident which occurred the night before on 11 p.m. - 7 a.m. shift. The NHA stated the resident reported a female came into her room and refused to give her the call light which was not within reach. The resident reported that the staff member said she was not assigned CNA and that she did not have a CNA and left. The resident stated she needed to be changed, and this CNA did not change her. The NHA stated she reviewed Resident #5's chart and did not see any documentation of the resident being changed, but once at 8:17 p.m. She stated she interviewed the CNA who was assigned and they said they were attending to another resident but eventually came back to Resident #5. The NHA stated they did not have an exact time when this occurred. She stated they could not get to the bottom of it because, the resident has glaucoma, she could not see clearly to tell us who it was. The NHA stated the resident was seen by psych and denied being abused. The NHA said the resident said, it was probably a misunderstanding. She stated having witness statements that were not reviewed during this investigation process. The NHA stated she treated this as a neglect incident and did not see it as abuse. She said it was not abuse because there was no physical injury. The NHA said she was notified on [DATE] at 2:30 p.m. and reported to AHCA on [DATE] at 7:48 p.m. The NHA said, To my knowledge we have 24 hours if there is no injury. The NHA confirmed abuse allegations should be reported within 2 hours. She stated they reviewed the abuse policy. Reviewed policy showed abuse also includes the deprivation by an individual, including a caretaker of goods or services. 4.Resident #8 was admitted to the facility on [DATE] with diagnosis to include Diabetes Mellitus. Review of the facility's abuse log dated [DATE] through [DATE] showed an allegation of abuse was documented for Resident #8 on [DATE]. An interview was conducted with the NHA on [DATE] at 5:54 p.m. regarding the incident. The NHA stated Resident #8 reported on [DATE] at 3:20 a.m. she was abused by staff. The NHA stated the resident thought it was abuse because the nurse would not leave her medications at bedside. The NHA stated even though the resident alleged abuse, she did not take it as abuse. She stated that night the resident refused care from her aide. She said the CNA had taken care of her before and she could not think of why she would refuse care from her. The NHA said she interviewed the CNA who said nothing happened on her shift. The NHA said, I thought it was odd, but I did not question her further. The NHA said the resident accepted care and medication from another nurse. The NHA stated being notified at 3:45 a.m. She stated she submitted (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an online neglect report to DCF at 4:52 p.m., police department at 4:05 p.m. and to AHCA on [DATE] at 5:31 p.m. The NHA said, She was saying she was abused, but I did not think it was abuse. She stated her findings were that it was neglect because the medications were provided. The NHA stated the resident refused to be interviewed by herself on [DATE] and [DATE]. She stated she believed the DON may have tried but it was not documented. The NHA said, I don't know why she refused that I interview her. I don't know what she meant by being abused. I never found out. The NHA stated she could have investigated why the resident alleged abuse and why she refused care from her CNA. On [DATE] at 11:30 a.m. an interview was conducted with the RDCS. The RDCS confirmed there were no reports filed or investigated for Resident #3. The RDCS stated they were reviewing their reportable events. She stated the NHA should have filed reports in the required timeframes. She stated if the NHA could not do it for one reason or another, another staff member could submit the report. Review of a job description signed by the Nursing Home Administrator on [DATE] revealed - the primary purpose of your position is to direct the day-to-day functions of the Facility in accordance with current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times.Duties and responsibilities included:-Review resident complaints and grievances and make written reports of action taken. Discuss such actions with resident and family as appropriate.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with the facility's nursing and administrative staff, record review and review of the facility policies, the facility administration failed to utilize their resources effectively to ensure allegations of abuse and neglect were thoroughly investigated and reported in a timely manner for five residents (#3, #4, #5, #6 and #8) out of five residents sampled for abuse and neglect, putting all the residents of the facility at risk for ongoing abuse and neglect. [Cross reference F609 and F610].Findings included: Review of a job description signed by the Nursing Home Administrator on [DATE] revealed - the primary purpose of your position is to direct the day-to-day functions of the Facility in accordance with current federal, state and local standards guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times.Duties and responsibilities included:Resident Rights: Ensure that the resident's rights to fair and equitable