STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105706	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vivo Healthcare West Orange	1556 Maguire Rd Ocoee, FL 34761

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 interview, and record review, the facility failed to honor a resident's wishes for Do Not Resuscitate (DNR) by not ensuring those wishes were completely and accurately documented to promote continuity of care between providers for 1 of 10 residents reviewed for advance directives, (#1). This failure contributed to resident #1 receiving cardiopulmonary resuscitation (CPR) efforts in violation of an explicit wish for a natural and dignified death. There was likelihood resident #1 would have experienced severe pain, and could have suffered broken bones, organ damage and a prolonged dying process. On [DATE] at approximately 5:45 AM, resident #1 was found unresponsive with no pulse and no respirations. Registered Nurse (RN) C verified resident #1's code status as DNR, then called Emergency Medical Services (EMS). RN C provided EMS with an incomplete Florida Do Not Resuscitate Order (DNRO) form. EMS determined the form was invalid due to being incomplete and began CPR. EMS discontinued CPR at 6:40 AM and resident #1 was pronounced deceased . The facility's failure to ensure complete and accurate documentation of the resident's do not resuscitate wishes placed all residents with a do not resuscitate order at risk for serious psychosocial harm, physical trauma, and a prolonged, undignified death from unwanted resuscitation efforts. This failure resulted in Immediate Jeopardy starting on [DATE]. The Immediate Jeopardy was removed on [DATE]. The census at the start of the survey was 106 with 23 residents identified as Do Not Resuscitate. Findings: Cross reference F678. Review of the face sheet revealed resident #1, a [AGE] year-old male, was admitted to the facility on [DATE] with diagnoses including stroke, type 2 diabetes, essential hypertension, Human Immunodeficiency Virus and unspecified dementia. Review of the Minimum Data Set Medicare 5-Day assessment with assessment reference date of [DATE] revealed resident #1 had a Brief Interview for Mental Status score of 12/15 which indicated he had moderate cognitive impairment. The document indicated the resident's primary reason for admission was stroke and had multiple medical conditions including heart failure, coronary artery disease, renal insufficiency and non-Alzheimer's dementia. Resident #1 had a care plan initiated on [DATE] and revised on [DATE] for impaired cognitive process related to history of dementia. Interventions included communicate with the resident and family regarding resident's needs. Review of physician orders revealed an order for Do Not Resuscitate (DNR) dated [DATE]. Review of resident #1's electronic medical record (EMR) revealed a 3008 Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form from the hospital which indicated resident #1 was a DNR. The EMR also contained a Florida DNRO form signed only by the hospital physician. In a phone interview on [DATE] at 2:01 PM, Licensed Practical Nurse (LPN) Supervisor A confirmed she worked the night of [DATE] when resident #1 admitted to the facility. She recalled resident #1 was confused upon admission, so she and another nurse contacted the resident's daughter by phone for consent to treat. She stated the resident had a Florida DNRO form that was sent from the hospital signed by a physician. LPN Supervisor A explained she and the other nurse confirmed resident #1's wishes to be a DNR with his daughter. She stated she and the other nurse signed the Advance Directives Discussion Document but did not sign off on the Florida DNRO form. On [DATE] at 3:31 PM, the Social Services (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 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director (SSD) stated she was responsible for addressing advanced directives with residents and/or their representatives. She explained she reviewed advanced directives for new admissions during morning meeting with other department heads as a follow up to efforts made by the nurse who admitted the resident. The SSD stated she verified residents' advanced directives and would request copies of other forms such as a Power of Attorney or Health Care Surrogate designation, if needed. She recalled resident #1 admitted on a Friday ([DATE]) and his advanced directives were reviewed on Monday morning ([DATE]). She stated the Florida DNRO form in the admission packet was only signed by a physician and lacked any other signature. The SSD reported that she, the former Director of Nursing (DON) and the former Assistant Director of Nursing (ADON) called resident #1's daughter to verify his wish not to have CPR. She verified the two nurses with her on the call were both RNs. The SSD was unable to state why the two nurses did not document the conversation, sign off on the Florida DNRO form until the resident or resident's proxy were able to sign, or obtain the signature by another means. In a phone interview on [DATE] at 4:53 PM, RN C verified she was the assigned nurse for resident #1 on the night of [DATE] going into [DATE]. She recalled his assigned Certified Nursing Assistant (CNA) approached her at 5:45 AM on [DATE] to let her know resident #1 was unresponsive. RN C stated she went to the resident's room, but he was unresponsive. She explained she left the room to get equipment to take his vitals. When she returned, she was unable to obtain a blood pressure, pulse or respirations. RN C stated she confirmed resident #1's code status as DNR and placed a call to EMS at approximately 5:54 AM. She recalled when EMS arrived, they viewed the DNR order in the EMR and requested a copy of the Florida DNRO form. The nurse stated she printed a copy of the form after locating the goldenrod-colored paper in the front office. RN C explained EMS personnel noticed the form was only signed by a physician and did not have the signature of the resident or authorized representative. The RN recalled EMS informed her the