

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105684	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Vivo Healthcare Normandy		STREET ADDRESS, CITY, STATE, ZIP CODE 8495 Normandy Blvd Jacksonville, FL 32221	
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	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on kitchen food service observations, staff interviews, and a review of facility policies and procedures, the facility failed to follow proper food safety sanitation standards and food handling practices to prevent potential injury and the potential outbreak of foodborne illness to residents by failing to serve meals using dinnerware in clean and good condition. 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 that can compromise residents' well-being. This failure had the potential to affect all residents who consumed food from the facility's kitchen. The findings include: A follow-up tour of the kitchen was conducted on 12/16/2025 at 11:00 a.m. Cracked plates and plates with food debris stuck on them were observed and pulled from the tray line. (Photographic Evidence Obtained) On 12/18/2025 at 9:00 a.m., an interview was conducted with [NAME] V. She was asked who was responsible for ensuring dinnerware and utensils were clean and in good condition. She replied, The Dietary Aides. On 12/18/2025 at 9:14 a.m., an interview was conducted with Dietary Aide U. When she was asked who was responsible for ensuring dinnerware and utensils were clean and in good condition, she replied, The Dietary Aides when they are washing the dishes. An interview was conducted on 12/18/2025 at 9:27 a.m. with the Certified Dietary Manager (CDM). He confirmed that Dietary Aides were responsible for ensuring dinnerware and utensils were clean and in good condition. A review of the facility's policy and procedure titled Food Safety Requirements (reviewed/revised: 1/2025), revealed: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 handling 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: .e. Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food. (Copy obtained) Reference: FDA Food Code 2022 at https://www.fda.gov/media/164194/download, (Accessed on 11/25/2025) Chapter 4. Equipment, Utensils, and Linens 4-6 Cleaning of Equipment and Utensils, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment Food-Contact Surfaces and Utensils. (A) Equipment Food Contact Surfaces and Utensils shall be clean to sight and touch. Cleanability; 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections; and (3) Free of sharp internal angles, corners, and crevices.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interviews, record review, and a review of facility policies and procedures, the facility failed to ensure food served was prepared by methods that conserved nutritive value and appearance by failing to follow standardized recipes to provide appetizing and appealing food in accordance with professional standards for food service. Residents at nutritional and hydration risk could be affected, potentially impacting their ability to heal, and possibly resulting in an overall health status decline. The findings include: During a follow-up tour of the kitchen on 12/16/2025 at 11:00 a.m., Employee V was observed as the cook on the tray line. During an observation of the tray line at this time, pureed meal components of savory based chicken, fluffy rice, seasoned spinach, and a white roll were observed smeared on the plate with no shape or consistent form. (Photographic Evidence Obtained) On 12/18/2025 at 9:00 a.m., an interview was conducted with [NAME] V. She was asked who was responsible for preparing pureed food. She replied, The Cook. When asked what was used to show cooks how to prepare pureed foods, she replied, When I first started cooking, they told me it had to be smooth; now they say it should be thick like mashed potatoes. I look at the consistency of it. If I overpour the liquid, then I add thickener to bring it back to the consistency it should be. On 12/18/2025 at 9:14 a.m., an interview was conducted with Dietary Aide U. When she was asked who was responsible for preparing pureed food, she replied, The Cook; Diet Aides only prepare pureed dessert. When asked what was used to show Cooks how to prepare pureed foods, she replied, The recipe. On 12/18/2025 at 9:27 a.m., an interview was conducted with the Certified Dietary Manager (CDM). He confirmed that the [NAME] was responsible for preparing pureed food. When he was asked what was used to show Cooks how to prepare pureed foods, he