treatment, self-determination, individuality, privacy. property and civil rights. including the right to wage complaints. are well established and maintained at all times. Review resident complaints and grievances and make written reports of action taken. Discuss such actions with resident and family as appropriate. Assist in establishing and implementing a Resident/Group Council. Ensure that policies governing the timely notice for resident discharges and/or room or roommate changes are strictly followed by all personnel. Ensure that resident funds maintained by the Facility are managed in accordance with current federal and state regulations and that appropriate accounting records are maintained. Maintain the confidentiality of all resident care information including protected health information. Report known or suspected incidents of unauthorized disclosure of such information. Review complaints and grievances made by the resident and make a written or oral report to the Nurse Supervisor, LPN, or RN. Follow Facility's established procedures. Maintain a written record of the resident's complaints and/or grievances that indicates the action taken to resolve the complaint and the current status of the complaint. Report all allegations of resident abuse and/or misappropriation of resident property. Must adhere to all HIPAA requirements.Review of a job description signed by the Director of Nursing (DON) on [DATE] revealed - Registered Nurses at [Name of Facility] provide direct bedside care and act as patient advocate and educator. The RN will educate the patient and family members what to expect when dealing with the challenges of aging or specific conditions the patient may have and help them understand what contributions to recovery and long-term wellness they can make. The RN will also inform family members of any changes in the patient's condition and discuss with them any alterations to the patient's medication or other treatments. Collaborating with the facility physician to help create and implement patient care plans and notifying the physician if there is a change in the patient's condition.Essential functions revealed the following: Promote the mission, vision, and values of the organization Provide basic nursing care to patients within [Name of facility] center's scope of practice that includes actions that meet psychosocial needs and physical needs. Provides direct and individualized nursing care to assigned patients based on nursing standards and under the supervision of the Director of Nursing. Ensures quality and safe delivery of nursing services to patients/clients and families/caregivers. Implements plan of care formulated by physicians. Provides accurate and timely documentation consistent with plan of care. Assesses and provides patient/client education and information pertinent to diagnosis and plan of care. Maintains safe and healthy working environment and uses safe work methods and procedures in accordance with company clinical standards. Assists patient in learning appropriate self-care activities. Uses equipment and supplies effectively and efficiently. Ensuring all work areas and residents' rooms (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	are maintained in accordance with safety and sanitation standards. Ordering medications, equipment and supplies as prescribed. Preparing and administering medications ordered by the physician in accordance with policies and procedures. ' Attending rounds with physicians, nurse practitioners and physician's assistants. Assisting with the orientation of new staff to the unit. Collaborating with the resident's physician to provide the care, services, treatments, and rehabilitation ordered. Communication with the resident's physician and/or family members when there is a change in resident's condition or if any incident occurs involving patient. Administering professional nursing practice services such as: tube feedings, suction, catheterization, changing of dressings, packs, and irrigations, as necessary. Gathering samples of sputum, urine and other specimens for lab tests as ordered. Continuous observation and monitoring of seriously ill residents. Being the patient advocate and ensuring that other health care team members are providing care according to the resident's care plan and personal wishes. Receiving, transcribing, and implementing physician's orders according to facility procedures. Accurately completing necessary charting as required and in a timely manner following established charting policies and procedures.Review of the admission record revealed Resident #3 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses to include metabolic encephalopathy, major depressive disorder, antineoplastic chemotherapy, secondary malignant neoplasm of unspecified lung, Malignant neoplasm of the brain, severe calorie malnutrition, Cachexia, COPD, personal history of pneumonia, Acute history respiratory failure with hypoxia.Review of a witness statement dated [DATE] revealed, Security camera footage of the smoking patio from [DATE], shows a resident [Resident #3] assigned to (Staff B, Certified Nursing Assistant- CNA) for care entering the smoking patio in the afternoon. He is seen on the video footage remaining on the smoking patio in the afternoon. He