form was invalid. She stated EMS began CPR but ceased resuscitation and called time of death at 6:40 AM. In a phone interview on [DATE] at 10:49 AM, resident #1's daughter confirmed she was his health care proxy. She recalled she spoke with facility staff and informed them he was a DNR, when her father was admitted to the facility. She stated a facility staff member called her the morning of her father's death and told her EMS performed CPR as the Florida DNRO form was not signed. Resident #1's daughter did not know why the form was not signed. She explained she had signed several papers at the hospital but could not recall signing the gold Florida DNRO form. In a meeting with the Administrator and DON on [DATE] at 10:18 AM, the Administrator stated the Quality Assurance and Performance Improvement (QAPI) Committee met and reviewed the event in an Ad Hoc meeting on [DATE]. She acknowledged nursing staff had recognized resident #1 and his family's desire for DNR upon admission and placed a physician's order for DNR but did not ensure they had a valid Florida DNRO form signed by the resident or his proxy and available before his death. Review of the facility's policy and procedure dated [DATE] for Residents' Rights Regarding Treatment and Advance Directives, revealed it was the facility's policy to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate advance directives. The document explained that any decision making regarding the resident's choices would be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care. The facility's policy and procedure for Documentation in the Medical Record revised [DATE] read, Each resident's medical record shall contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. The document listed one of the principles of documentation was that documentation should be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. Review of the immediate corrective measures implemented by the facility revealed the following, which were verified by the survey team on [DATE] and [DATE]: *On [DATE], the attending physician, Medical Director, Administrator, interim DON and resident representative were notified of the incident and an (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	investigation was initiated. *On [DATE], the SSD/Designee conducted an immediate 100% audit of all current residents' code status and care plan; verified the presence of a valid Florida DNRO form for each applicable resident in the EMR; confirmed the form contained the physician and resident/proxy signatures, signature dates, and legal proxy authority; and contacted attending physicians and legally authorized representatives immediately to complete any missing or incomplete Florida DNRO form documentation. *On [DATE], the SSD printed the Florida DNRO form for each applicable resident and put in Emergency Response Binders. These binders were placed on each unit, rehabilitation (therapy) room, and social services on [DATE]. *On [DATE], SSD/designee initiated advanced directives audits weekly for three months with focus to ensure the Florida DNRO form was complete and valid. *On [DATE], the facility implemented a revised admission/readmission process which included Resident Rights & Advance Directive education upon admission; completion of an Advance Directives Discussion Document and validation of advance directives by Social Services/designee. *On [DATE], the Regional Director of Education initiated education to licensed nurses, Social Services Director and Admissions Coordinator on location of goldenrod (yellow) paper for printing Florida DNRO forms. *On [DATE], the ADON initiated education with licensed nurses, Admissions Coordinator, and SSD on documentation in the medical record to ensure each resident's medical record contained complete, accurate, and timely documentation. *On [DATE], the SSD was educated on ensuring accuracy of advance directives/Florida DNRO form. *On [DATE], the facility implemented the Florida DNRO form admission & readmission Checklist to ensure verification of required signatures, confirmation of proxy authority, proper form completion and physical availability of the Florida DNRO form. *On [DATE], an Ad Hoc Quality Assurance and Performance Improvement (QAPI) committee meeting was held. Education and audits were reviewed. 100% chart audit of advanced directives including code status, DNR orders and Florida DNRO forms was completed by [DATE]. *From [DATE] to [DATE], the facility educated all licensed nurses on the topics of Resident Rights in regard to Advanced Directives; verification of advanced directives; DNR orders; Florida DNRO forms and requirements; and complete and accurate documentation in the EMR. A post-test was completed following the educations to ensure understanding of the training received. *On [DATE], 100 percent of licensed nurses were trained and completed post-tests. Education continued to include new employees. *Ad HOC QAPI meetings were held on [DATE], [DATE] and [DATE], and monthly QAPI meeting on [DATE] with Administrator, Director of Nursing, Medical Director and administrative staff. Education, audits and post-tests were reviewed and revised as indicated. *Interviews were conducted on [DATE] with 32 staff members representing all shifts (15 CNAs, 6 RNs, 9 LPNs, 1 SSD and 1 Admissions Coordinator). Staff interviews revealed they were knowledgeable of advanced directives; how to verify the code status; completion of Florida DNRO form and location of Emergency Response Binders. The surveyors validated the education through interviews and review of attendance sheets and post-tests for the in-services. Review of monthly and Ad HOC QAPI meetings revealed education was completed and audits were conducted as stated. The resident sample was expanded to include seven additional residents who elected DNR status. Interviews and record reviews revealed no concerns for residents #2, #3, #4, #5, #6, #7, #8, #9 and #10 related to advance directives. Based on the facility's corrective actions, the survey team determined the facility was in substantial compliance on [DATE].