replied, Use of the recipe. A review of the facility's policy and procedure titled Menus and Adequate Nutrition (reviewed/revised: 1/2025), revealed: The purpose of this policy is to ensure menus are developed and prepared to meet resident choices including their nutritional, religious, cultural, and ethnic needs, while using established guidelines. Policy Explanation and Compliance Guidelines: The facility will provide residents with nourishing, palatable, well-balanced diets that meet his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident and established menus based upon this guidance. (Copy obtained)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to update comprehensive care plans to accurately reflect residents' current status related to intravenous access (Resident #30), skin condition (Resident #60), and Life Vest (Resident #139) for three of 22 residents reviewed for care plan development, implementation and revision. The findings include: 1. During an observation on 12/16/2025 at 10:15 a.m., Resident #30 was observed with a Peripherally Inserted Central Catheter (PICC) line to his right upper inner arm. The area was observed to be clean and dry with a dressing dated 12/16/2025. During an interview on 12/16/2025 at 10:15 a.m., Resident #30 stated, They just changed the dressing this morning. I think I've got until 12/24/2025 for my last dose [of intravenous antibiotics]. During an observation on 12/18/2025 at 8:00 a.m., Resident #30 was observed with a PICC line to his right upper inner arm. During an interview on 12/18/2025 at 9:30 a.m., Licensed Practical Nurse (LPN) E stated, His [Resident #30] PICC line is in his right arm. A review of Resident #30's medical record revealed that he was admitted to the facility on [DATE] with the following diagnoses: Hereditary and Idiopathic Neuropathy, Other Specified Persistent Mood Disorders, Cutaneous Abscess of Chest Wall, Elevated [NAME] Blood Cell Count, Anemia, Anxiety Disorder, Depression, Pain and Essential (Primary) Hypertension. Resident #30 was admitted with the following physician's orders: PICC/Midline: Right Arm - Change dressing q 7 Days (every seven days) and as needed. A review of Resident #30's Care Plan revealed no care plan documentation for a Peripherally Inserted Central Catheter (PICC) line. During an interview on 12/18/2025 at 1:00 p.m., Minimum Data Set (MDS) Coordinator A stated, It should have been in there; I'm not sure why I would care plan the antibiotic but not the actual PICC line. 2. During an observation on 12/16/2025 on 11:00 a.m., Resident #60 was observed with a dressing on her right heel. During an interview on 12/18/2025 at 12:49 p.m., Wound Care Nurse D stated, We did a bilateral duplex lower extremities ultrasound on 9/25/2025 on her [Resident #60]. MDS Staff does the wound care plans. A review of Resident #60's record revealed that she was admitted to the facility on [DATE] with the following diagnoses: Cerebral Infarction due to Unspecified Occlusion or Stenosis of Left Posterior Cerebral Artery, Aphasia, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right Dominant Side, Unspecified Protein-Calorie Malnutrition, Atrial Fibrillation, Hypothyroidism, Gout, Dysphagia, Essential (Primary) Hypertension, Personal History of Malignant Neoplasm of Ovary, Age-related Osteoporosis, Gastrostomy Status, Depression and Gastro-Esophageal Reflux Disease. Resident #60 had orders for the following: Wound care to right heel - cleanse with wound cleanser, pat dry, apply collagen cover with bordered gauze three times weekly on Monday, Wednesday, and Friday. A review of Resident #60's Care Plan revealed no care plan addressing the arterial ulcer on her right heel. During an interview on 12/18/2025 at 1:10 p.m., Minimum Data Set (MDS) Coordinator A stated, We go over new wounds in morning meeting; that's how I am notified. I don't know how that got missed. 