is seen on the video footage remaining on the smoking patio without receiving any visits or care from his assigned CNA. At 5 p.m. the resident was found by other staff to be unresponsive. He was assisted indoors and subsequently a code blue was called. Video shows that the resident received no care of kind from [Staff B, CNA] for over 4.5 hours. The statement was signed by Staff A, Licensed Practical Nurse (LPN), and dated [DATE]).Review of the facility's abuse log dated [DATE] through [DATE] showed the incident above was not listed.During a complaint survey conducted on [DATE] - [DATE] interviews with key personnel revealed the facility staff were not willing/able to participate in the survey process regarding the investigation of abuse and neglect. The key personnel who were employees of this facility during the period of the investigation included; Staff E, RN Unit Manager, Director of Rehabilitation (DOR), Housekeeping Manager, Assistant Director of Nursing, Social Services Directors 1 and 2, and Therapy Staff F and G. They denied knowing anything about Resident #3 having been left unattended for an alleged 4.5 hours, or that he coded and required CPR which lasted more than 10 minutes, from which the resident expired. Their answers included, I do not remember anything about that incident, The administration did not tell us anything, I do not know, I do not feel comfortable answering, I do not have specifics. At the time of the investigation, it was unclear if the key staff had not participated in the investigation of a traumatic event, or if they were not forthcoming, impacting the survey process. On [DATE] at 9:15 a.m. an interview with the RDCS and the facility's Chief Nursing Officer (CNO) revealed, We became aware last night of the witness statement of the resident left outside for 4.5 hours and have now reported neglected. We suspended the DON, unit manager and the NHA, pending investigation. The CNO said they interviewed [Staff A,LPN] and asked why the statement did not go anywhere. The CNO said, She was essentially focusing on the caregiver not the resident. We know the way it looks, it is not good, she said the CNA was not good, so she wanted to school the CNA and get back at him. The RDCS stated Staff A, LPN did not review the video (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	for four and half hours of video. She stated the administration was not forthcoming at all. She stated they had an unsupervised smoking patio which they corrected in [DATE]. The RDCS said, I wanted to be transparent. I have integrity. I did not know about the 4.5 hours. I would have investigated it further. The RDCS stated they took immediate action last night and have several staff members who will not be returning. The RDCS said, We have now reported the neglect allegation. The CNO stated they became aware the NHA had a culture of hiding everything. She said, She is not returning. She hid stuff from us. The CNO stated they could not have an unethical culture.Review of a facility policy titled, Compliance and Ethics Reporting, revised 01/2026 revealed the facility implements and publicizes a reporting system that allows anyone to report compliance violations anonymously without fear of retribution and that ensures the integrity of the reports.Policy explanation and compliance guidelines:1. This facility supports an open door policy in which anyone may discuss concerns or report compliance violations to any supervisor, manager, HR representative, or compliance professional at any time.2. The facility has a designated contact person to which anyone may report suspected violations. This person is (insert job title) and may be reached at (insert contact information, or location of contact information).3. This facility has a (hotline number, intranet application, drop box, etc.) for reporting suspected violations anonymously, without fear of retribution.4. Information related to reporting compliance violations is posted (insert locations). Training shall be provided on a regular basis, not less than upon orientation and annually, to remind individuals of the reporting system, what to report, timeframes for reporting, and how to report.5. All information pertaining to a report will be kept confidential within the law. Anyone who reports a violation or suspected violation in good faith shall not be harassed, reprimanded, or discriminated against in any way.6. Employees with knowledge of a violation or suspected violation of the compliance program's standards, policies, and procedures are required to report it immediately. Staff who knowingly fail to report a violation shall be subject to disciplinary action, up to and including termination.7. Should any person have questions regarding compliance with state or federal laws, they should immediately seek clarification from the compliance officer, a supervisor, or through the facility hotline and/or web reporting.8. Once a report is received, an investigation will be conducted to determine whether a substantial violation or opportunity for improvement exists. Corrective actions will be implemented as necessary.9. The compliance and ethics program contact person shall follow up with those individuals making a report, except in those instances where the report was made anonymously.10. All reports will be tracked for purposes of QAPI and evaluating the effectiveness of the compliance and ethics program. Documentation shall be maintained for a minimum of three years by (insert job title).