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	03/27/2026

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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure resident rights were honored, related to advance directives and code status, for one resident (#1) out of three residents sampled.On [DATE], facility staff initiated cardiac compressions (use of hands to push down hard and fast to manually pump blood through the heart. The pressure from cardiac compressions commonly causes physical damage including fractured ribs or sternum, bruising, and internal organ injury), on Resident #1 when the resident was found unresponsive for approximately twelve minutes. Failure to honor the resident's wishes for Do Not Resuscitate (DNR) caused unnecessary physical and psychosocial harm and denied Resident #1 a peaceful death.This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and or death to Resident #1 and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the scope and severity was reduced to a D after verification of removal of immediacy. Findings included:Review of Resident #1's medical record revealed an admission date of [DATE] with medical diagnoses to include: Cerebral Infarction, Chronic Obstructive Pulmonary Disease, Cardiomyopathy, Atherosclerotic Heart Disease of Native Coronary Artery Without Angina Pectoris, Nonrheumatic Mitral Valve Disorder Unspecified, Cognitive Communication Deficit, and Immunodeficiency due to conditions classified elsewhere.Review of Resident #1's order summary revealed:Do Not Resuscitate (DNR), created [DATE], no end date.DNR created, [DATE], no end date.Review of Resident #1's medical record documents revealed a Do Not Resuscitate order, dated [DATE], signed by Resident #1 and Staff G, Nurse Practitioner (NP). Review of a 3008 document, dated [DATE], revealed Resident #1's advance directive as a DNR.Review of Resident #1's Minimum Data Set (MDS), dated [DATE], Section C showed Resident #1 had a Brief Interview Mental Status of 15, which indicated intact cognition. Review of progress notes for Resident #1 revealed:-[DATE] 01:00 encounter The difference between Do Not Attempt Resuscitation (DNR/no CPR) and full code was explained to the patient over 30 minutes. The patient decided on a Do Not Attempt Resuscitation (DNR/no CPR) status. During a medical emergency, the patient does not wish to receive resuscitation efforts. --[DATE] 11:32 Social Service, Resident #1 requested and signed a DNR previously. Resident #1, again stated that she does not want to be resuscitated. Resident #1, informed staff that she wants to be a DNR and clearly stated that she does not want to go through chest compressions, etc.-[DATE], revealed the resident had been seen by a provider and the code status was DNR.Review of Resident #1's care plan revealed a focus area as:Resident #1 request DNR, initiated [DATE].The goal was for Resident #1's wishes to be honored, initiated [DATE].During an interview on [DATE] at 12:28 PM, Staff B, Licensed Practical Nurse (LPN), stated having heard an announcement for a code blue, on [DATE] and she went to Resident #1's room. Staff B stated upon arrival, having seen Resident #1 being transferred to the bed by Staff I, Registered Nurse (RN), and a Certified Nursing Assistant (CNA). Staff B stated Resident #1's eyes were closed and the resident was unresponsive. Staff B stated having asked what Resident #1's code status was and there was no response. Staff B stated having seen Staff I, begin chest compressions on Resident (continued on next page)