3. During an interview on 12/16/2025 at 2:20 p.m., Resident #139 stated he got his Life Vest in the hospital and staff helped him change the battery. He added that he had not taken the Life Vest off and had not gotten a shower since he was admitted. He said he wiped off with a washcloth. A review of Resident #139's medical record revealed that he was admitted on [DATE] with diagnoses including Pulmonary Embolism without Acute Cor Pulmonale, Chronic Systolic Congestive Heart Failure, Acute Respiratory Failure with Hypoxia, and Chronic Obstructive Pulmonary Disease. He was admitted with a Life Vest. Per a Social Services note dated 12/12/2025 at 2:45 p.m., the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15 possible points, indicating intact cognition. A review of the hospital transfer form dated 12/10/2025 revealed that a Life Vest from [Provider] with a phone number for contact was listed. A review of the resident's care plan revealed no care plan present for the Life Vest or orders. On 12/16/2025 at 6:03 p.m., an order for a battery change once daily for the (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Life Vest was entered by staff into Resident #139's electronic health record. During an interview on 12/18/2025 at 12:45 p.m., MDS Coordinator A stated, Yes, it needs to be care planned. In the mornings we have clinical meetings and we go over new admissions and the list of diagnoses. Also, during their stay, as orders come in, we adjust the care plans. When Employee A was asked if he was able to identify Resident #139's Life Vest in the current care plan now, he replied, No I do not. During an interview on 12/18/2025 at 2:30 p.m., the Administrator stated, I expect everything pertinent and relevant to a resident's care plan be included in their care plan.		

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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** Based on observations, interviews, record reviews and a review of facility policies and procedures, the facility failed to ensure adequate grooming for one resident (#116) who was unable to carry out activities of daily living (ADLs) independently, out of four residents reviewed for ADLs, from a total survey sample of 39 residents. Failure to provide assistance with ADLs can result in resident discomfort and negatively impact a resident's feelings of self-worth. The findings include: A review of the medical record revealed that Resident #116 was admitted to the facility on [DATE] with diagnoses including a need for assistance with personal care, Myasthenia Gravis without (acute) exacerbation, Encephalopathy and Seizures. On 12/15/2025 at 11:10 a.m., Resident #116 was observed in bed with excessively long hair on his face. He was asked if he was able to shave himself or if the staff shaved him. He stated, The staff shaves me. He was asked when the last time was that he recalled being shaved. He replied, a couple of weeks ago. The resident had greasy hair with a lot of white/gray flakes in it. (Photographic Evidence Obtained). The resident stated he could not remember the last time the staff washed his hair. On 12/17/2025 at 12:41 p.m., Resident #116 was observed lying in bed with excessively long hair on his chin and hair on his upper lip that partially covered his lip. The hair on his head was greasy with many white/gray flakes. (Photographic Evidence Obtained) The resident was asked if he desired a shampoo and shave. He stated, Yes. A review of the resident's Annual MDS (minimum date set) assessment, dated 9/30/2025, revealed that the resident had a BIMS (brief interview for mental status) score of 10 out of 15 possible points, indicating moderate cognitive impairment. He required set-up or clean-up assistance from staff with eating, and substantial/maximal staff assistance with toileting, bed mobility, and personal hygiene. Resident #116 required total staff assistance with transfers. He received antidepressant and opioid medications. A review of the resident's active physician's orders revealed the following orders:Oxygen continuous at 3 Liters via Nasal Cannula every shift for shortness of breath (8/14/2025)Sertraline Oral Tablet 50 mg (milligrams), give 3 tablets via G-Tube (feeding tube) one time a day for depression (11/7/2025)Hydrocodone-Acetaminophen Oral Tablet 7.5-325 mg, give 1 tablet via G-Tube every 6 hours as needed for pain moderate to severe (8-10) (6/26/2025)Gabapentin Oral Tablet 100 mg tablet via G-Tube three times a day for neuropathy (6/26/2025)Topamax Oral Tablet 25 mg via G-Tube at bedtime for breakthrough seizure (6/26/2025)Regular diet, Pureed texture, Thin consistency (7/3/2025). A review of Resident #116's active care plan revealed he had care plans for the following focus areas:FOCUS: The resident has an ADL/Self-Care Performance Deficit r/t impaired balance, limited mobility, and weakness. Date Initiated: 03/05/2024FOCUS: The resident has Impaired Cognitive Function/Dementia or Impaired Thought Processes. Date Initiated: 12/15/2025 Revision on: 12/15/2025 On 12/17/2025 at 1:21 p.m., Certified Nursing Assistant (CNA) Q was observed coming out of room [ROOM NUMBER] with a bag of soiled briefs in her hand. She was asked by the surveyor which resident she had