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure a resident did not receive Cardiopulmonary Resuscitation (CPR) against his wishes by providing an invalid Florida Do Not Resuscitate Order (DNRO) form to Emergency Medical Services (EMS) during an emergency for 1 of 10 residents reviewed for advance directives, (#1). On [DATE] at approximately 5:45 AM, resident #1 was found unresponsive with no pulse and no respirations. Registered Nurse (RN) C verified resident #1's code status as Do Not Resuscitate (DNR) and called EMS. RN C provided EMS with an incomplete Florida DNRO form. EMS determined the form was invalid due to missing signatures and began CPR. After three rounds of CPR efforts, EMS discontinued CPR at 6:40 AM and resident #1 was pronounced deceased . The facility's failure to ensure complete and accurate documentation of the resident's DNR wishes placed all residents with a DNR order at risk for serious psychosocial harm, physical trauma, and a prolonged, undignified death from unwanted resuscitation efforts. This failure resulted in Immediate Jeopardy starting on [DATE]. The Immediate Jeopardy was removed on [DATE]. Substandard Quality of Care was identified at F678. A partial extended survey was conducted on [DATE]. The noncompliance at F678 was determined to be past noncompliance as of [DATE]. Findings: Cross reference F578. Resident #1, a [AGE] year-old male, was admitted to the facility on [DATE] with diagnoses including stroke, type 2 diabetes, heart failure, Human Immunodeficiency Virus and unspecified dementia. Review of the Minimum Data Set Medicare Five-Day assessment with assessment reference date of [DATE] revealed resident #1 had a Brief Interview for Mental Status score of 12/15 which indicated he had moderate cognitive impairment. The document indicated the resident's primary reason for admission was stroke and had multiple medical conditions including heart failure, coronary artery disease, renal insufficiency and non-Alzheimer's dementia. Resident #1's electronic medical record (EMR) contained a physician order dated [DATE] which read, DNR - DO NOT RESUSCITATE. There were no documents scanned in the EMR for power of attorney, health care surrogate, or health care proxy. Review of resident #1's EMR revealed a 3008 Medical Certification for Medicaid Long Term Care Services and Patient Transfer Form from the hospital indicated resident #1 was alert, but disoriented. The form detailed that resident #1 required a surrogate for decision making and that he was a DNR. The EMR also contained a Florida DNRO form dated [DATE] signed only by the hospital physician. A Late Entry Nurses Note created [DATE] at 12:01 PM, with effective date of [DATE] at 7:15 AM revealed RN C was called to the room by Certified Nursing Assistant (CNA) D at 5:45 AM. Resident #1 was observed unresponsive. RN C the room to retrieve vital sign equipment. Upon her return to the resident's room, she checked resident #1's blood glucose level and attempted to obtain his vital signs. She documented she was unable to obtain a blood pressure, pulse, or respirations and left the room, again to check code status in the medical record The note indicated the nurse confirmed resident #1 's code status was DNR per the medical record, and at 5:54 AM she called EMS via 911. When EMS arrived, the DNR Code Status order was verified in the medical record. The RN documented that EMS responders requested a copy of the goldenrod-colored Florida DNRO form and were willing to wait up to 20 minutes for the form. The noted detailed that when the Florida DNRO form was presented, EMS responders stated the form was incomplete due to missing signature of resident or proxy and CPR was initiated. Resuscitation efforts were unsuccessful and EMS ceased efforts at 6:40 AM. In a phone interview on [DATE] at 11:52 AM, CNA D confirmed she was assigned to resident #1 during the night shift of [DATE] into [DATE]. She stated she checked on the resident several times during the shift. The CNA recalled when she checked on resident #1 again at about 5:45 AM, he was unresponsive and did not move when she shook him. She explained she notified RN C who said she would call emergency medical services, even though she told her the resident was a DNR. CNA D recalled EMS arrived and started doing CPR. They were asking for the paper (the DNR), she (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	conveyed. In a phone interview on [DATE] at 4:53 PM, RN C confirmed she was resident #1's assigned nurse on the night shift from [DATE] into [DATE]. She recalled CNA D approached her at 5:45 AM on [DATE] and informed her resident #1 was unresponsive. RN C stated she went to the resident's room and rubbed him hard on the chest bone, but he did not respond. She explained she went to get equipment to check his vital signs but was unable to obtain a blood