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure infection control practices were consistently followed to notify visitors of an influenza outbreak and/or offer personal protective equipment (PPE) such as masks prior to entering the resident care area and in nebulizer masks were not stored in a manner to prevent infection in two of four units (100 and 300).Findings Include: On 1/28/26 at 9:10 a.m. during the initial tour of the facility, all staff members observed in the resident care area were wearing masks. When asked, staff stated that mask use was required due to an influenza (flu) outbreak. Upon further review of the lobby area, no signage was posted to notify visitors of the outbreak or to recommend appropriate personal protective equipment (PPE) and the receptionist did provide information or instructions about the influenza outbreak. On 1/28 /26 at 10:25 a.m. an interview was conducted with Family Member #1 visiting room [ROOM NUMBER]. The visitor stated he had been at the facility this week and last week. He stated he was not notified there was a flu outbreak and he had not been offered a mask. The family member stated not knowing if his family member or his roommate had the flu. On 1/28/26 at 10:27 a.m. an interview was conducted with Family Member #2 visiting rooms [ROOM NUMBERS]. The family member stated she did not receive any notification regarding the flu outbreak. She stated there was no notification posted anywhere. She stated she was not offered a mask upon entering the facility. The family member stated she visited the facility daily. The family member stated the receptionist did not mention it. She said she became aware of the outbreak from being at the facility and seeing staff wearing masks. During an interview and record review on 1/28/26 at 10:30 a.m. with the Infection Preventionist (IP) nurse and the Regional Director of Clinical Services (RDCS), the IP nurse stated that the influenza outbreak began on 1/23/26, at which time 21 residents tested positive for the influenza virus. The IP nurse stated only reporting the newly identified positive residents on 1/26/26. Notification was completed to Resident Representatives (RR) of the flu outbreak by telephone, at this time. During a follow-up interview on 1/29/26 at 9:37 a.m. the IP nurse stated when the RRs were notified of the outbreak the facility did not encourage the use of masks as a precaution when visiting. She stated signage was not posted to notify visitors of the outbreak or to recommend/encourage the use of masks. On 1/28/26 at 10:10 a.m. while touring the facility on the 300 unit an uncovered nebulizer mask on the resident's dresser in front of the television was observed. On 1/28/26 at 10:40 a.m. while touring the facility on the 100 unit an uncovered nebulizer mask on a circular table in the resident's room was observed. (Photographic Evidence Obtained). During a follow-up interview and record review on 1/29/26 at 9:37 a.m. the IP nurse viewed the pictures of the uncovered nebulizer masks. The IP nurse stated the items should be stored in a bag, and all staff members have received instructions every nurse knows. Review of the facility's policy titled, Infection Prevention and Control Program, revised 1/2026 revealed the following: Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. Policy Explanation and Compliance Guidelines: 1) The designated Infection Preventionist is responsible for oversight of the program and serves as a consultant to our staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases. 2) All staff are responsible for following all policies and procedures related to the program .5g) Visitors coming to visit a resident who is on transmission-based precautions or quarantine, will be informed by the facility of the potential risk of visiting and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105491	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vivo Healthcare Gandy	4610 S Manhattan Ave Tampa, FL 33611

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	precautions necessary when visiting the and precautions necessary when visiting the resident . 13) Resident/Family/Visitor Education and Screening: a) Residents, family members, and visitors are provided information relative to the rationale for the isolation, behaviors required of them in observing these precautions, and conditions for which to notify the nursing staff. Isolation signs are used to alert staff, family members, and visitors of transmission-based precautions . 13) Resident/ Family/Visitor Education and Screening: a)Residents, family members, and visitors are provided information relative to the rationale for the isolation, behaviors required of them in observing these precautions, and conditions for which to notify the nursing staff. D) Passive screening, such as signs, are posted in the facility to alert family members use. Review of the facility's policy titled, Oxygen Administration, revised 1/2026 revealed the following: . 5 e) Keep delivery devices covered when not in use.