been working with. She confirmed that she had just provided incontinent care for Resident #116, and that she was finished with his care. An interview was conducted. She was asked if the facility provided in-service education for abuse/neglect prevention and reporting. She stated, Yes. She was asked to identify three types of neglect. She stated, Not feeding a resident that needs to be fed, not answering call bells, and ignoring a patient when they try to talk to you. She was asked what her room assignment was today. She replied, I have rooms 107-111. She confirmed that she had provided care throughout the shift (7am-7pm) for Resident #116. She was asked how many residents she usually had on her assignment. She stated, Anywhere from 8 to 12 depending on if there are 4 or 5 aides. She was asked if she believed there was enough staff to provide the care the residents needed. She stated, Usually yes, but there are times when I feel we should get more help, like we used to have a shower team and that really helped. She was asked how she knew what the residents' shower schedules were. She stated, We have a printed (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shower schedule by the nurses' desk; they update it periodically according to the residents' preference, so we must check the shower schedule and the therapy schedule every morning. She was asked how she determined what the residents' preference was for showers. She replied, I ask the resident themselves. If they can't tell me, I ask the nurse or see if the resident will allow me to do another form of shower like a bed bath and observe their reaction. If they refuse, I leave them be and go back and try again later. First, we try, then we take another CAN, and then we take the nurse who will document the refusal. She was asked how often showers were offered. She stated, Two to three times weekly. She was asked to describe what grooming consisted of. She stated, Brushing teeth, brushing hair, making sure nails aren't too long or too sharp. She was asked how often grooming should be provided. She stated, Teeth and hair every day, nail care 2-3 times weekly. She was asked how showers were documented. She explained the facility's process for documenting showers on shower sheets. She further explained that the CNA filled it out after the resident's shower or bath, then it was given to the nurse to review and sign. The nurse passed it on to the unit manager or gave it back to the CNA to pass on to the unit manager. She stated she did not know what the unit manager did with it. She was asked if she provided care to Resident #116 today. She confirmed she had provided incontinent care, assisted him with eating, and straightened up his bed. She was accompanied to Resident #116's bedside. There she confirmed that the resident's hair was greasy with white flakes. She confirmed that his facial hair was excessive and long. At that time, the resident was asked if he wanted his hair washed and a shave. He confirmed that he did. On 12/17/2025 at 2:41 p.m., an interview was conducted with Licensed Practical Nurse (LPN)/Unit Manager W. She was asked if the facility provided in-service education for abuse/neglect prevention and reporting. She stated Yes. She was asked to name three types of resident neglect. She stated, Not giving a resident a shower, not providing care and not giving medication. She was asked what the facility shower schedule was. She stated, The residents get showers three times weekly, but there are some who get showered daily per their preference. She was asked how she knew if the resident preferred a bed bath or a shower. She stated, I ask them. She was asked what other services were provided for the residents along with their showers. She stated, They also get their hair washed, if they ask; they get feet/nail care; they get their linen changed. She was asked what her role was regarding the shower sheets. She stated, Primarily just to keep them organized. I place them in a binder so we can keep up with them. She was asked who was responsible for reviewing the shower sheets once they were completed by the CNAs. She stated, The floor nurse is responsible for making sure the shower is documented. She was asked to name three grooming tasks. She stated, Nailcare, facial hair, brushing teeth, and washing their face. She was asked how often grooming should be provided to the residents. She stated, Daily and as needed. LPN W was accompanied to Resident #116's bedside. Upon observation of the resident, LPN W confirmed that his hair was greasy with numerous