pressure or respirations. RN C said she was unable to locate a paper copy of the Florida DNRO form, only a scanned copy in the computer. She explained she thought she would see him take a small breath every so often, so she placed a call to EMS at approximately 5:54 AM. RN C was unable to explain why she documented she was unable to obtain respirations in the EMR if she thought she saw him take breaths. She clarified she called EMS because it was the policy of the previous company. RN C recalled when EMS arrived, she showed them the DNR order in the EMR and they asked for the paper copy of the Florida DNRO form. She stated since she was unable to locate a paper copy of the DNRO form she printed the copy from the EMR after locating some goldenrod (yellow) colored paper. RN C explained EMS realized the Florida DNRO form was only signed by a physician and did not contain the signature of the resident or authorized representative. She stated they informed her the form was therefore invalid. RN C recalled EMS began CPR but were unable to resuscitate him and called his time of death at 6:40 AM. RN C acknowledged all residents with DNR orders should have a valid, signed Florida DNRO form. In a phone interview on [DATE] at 10:49 AM, resident #1's daughter confirmed she was his health care proxy, having signed that and many other papers at the hospital. She recalled facility staff called her to confirm her father's advance directives, and she informed them he wished to be a DNR. She stated a facility staff member called her the morning of her father's death and told her EMS performed CPR on her father as the Florida DNRO form had not been signed. Resident #1's daughter did not know why the facility did not ensure the form was signed, as per his wishes. On [DATE] at 3:31 PM, the Social Services Director (SSD) stated she was responsible for addressing advanced directives with residents and/or their representatives. She recalled she reviewed resident #1's advanced directives on Monday, [DATE], following his weekend admission. She realized the Florida DNRO form in the admission packet was only signed by a physician and lacked any other signatures. The SSD explained she made the department heads aware of the incomplete form during morning report. She recalled she, the former Director of Nursing (DON) and former Assistant Director of Nursing (ADON) called resident #1's daughter to verify his wishes not to have CPR. The SSD was unable to state why the two nurses did not document the conversation or sign off on the Florida DNRO form until the resident or resident's proxy were able to sign. She explained resident #1 became unresponsive on the overnight shift and EMS performed CPR on him when the Florida DNRO form was determined to be invalid because the resident or resident's representative had not signed it. On [DATE] at 10:18 AM, the Administrator and DON discussed the incident investigation and Root Cause Analysis related to resident #1 receiving CPR despite the family's wishes and documentation of a DNR order. The Administrator stated during the investigation, it was discovered the hospital sent an incomplete Florida DNRO form in the admission packet for resident #1. She explained the admission nurse reviewed the admission packet and called the resident's daughter in the presence of another nurse to verify his code status. She verified the two nurses signed the advance directives discussion document for him to be a DNR, but did not sign the Florida DNRO form. The Administrator reported that resident #1's advanced directives were also reviewed in morning report with the interdisciplinary team on [DATE] and it was identified the Florida DNRO form lacked signatures of resident and/or authorized representative. She stated a call was placed to resident #1's daughter after the meeting but was unsure as to who was on the call as she left it to the interdisciplinary team to address. The Administrator reported the investigation timeline showed that resident #1 was found unresponsive at 5:45 AM on [DATE]. His nurse was notified and responded to the room but was unable to obtain vital signs. She said the nurse verified resident #1 was a DNR in the computer then placed a call to EMS. The Administrator was unable to state why the (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	nurse called EMS. She stated EMS arrived at approximately 6:05 AM and requested a copy of the Florida DNRO form. Upon receiving the copy, EMS notified the nurse that the Florida DNRO form was invalid as it was not signed by the resident or his authorized representative. She stated EMS then initiated three rounds of CPR per their protocol before pronouncing the resident deceased at 6:40 AM. The Administrator and DON explained as part of their investigation they found a note in the hospital records that resident #1 expressed to hospital staff