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

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#1. Staff B stated having seen Staff A RN, performing chest compressions on Resident #1. Staff B stated Resident #1 was a DNR.During an interview on [DATE] at 1:07 PM, Staff A RN, stated having heard an announcement for a code blue over the intercom on [DATE]. Staff A stated she went to Resident #1's room with Staff B LPN. Staff A stated upon arrival, having helped Staff I RN, and two CNA's put Resident #1 on a bed. Staff A stated at this point, Staff B asked what the code status was and Staff I did not know the code status. Staff A stated Staff B left the room to verify the code status for Resident #1. Staff A stated Staff I had begun assisting with chest compressions on Resident #1, and Staff A assisted with chest compressions as well. Staff A stated shortly after, Staff B returned to the room and stated Resident #1 was a DNR. Staff A stated having switched out with Staff C and Staff D as well, to provide chest compressions on Resident #1. Staff A stated she did not ask about Resident #1's advance directive.During an interview on [DATE] at 1:24 PM, Staff E CNA, explained having been assigned to Resident #1 on [DATE]. Staff E stated having checked on Resident #1 at 12:15 PM, and noticed the resident was sitting in a wheelchair and was not responding after calling out to the resident multiple times. Staff E stated she left the room and notified Staff I RN, of Resident #1's condition. Staff E stated she assisted Staff I, another nurse, and another CNA, with placing Resident #1 on a bed. During an interview on [DATE] at 1:44 PM, Staff D RN, stated having heard a page, for a code blue over the intercom on [DATE]. Staff D explained going to Resident #1's room and saw staff performing CPR on the resident. Staff D stated Staff A was using the bag valve mask, and Staff C was in the room. Staff D stated he assisted with chest compressions, once one of the other nurses got tired. Staff D stated afterwards, a staff member entered Resident #1's room and stated she's a DNR. Staff D explained not having checked Resident #1's code status prior to assisting with CPR. Staff D stated EMS arrived afterwards and told everyone to stop CPR.During an interview on [DATE] at 02:35 PM, the physician stated the facility called when Resident #1 was already deceased . The physician stated the resident was already in the system as a DNR. The physician explained having expectation of the facility staff to have checked Resident #1's code status, prior to performing CPR.During an interview on [DATE] at 05:12 PM, Staff C LPN stated an announcement was made over the intercom, for a code blue. Staff C explained upon arrival to Resident #1's room Staff I RN, and Staff A RN, had begun performing chest compressions on Resident #1. Staff C stated having placed the bag valve mask on Resident #1 to assist with respirations. Staff C stated he did not know Resident #1's code status. Staff C stated no one knew the code status of Resident #1 at the time of compressions. Staff C stated the code status of Resident #1 was determined afterwards. Staff C stated compressions continued until EMS arrived. Staff C stated once EMS arrived, EMS asked why are you even bothering? Staff C stated EMS told the facility staff to stop and promptly proceeded to walk out.During an interview on [DATE] at 02:39 PM, the Social Services Director (SSD), stated the facility checked resident code statuses upon admission and throughout the stay. The SSD stated Resident #1 requested a DNR so staff would not perform chest compressions, due to possible puncture of chest or ribs. The SSD stated Resident #1 was adamant she did not want to be resuscitated or go through the process. The SSD stated Resident #1 just wanted to go to sleep and did not want all the heroics and wanted a natural death. The SSD stated Resident #1's Brief Interview Mental Status was 15 at the time.During an interview on [DATE] at 11:29 AM, Staff G Nurse Practitioner (NP), explained having spoken to Resident #1 in 2025, related to a DNR. Staff G stated the resident wanted to be a DNR. Staff G stated when responding to a code blue, expectations were for two staff to check the code status of the resident on the computer. Staff G stated staff should have followed the code status for the resident.During an interview on [DATE] at 11:34 AM, Staff G NP, stated consequences of performing CPR on a resident with a DNR could include prolonging the life expectancy of a resident. Staff G stated there was a potential for the resident to become a vegetable. Staff G stated the resident could have had ribs broken or fractured.During an interview on [DATE] at 03:30 PM, The Director of Nursing (DON), and Staff H Regional Nurse Consultant (RNC), stated Staff E found Resident #1 unresponsive at 12:15 PM on [DATE]. They stated Staff E alerted the nurse and a (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DirectivesOn [DATE] Director of Clinical Services and/or designee educated licensed/certified staff on the following:Medical Emergency response/Communication of advance directives code statusFollowing physician's orders related to Advance directiveIt Takes Two education (To verify code status/ Advance Directives)On [DATE] Director of Clinical Services and/or designee educated all staff on the following:Abuse, Neglect, and ExploitationResident Rights with focus on honoring Advance DirectivesOn [DATE]- 100% Honoring Advance Directives attestation was completed with facility licensed nursing staffOn [DATE]- Licensed nursing staff- Physicians Orders Education 100 percentOn [DATE] Licensed nurse staff -Medical Emergency response/Communication of advance directives code status Education- 100 percentOn [DATE] ANE/Resident Rights Education was completed with all staff-100 percentOn [DATE]-Advance directives posttest was completed with licensed staff -100 percentOn [DATE] ANE/Resident Rights posttest was completed with all staff-100 percentOn [DATE]- Licensed nursing staff- Code blue process/ It takes Two Education-100 percentOn [DATE] the facility began code blue drills every shift and 97.1% completed of licensed staff with one remaining nurse who has not worked and will not work until she attends a blue drill. 100% completed of C.N.A roles in a code blue.Licensed Nurse will not work prior to attending a mock code blue quality assurance drill.-26 quality reviews were completed with 146 facility staff members validating competencies of education completed.-11 quality reviews were completed of 25 residents newly admitted to the facility to verify completion of advance directive discussion form-Director of Clinical services completes a chart review of residents who expire at the facility or residents who are transferred to the hospital after a cardiac event to verify advance directives were followed.Verification of the facility's removal plan was conducted by the survey team on [DATE] and included the following: Interviews were conducted with 48 staff, 11 licensed nurses, 24 CNAs and 14 ancillary staff. All staff members were able to state that they had been trained and were knowledgeable about the new policies. Record review of education provided by the facility revealed the following:On [DATE] code status orders and care plan review was completed for all residents. This was verified.On [DATE] transfers and death review, to verify advanced directives were honored, was Verified.Reviewed facility audit for [DATE], which showed CPR cards were reviewed for all nurses. This was verified.Between [DATE] and [DATE] education for abuse, neglect, and exploitation was completed. 232 signatures were verified.Reviewed resident rights and advanced directives education sign in sheets were completed for [DATE] through [DATE]. 182 signatures were verified.Reviewed it takes 2, sign in sheets were completed for [DATE] through [DATE], (includes verifying code status). 164 signatures were verified.Reviewed education and competency for CPR, dated [DATE] to [DATE]. 68 signatures were verified.Reviewed education and competency for Medical Emergency Response/Communication of Code Status, dated [DATE] to [DATE]. 69 signatures were verified.Reviewed education and competency for Physician Orders, dated [DATE] to [DATE]. 54 signatures were verified.Reviewed education and competency for Honoring Advanced Directives Attestation, dated [DATE] to [DATE]. 43 signatures were verified.Licensed Nurse Post test - 38 signatures were verified.Code blue drills: - 15 between [DATE] and [DATE], different shifts, were verified.On [DATE] at 10:25 AM, the facility conducted a code blue drill. Staff arrived promptly, with laptops, and a crash cart. A sign on the crash cart showed stop, check physician order prior to starting CPR. Staff confirmed the resident's code status as a full code. The staff started CPR and a staff member documented a timeline. Multiple staff members confirmed if EMS had been contacted. Staff continued CPR, until EMS arrived and took over. Multiple staff members were observed performing CPR and checking the resident's code status.Based on verification of the facility's Immediate Jeopardy removal plan the Immediate Jeopardy was determined to be removed on [DATE] and the non-compliance was reduced to a scope and severity of D.