white flakes. She confirmed that his facial hair was excessive and long. The surveyor asked the resident if he wanted his hair washed and his face shaved. The resident stated, Yes. On 12/18/2025 at 3:02 p.m., an interview was conducted with the Director of Nursing (DON). She was asked what the facility's expectation was for residents receiving showers and baths. She stated, The residents are to get showers or baths on assigned days, as requested and per their preference, day or night. She was asked what the facility's expectation was for residents receiving proper grooming. She replied, The same thing, that should be done on a daily basis, hair combed, washed when needed, facial hair removed, just like they would want to be cared for. She was asked if the facility provided the nursing staff in-service training related to ADL (activities of daily living) care and proper grooming. She stated, Yes. A review of the facility's policy and procedure titled Activities of Daily Living (ADLs) (Effective: 9/1/23, Reviewed/Revised: 1/1/25 by Clinical Services) revealed: The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: Bathing, dressing, (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	grooming, and oral care. Policy Explanation and Compliance Guidelines: 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide residents treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (Resident #11) of two residents reviewed for wound care and for one (Resident #129) of one resident reviewed for positioning/mobility, from a total survey sample of 39 residents. The findings include: 1. On 12/16/2025 at 11:00 a.m., Resident #11 was observed with a dressing to his right lower leg dated 12/10/2025. (Photographic Evidence Obtained) On 12/17/2025 at 12:20 p.m., Resident #11 was observed with a dressing to his right lower leg dated 12/10/2025. (Photographic Evidence Obtained) On 12/18/2025 at 8:10 a.m., Resident #11 was observed with a dressing to his right lower leg dated 12/10/2025. (Photographic Evidence Obtained) During an interview on 12/18/2025 at 8:10 a.m., Resident #11 stated, I banged my leg in therapy. I can't remember when they changed it (the dressing). During an interview on 12/18/2025 at 12:10 p.m., Licensed Practical Nurse (LPN) E stated, The floor nurses do the skin tears (dressing changes), but I haven't had him in several days. A review of Resident #11's electronic medical record (EMR) revealed that the resident was admitted on [DATE] with the following diagnoses: Hereditary and Idiopathic Neuropathy, Unspecified Protein-Calorie Malnutrition, Sepsis, Type 2 Diabetes Mellitus, Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Muscle Wasting and Atrophy, Resistance to Multiple Antibiotics, Extended Spectrum Beta Lactamase (ESBL) Resistance and Bacteremia. Further review of the record revealed that the following change in condition documentation was noted on 12/10/2025: Skin Status Evaluation: Skin tear with the following recommendations: Skin tear addressed by wound care. The following physician's orders were noted: Skin care to right lower leg, cleanse with wound cleanser, pat dry apply xeroform and cover with border gauze three times weekly on Monday, Wednesday, Friday until resolved, with a start date of 12/11/2025. A review of the resident's December 2025 Treatment Administration Record (TAR) revealed that the dressing change was documented as having been completed on the following dates: 12/12/2025, 12/15/2025 and 12/17/2025 . During an interview on 12/18/2025 at 12:49 p.m., Registered Nurse (RN) D/Wound Care Nurse stated, There was a Change in Condition completed on 12/10/2025 regarding a skin tear with the documentation that the wound care nurse did the treatment. It just says addressed by wound care nurse. I do not follow their skin tears. I cannot explain why she did what she did. During an interview on 12/18/2025 at 1:51 p.m., the Director of Nursing (DON) stated, Dressing changes-skin tears, once the nurses identify the skin tear, they notify the wound care nurse, the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family and the physician for orders. That is the procedure; there should have been an order put in right then. 2. On 12/15/2025 at 12:53 p.m., Resident #129 was observed sitting in his wheelchair watching TV. He stated he had no concerns with his care. When asked if he had limited range of motion, he replied yes, in his left hand. When asked if he wore a brace or splint on this hand, he replied that he had a brace in his drawer but did not wear it. On 12/16/2025 at 8:41 