he wanted to be a DNR and understood what that meant. They acknowledged facility nurses recognized the Florida DNRO form from the hospital was not valid but failed to ensure a signed and valid copy was available. The facility's policy and procedure for Cardiopulmonary Resuscitation (CPR) revised [DATE] revealed, It is the policy of this facility to adhere to resident's rights to formulate advance directives. The form indicated the facility staff would provide basic life support in accordance with the resident's advanced directives. The facility's policy and procedure for Documentation in the Medical Record revised [DATE] indicated that documentation should be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. Review of the immediate corrective measures implemented by the facility revealed the following, which were verified by the survey team on [DATE] and [DATE]: *On [DATE], the facility initiated an internal investigation which included resident record review, staff interviews, notification to the Department of Children and Families, the Florida Agency for Health Care Administration, local law enforcement and validated the attending physician/medical director and resident's responsible party were notified regarding the event. *On [DATE], the SSD/Designee conducted an immediate 100% audit of all current residents' code status and care plan; verified the presence of a valid Florida DNRO form for each applicable resident in the EMR. *On [DATE], the facility initiated code blue drills and continued across all shifts. *On [DATE], the facility implemented Emergency Response Binders containing the Florida DNRO form for applicable residents, facility Florida DNRO verification checklist and code status reference guide for staff. Binders were placed at each nurses' station, rehabilitation department and the social services office. All binders were put into place by [DATE]. *On [DATE], the Regional Director of Education initiated education to licensed nurses, Social Services Director and Admissions Coordinator on location of goldenrod (yellow) paper for printing Florida DNRO forms. *On [DATE], the facility educated staff that CPR must be initiated by EMS unless a valid Florida DNRO form was physically available. *On [DATE], the facility established designated locations for goldenrod (yellow) paper for Florida DNRO forms to prevent delays. These were located in yellow folders at A Wing nurses station, B Wing nurses station and the front desk. *On [DATE], an Ad Hoc Quality Assurance and Performance Improvement (QAPI) committee meeting was held. Education and audits were reviewed. 100% chart audit of advanced directives including code status, DNR orders and Florida DNRO forms was completed by [DATE]. *From [DATE] to [DATE], the facility educated all licensed nurses on the topics of Resident Rights in regard to Advanced Directives; verification of code status and advanced directives; DNR orders; Florida DNRO forms and requirements; CPR policy and EMS response requirements; communication of code status; location of goldenrod (yellow) paper for printing Florida DNRO forms; and complete and accurate documentation in the EMR. A post-test was completed following the educations to ensure understanding of the training received. *On [DATE], 31 of 31 (100%) of licensed nurses were trained and completed post-tests. Education continued to include new employees. *On [DATE], the facility had conducted 28 Code Blue Drills with 30 of 31 (96.7%) licensed nurses. The remaining one staff member was scheduled to complete a code blue drill upon return from medical leave. *Ad HOC QAPI meetings were held on [DATE], [DATE], and [DATE], and Monthly QAPI meeting on [DATE] with Administrator, Director of Nursing, Medical Director and administrative staff. Education, audits, code blue drills and post-tests were reviewed and revised as indicated. *Interviews were conducted on [DATE] with 32 staff members representing all shifts (15 CNAs, 6 RNs, 9 LPNs, 1 SSD and 1 Admissions Coordinator). Staff interviews revealed they were knowledgeable of advanced directives; how to verify the code status; completion of Florida DNRO form and location of Emergency Response (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Binders. The surveyors validated the education, audits and participation in code blue drills through interviews and review of attendance sheets and post-tests. Review of Monthly and Ad HOC QAPI meetings revealed educations, audits and code blue drills were conducted as stated. The resident sample was expanded to include seven additional residents who elected DNR status. Interviews and record reviews revealed no concerns for residents #2, #3, #4, #5, #6, #7, #8, #9 and #10 related to advance directives. Based on the facility's corrective actions, the survey team determined the facility was in substantial compliance on [DATE].