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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105702 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 12/23/2025 |
| NAME OF PROVIDER OR SUPPLIER Vivo Healthcare Meadows | | STREET ADDRESS, CITY, STATE, ZIP CODE 5157 Park Club Drive Sarasota, FL 34235 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some | Give the resident's representative the ability to exercise the resident's rights. (continued on next page) |

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

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

TITLE

(X6) DATE

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| <p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Based on interviews, records reviewed and facility policy the facility failed to properly exercise the rights of 3, (Resident #5, Resident #3 and Resident #4), of 3 residents with dementia that had designated representatives by disenrolling the residents from their Medicare Advantage coverage without proper authorization and documentation. The findings included: Review of Facility Policy titled Resident Rights implemented 9/1/23 documented the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. 1) Exercise of Rights: The resident has the right to exercise his or her rights of the facility as a citizen of the United States. b) In the case of a resident who has not been adjudged incompetent by the State court, the resident has a right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by State law. Review of Facility Enrollment/Disenrollment Rights for Medicare Beneficiaries not dated documented skilled nursing facility residents have the right to choose their own healthcare insurance coverage. Residents have a right to understand the differences. Only a Medicare beneficiary, the beneficiaries authorized or designated representative, or the party authorized to act on behalf of the beneficiary under state law can request enrollment in or voluntary disenrollment from a Medicare health or drug plan. If you desire, the facility may act as your designated representative to make the process easier. With written authorization, the facility can help you switch at any permissible time. Review of the clinical record revealed Resident #5 was admitted to the facility 8/27/24 with diagnosis fracture of T7-T8 vertebra, cognitive communication deficit, and unspecified dementia. Review of the admission Minimum Data Set (MDS) with a reference date of 9/3/24 documented Resident #5 required partial/moderate assistance with Activities of Daily Living (ADLs). The MDS noted the residents' cognitive status was moderately impaired. Review of Hospital Patient Transfer Form 8/27/24 documented Resident #5 was unable to make healthcare decisions and required a surrogate. Review of admission Record documented Resident #5 designated his spouse as Responsible Party, Power of Attorney/Financial and Power of Attorney/Care. Review of Care Plan initiated 8/27/24 documented Resident #5 had impaired cognitive function/dementia or impaired thought processes related to dementia. Interventions 8/27/24 included communicate with the resident/family/caregivers regarding resident capabilities and needs. Cue, reorient and supervise as needed. Review of census documentation revealed Resident #5 was admitted under Blue Cross Blue Shield Medicare Advantage A. 9/1/24 census documentation revealed resident's primary payor was changed to Medicare A. Review of the clinical record revealed Resident #3 was admitted to the facility 7/8/25 with diagnosis displaced fracture of left lower leg and unspecified dementia. Review of the admission Minimum Data Set (MDS) with a reference date of 7/14/25 documented resident required partial/moderate assistance to substantial/maximal assistance with Activities of Daily Living (ADLs). The MDS noted the resident's cognitive status was moderately impaired. Review of Hospital Patient Transfer Form 7/8/25 documented Resident #3 was unable to make healthcare decisions and required a surrogate. Review of admission Record documented Resident #3 designated her daughter as Responsible Party and Power of Attorney/Care. Review of Care Plan initiated 7/16/25 documented Resident #3 had impaired cognitive function/dementia or impaired thought processes related to short term memory loss. Interventions 7/16/25 included communicate with the resident/family/caregivers regarding resident capabilities and needs. Cue, reorient and supervise as needed. Review of census documentation revealed Resident #3 was admitted under United Healthcare Medicare Advantage A. 8/1/25 census documentation revealed resident's primary payor was changed to Medicare A. Review of the clinical record revealed Resident #4 was admitted to the facility 7/25/25 with diagnosis complication of internal fixation device of right femur and unspecified dementia with other behavioral disturbance. Review of the admission Minimum Data Set (MDS) with a reference date of 8/7/25 documented resident required dependent on staff for Activities of Daily Living (ADLs). The MDS noted the residents' cognitive status was severely impaired. Review of the Hospital Patient Transfer Form 7/25/25 documented Resident #4 mental/cognitive status at transfer was alert, disoriented, but can follow simple instructions. Review of admission Record documented Resident #4 had an appointed Guardian as Responsible Party, Legal Guardian and Care Conference Person. Review of Care Plan initiated 7/28/25 documented Resident #4 had impaired cognitive function/dementia or impaired thought processes related to dementia. Interventions 7/28/25 included communicate with the resident/family/caregivers regarding resident capabilities and needs. Cue, reorient and supervise as needed. Review of census documentation revealed</p> | | |