a.m., Resident #129 was observed lying in bed with covers pulled to his chest. He stated he had no concerns. A review of the resident's medical record revealed active physician's orders for: Skilled Occupational Therapy (OT) for left hand splint placement, splint to be worn daily when out of bed, off at night and hygiene care (6/2/2025). Physical Therapy (PT): Continue to evaluate and treat as recommended (10/3/2025). Skilled Maintenance PT Evaluation and Treatment for 3 times/week for 90 days for Therapeutic Exercise; Therapeutic Activities; Manual Therapy; Diathermy (10/3/2025) A review of the medical record revealed that Resident #129 was admitted to the facility on [DATE]. Primary diagnoses included: Hemiplegia and Hemiparesis following cerebral infarction affecting left non-dominant side; contracture of muscle, unspecified site; muscle wasting and atrophy, not elsewhere classified, multiple sites; and need for assistance with personal care. A review of the Quarterly minimum data set (MDS) assessment dated [DATE] revealed that Resident #129 had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 possible points indicating moderate cognitive impairment. Behaviors and/or rejection of care were not exhibited. The resident had impairment on both sides of his upper and lower extremities and required set-up or clean up assistance for eating. Toilet transfers were not attempted due to his medical condition or safety concerns per documentation. A review of the Care Plan focus and goals included Activities of Daily Living (ADL)/Self-care performance deficit related to Activity Intolerance, Hemiplegia, Impaired balance, Limited Mobility, Musculoskeletal impairment, and weakness. Interventions included PT/OT evaluation and treatment as per medical doctor orders. (Copy Obtained) A review of the resident's December 2025 Medication Administration Record (MAR) revealed no documentation for the left hand splint placement order dated 6/2/2025, Skilled Occupational Therapy (OT) for left hand splint placement, splint to be worn daily when out of bed, off at night and hygiene care. (Copy Obtained) A review of a Nursing Comprehensive Assessment, dated 6/13/2024 on admission, revealed that Resident #129 was alert and cognitively intact with verbal communication. He required Therapy and Social Services with functional goals to improve functional status. A review of a Range of Motion: Functional Limitation Screen, dated 6/14/2024, revealed that Resident #129 was a new admission and a PT (physical therapy) evaluation was completed. Upper Extremity (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Vivo Healthcare Normandy		STREET ADDRESS, CITY, STATE, ZIP CODE 8495 Normandy Blvd Jacksonville, FL 32221	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Functional Range of Motion (ROM) for wrist: Left Hand: Severe Limitation in ROM. On 12/18/2025 at 2:18 p.m., CNA K was asked how she was made aware of residents' daily care needs or any changes to them. She replied, Through morning reports from the previous CNA or resident charts. When asked whether she was aware that Resident #129 was to wear a splint, she replied, I don't normally get that section; I have the first four rooms on 100 and the first three rooms on 200. When asked if she had received training on abuse, neglect, and exploitation, she replied, Yes, at the facility three months ago. On 12/18/2025 at 2:25 p.m., CNA J was asked how she was made aware of residents' daily care needs or any changes to them. She replied, through the nurse. When asked whether she was aware that Resident #129 was to wear a splint, she replied, No, I have not worked with the resident; I normally work rooms 105-110. When asked if she had received training on abuse, neglect, and exploitation, she replied, Yes, on-line at the facility two weeks ago. On 12/18/2025 at 2:45 p.m., LPN I was accompanied to Resident #129's room. He was observed lying in bed not wearing his splint. The resident stated he was aware that he was to wear a splint during the day. When asked where his splint was, he stated it was in his drawer. When he was asked if he had been wearing the splint, LPN I responded no. When LPN I was asked if she was aware that the resident was to wear a splint, she replied No, I was on 200 and just returned from emergency leave on 12/3/2025. When asked how she was made aware of residents' daily care needs or any changes to them, she replied, Through the treatment administration record, if I see something wrong, I ask someone. She also reported that the nurse was responsible for putting on and taking off the resident's splint. When she was asked what the current treatment plan was for Resident #129's splint, she replied, I did not find an order unless I did not see it. She stated Resident #129 was not wearing the splint because his hand was opening a little and she thought he did not need it. A review of the facility's policy and procedure titled Prevention of Decline in Range of Motion (date reviewed/revised: 1/2025), revealed: Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable. Policy Explanation and Compliance Guidelines: .3. b. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to, . i. Appropriate services (specialized rehabilitation, restorative, functional maintenance). ii. Appropriate equipment (braces or splints). (Copy Obtained)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure that a resident with a pressure ulcer received necessary treatment and services, consistent with professional standards of practice, to promote healing and prevent infection for one (Resident #99) of one resident reviewed for pressure ulcer care and treatment. The findings include: During an observation on 12/18/2025 at 9:30 a.m., Registered Nurse (RN) D/Wound Care Nurse, prepared to change the ordered dressing to Resident #99's sacral pressure wound. Resident #99 positioned herself on her left side in preparation for the dressing change. Upon positioning with the sacral and gluteal area exposed, it was observed that there was a dark brown substance present, beginning at the top of the gluteal cleft and extending down to the bottom of the cleft. There was a fecal odor present. RN D cleaned the wound using wound cleanser, placed a new treatment and dressing over the sacral wound, refastened the resident's brief, and instructed her to position herself on her back. RN D did not clean the fecal matter from Resident #99's gluteal cleft prior to redressing the pressure ulcer and refastening the brief. A review of Resident #99's medical record revealed that the resident was admitted on [DATE] with the following diagnoses: Cerebral Infarction, Unspecified Fracture of the Upper End of the Right Humerus, Anemia, Hemiplegia, unspecified affecting Right Dominant Side, Unspecified Protein-Calorie Malnutrition, Muscle Wasting and Atrophy, Paralytic Gait, Other Fracture of Shaft of Right Tibia, Displaced Fracture of Shaft of Right Clavicle, Other Low Back Pain, Hereditary and Idiopathic Neuropathy, Other Specified Arthritis, Polyneuropathy, Personal History of Transient Ischemic Attack and Cerebral Infarction without Residual Deficits, Homelessness, and Depression. Further review of the record revealed the following physician's orders: Wound care: Cleanse sacrum with normal saline, pat dry. Apply Medihoney, collagen, and cover with border gauze dressing every day shift for Stage 3 PU (Pressure Ulcer) and as needed for soilage/dislodgement. During an interview on 12/18/2025 at 12:49 p.m., RN D/Wound Care Nurse, was asked if it was considered a professional standard of practice to change a sacral pressure dressing to an open wound and leave visible feces present in the gluteal cleft. RN D replied, I can't leave it open, but we should have cleaned her better. When asked to describe normal procedure if a resident was soiled when she approached them for a dressing change, RN D replied, We will let the CNAs know and then we will come back. When asked if this was an acceptable standard of practice, RN D replied, No Ma'am, we should change it if the CNAs are busy. During an interview on 12/18/2025 at 1:51 p.m., the DON stated the wound care assistant was a CNA as well and they could provide incontinent care. They don't have to wait on anyone. No ma'am. Tell me that didn't happen.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to appropriately document the correct location of the Peripherally Inserted Central Catheter (PICC) line in five of 14 daily chart notes for one (Resident #30) of eight residents reviewed for required resident record components, from a total survey sample of 39 residents. The findings include: During an observation on 12/16/2025 at 10:15 a.m., Resident #30 was observed with a Peripherally Inserted Central Catheter (PICC) line to his upper inner right arm. The area was observed to be clean and dry with a dressing dated 12/16/2025. During an interview on 12/16/2025 at 10:15 a.m., Resident #30 stated, They just changed the dressing this morning. I think I've got until 12/24/2025 for my last dose [of intravenous antibiotics]. During an observation on 12/18/2025 at 8:00 a.m., Resident #30 was observed with a PICC line to his right upper inner arm. During an interview on 12/18/2025 at 9:30 a.m., Licensed Practical Nurse (LPN) E stated, His [Resident #30] PICC line is in his right arm. A review of Resident #30's medical record revealed that Resident #30 was admitted to the facility on [DATE] with the following diagnoses: Hereditary and Idiopathic Neuropathy, Other Specified Persistent Mood Disorders, Cutaneous Abscess of Chest Wall, Elevated [NAME] Blood Cell Count, Anemia, Anxiety Disorder, Depression, Pain and Essential (Primary) Hypertension. Resident #30 was admitted with the following physician's orders: PICC/Midline: Right Arm - Change dressing q 7 Days (every 7 days) and as needed. A review of Resident #30's Daily Skilled Notes for 12/2/2025, 12/4/2025, 12/8/2025, 12/10/2025 and 12/11/2025, revealed that the PICC placement was in the resident's Left arm. During an interview on 12/18/2025 at 2:00 p.m., the Director of Nursing stated, I expect them (nursing staff) to document accurately.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on facility observations, interviews, and a review of facility policies and procedures, the facility failed to provide a safe, sanitary, and comfortable homelike environment for residents, by failing to ensure separate rooms for resident showers and equipment storage for the 32 residents residing on the 100 hallways, from a total facility census of 110 residents. This had the potential to put residents at risk for infection, compromised dignity and privacy, and physical harm. The findings include: On 12/16/2025 at 9:44 a.m., a storage sign was observed on the 100 hallways' resident shower room door. When the door was opened, mechanical lifts were observed stored in the room. (Photographic Evidence Obtained) On 12/17/2025 at 10:34 a.m., Certified Nursing Assistant (CNA) S was asked why the storage sign was posted on the 100 hallways' shower room door. She stated she did not know why it was on the door, as this was a shower room. On 12/17/2025 at 10:35 a.m., the same storage sign was posted on the 100 hallways' resident shower room door, the shower room that was being used for the 100 hallways' residents. (Photographic Evidence Obtained) On 12/17/2025 at 10:40 a.m., Licensed Practical Nurse (LPN) R was asked why the storage sign was posted on the 100 hallways' shower room door. She stated the room was a shower room and she did not know why the storage sign was on the door. On 12/18/2025 at 9:41 a.m., Housekeeper P reported she worked on the 100 hallways. When asked to explain the storage sign on the 100 hallways' shower room door, she replied, It was not told to me. On 12/18/2025 at 9:49 a.m., Environmental Services Director O reported that he completed AM and PM rounds checking for cleanliness and whether or not toilet paper and paper towels had been refilled. Showers were checked during his AM tour. He was asked to explain the storage sign on the 100 hallways' shower room door. He replied, They were putting equipment in the room; they started using it for storage. I thought residents were just using the shower on the 200 hallways. During the interview with Employee O at 9:56 a.m., Resident #77 was observed exiting the 100 hallways' shower/storage room after completing his shower. On 12/18/2025 at 10:12 a.m., Maintenance Assistant N reported he did not know the shower room was used for both showers and storage. On 12/18/2025 at 10:21 a.m., the same storage sign was observed on the 100 hallways' resident shower room door that was being used as the 100 hallways' residents' shower room. (Photographic Evidence Obtained) On 12/18/2025 at 10:12 a.m., Maintenance Director M reported he checked the shower rooms once monthly and the 100 hallways' shower room was being used for storage. He stated the storage sign had been on the door for about one year. There were too many lifts and no room to store them. That room became the storage room for the lifts. We are not supposed to provide showers to residents when the room is used as a storage. A review of the facility's policy and procedure titled Resident Rights (reviewed/revised: 1/2025), revealed: The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility will also provide the resident with prompt notice (if any) of changes in any State or Federal laws relating to resident rights or facility rules during the resident's stay in the facility. Receipt of any such information must be acknowledged in writing.8. Safe environment: The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safety. (Copy Obtained)		