Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95601	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS An unannounced Relicensure survey was conducted on through at Vivo Healthcare Fort Pierce. The facility had deficiencies at the time of the survey.	N 000		
N 110 SS=E	400.141(1)(h) FS; 59A-4.122(1) FAC Physical Environment - Safe, Clean, Homelike 400.141(1)(h) FS Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner. 59A-4.122(1) FAC The licensee must provide a safe, clean, comfortable, and homelike environment, which allows the resident to use his or her personal belongings to the extent possible This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure timely housekeeping and maintenance in 2 of 4 (100 and 300) resident hallways, affecting Resident #224, #42, #23, and #66; and failed to maintain ceiling vents and common area walls on all four resident units and in the central common area. The findings included: 1. The following environmental and housekeeping concerns were observed during the survey: a) On at 10:24 AM, Resident #224 stated the window air conditioner in her room was broken, and had been since her admission on . The panel on the air conditioning unit	N 110	N-110 Safe/Clean/Homelike Environment 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Ceiling vents have been corrected. Ceiling vents on 100, 200, 300 and 400 Halls, and in the central common area have been removed, sanded & repainted to an acceptable condition, and then replaced in their proper slots. This was completed on . All areas of bubbling and peeling paint were repaired and repainted in Hall 300 and Hall 400, as of . Resident # 42 privacy curtains were replaced with new clean curtains on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95601	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 110	Continued From page 1 showed a code of E3, indicating an error, and no air was blowing. b) On at 11:09 AM, the privacy curtains for Resident #42 were noted to be stained on both sides. Photographic Evidence Obtained. There was also a odor noted upon entering the room. On at 10:35 AM and on at 9:29 AM, the odor remained. An observation of the resident's mattress at this time lacked any obvious signs of previous episodes and during a skin check at this time, the resident's skin lacked any skin , which would indicate a lack of care. Upon further investigation, the privacy curtain had an odor as well as the room itself. The baseboard on the wall behind the bed had also pulled away from wall several inches and the laminate trim from the footboard of the bed was missing. The floors were visibly dirty with debris and darkened stains. Photographic Evidence Obtained. c) On at 11:19 AM, the over-the-bed table for Resident #23 had an open rusted square area on the , and the headrest area of the recliner had a worn off, and could no longer be effectively cleaned. Photographic Evidence Obtained. d) On at 10:35 AM, an area of white plaster, approximately 2 by 3 , was noted on the yellow wall located behind the bed of Resident #66. During a supplemental interview on at 9:42 AM, the resident stated it had been there ever since she could remember. When asked if it bothered her, the resident stated, "Well it's not pretty." During an interview on at approximately	N 110	, , 3/ , , , and . Privacy curtains will be examined daily and changed daily, or as needed. Resident # 42 baseboard behind bed was replaced with new, as of Resident # 42 A new bed was provided to this resident as of Resident # 42 Floor was sanitized and cleaned on , , , , , and . This room is inspected daily and will be cleaned daily or as needed. Resident # 23 A new overbed table was provided for this resident, as of . Resident # 23 The recliner was removed from this resident's room, as of Resident # 66 The wall behind the bed was repaired to an acceptable condition as of . Resident # 244 A new Air Conditioner has been Installed in this room, on . Resident #42: room where this resident resides has been added to the 'target list' of rooms that are inspected every day (2) How will you identify other residents having potential to be affected by the same practice and what corrective actions will be taken; Maintenance & Housekeeping Department Heads will incorporate a weekly resident room Inspection at the beginning of the week. These Inspections will be documented and discussed upon completion to identify areas of concern. Findings will be addressed and corrected depending on the severity & impact on the residents. Inspections for the room inhabited by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95601	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 110	Continued From page 2 10:00 AM, when asked the process for ensuring clean privacy curtains, the Housekeeping Director stated the curtains are taken down and replaced monthly when each room is deep cleaned. When asked specifically about the deep cleaning schedule, the Housekeeping Director stated he makes out a monthly calendar and ensures each room and all common areas are deep cleaned monthly. The Housekeeping Director also identified two "target" rooms that are completed weekly due to odors, but did not include the room of Resident #42. When asked if the staff did any type of rounds to identify new areas of concern, the Housekeeping Director stated managers do daily angel rounds and should be reporting any concerns during their morning meetings. An additional observation was made at this time and the Housekeeping Director agreed with the concerns for Residents #42 and #23. During an interview and tour on at 11:12 AM, when asked the process for repairs, the Maintenance Director stated they had a maintenance book to log needed repairs, and many staff just tell him of needed repairs. The Maintenance Director stated, "Remember, I'm the only maintenance person, so I can't always get to things right away. And I do life safety as well." Review of the 100 unit Maintenance Book lacked any entries for 2025. During an observation of the plaster wall in Resident #66's room, with the Maintenance Director, he stated the repair of that wall had been done in or (of 2024), and that he hadn't had a chance to get and paint the area or the wall. Observation of Resident #244's room revealed a temporary air conditioner. The Maintenance Director stated he had just heard about the issue that morning. When told it had not been working since the resident's admission, the Maintenance	N 110	resident #42 will be daily. The resident uses the privacy curtains to wipe himself when using the bathroom. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur? Maintenance & Housekeeping staff have been made aware of the additional weekly Inspections. All other staff members have been re-educated regarding reporting Maintenance & Housekeeping issues in the Maintenance logbooks posted at the nurse's stations. All staff members have also been instructed to verbalize their requests, when possible, in addition to noting them in the Maintenance logs. All staff members have been educated on the escalation process should they feel an environmental issue has not been addressed. Daily inspections of the 'target rooms' list will continue ongoing. Facility staff were educated by the Executive Director/Designee on on ensuring a safe, clean, homelike environment, and how to report concerns for maintenance and environmental services. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place; The Maintenance & Housekeeping Departments will conduct a weekly efficiency & quality review of the additional maintenance and housekeeping Inspections & reporting process x 4 weeks, and then every 2 weeks x 2 months then PRN as indicated. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95601	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 110	Continued From page 3 Director stated he just heard of the issue that day. 2. Observation of the common area and four hallways on beginning at approximately 11:30 AM, with Photographic Evidence obtained, revealed the following: a) On the 100 hall, 5 of 6 ceiling vents had a rust-like substance and or were dirty. b) On the 200 hall, 6 of 6 ceiling vents had a rust-like substance and or were dirty. c) On the 300 hall, 6 of 6 ceiling vents had a rust-like substance and or were dirty. There were multiple areas of bubbling and or pealing paint on the walls. d) On the 400 hall, 4 of 6 ceiling vents had a rust-like substance and or were dirty. The walls had areas of bubbling paint. e) In the common central area, 6 of 8 ceiling vents had a rust-like substance and or were dust laden. During an interview on at approximately 1:00 PM, the Maintenance Director agreed with the findings. Class III	N 110	findings of these quality reviews are to be reported to the Quality Assurance/Performance Improvement Committee monthly x 3 months, or until committee determines substantial compliance. The Administrator/Designee will conduct a quality review of resident rooms, kitchen, to ensure facility is providing safe, clean and comfortable homelike environment 3 times weekly x 4, then weekly x 4 weeks, then monthly x 1 month and PRN as indicated. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is maintained.	
N 201 SS=D	400.022(1)(i), FS Right to Adequate and Appropriate Health Care (I) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency.	N 201		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95601	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on policy review, observation, interview, and record review, the facility failed to effectively communicate the resident's complaint of , failed to evaluate the effectiveness of , interventions and failed to appropriately treat , for 1 of 5 sampled residents, Resident #42, reviewed for , management; failed to ensure timely care for 2 of 5 sampled residents, Residents #6 and #61, reviewed for activities of daily living (ADLs) care; and failed to ensure changes were completed per physician order for 1 of 2 sampled residents, Resident #61, reviewed for care. The findings included: 1. Review of the record revealed Resident #42 was admitted to the facility on . Review of the Quarterly Minimum Data Set (MDS) assessment dated documented the resident had a ( ) score of 3, on a 0 to 15 scale, indicating severe , . This MDS documented the resident needed maximum to dependent assistance for Activities of Daily Living (ADL). Review of the care plan, initiated on and revised on , documented the resident had , related to a , , , (,), , , and left , . This care plan instructed "staff to evaluate the effectiveness of , interventions as needed." It documented to "review for compliance, alleviating symptoms, dosing schedules and resident satisfaction with results, impact on functional ability, and impact on cognition. Staff instructed to monitor, record, and report to the nurse any signs	N 201	#1 Tag Management What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The physician was notified of the resident's complaint of spasms and an order obtained for relaxant on . Resident was referred to Management practitioner and evaluated on and an as needed order for was obtained. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. An audit of all residents was done to verify they have active orders for assessment on . Nursing staff will be reeducated to report all symptoms to primary physicians and Management provider when identified by . What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur. Residents will have assessment by licensed nurse every shift to identify incidence of for timely intervention by . CNAS reeducated to immediately report any complaints by residents of or discomfort to the floor nurse and immediately by . How the corrective action(s) will be monitored to ensure the deficient practice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95601	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 5 and symptoms of non-verbal , , such as changes in breathing (noisy, deep / shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); /behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); (wide open/narrow slits/shut, glazed, tearing, no focus); (, crying, worried, scared, clenched , grimacing) Body (tense, rigid, rocking, curled up, thrashing)." Review of physician progress notes dated revealed in part that a significant was present in the left arm and with significant , , consistent with prior history of . The record lacked any other documentation related to spasms or cramps. Review of the recent daily skilled nursing notes documented inconsistency with the location of , , documenting on right , on left , on left , level 5, on , on right , on right , and on right , . Further review of the record documented an order dated for , (a medication for and ,) but lacked any medication order for cramps or spasms. An observation of personal care by Staff B, Certified Nursing Assistant (CNA), was made on at approximately 9:45 AM for Resident #42. During the care, Resident #42 experienced left rigidity and extension, with the left involuntarily pulling inward and crossing over right , with the resident expressing , and calling it a "cramp." The CNA gave verbal instructions to relax and on breathing exercises. The CNA was	N 201	will not rec, i.e., what quality assurance program will be put into place. Weekly quality review will be conducted by DON or designee weekly x 4, then bi-weekly X 2 then monthly X1. Quality reviews will be entered by DON in QAPI for monitoring x 3 months or until substantial compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. #2 and #3 Tag ADL Care : Nail grooming not performed for two residents #6 and #61 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident# 6, nails were cut and cleaned during survey Resident # 61, nails were cut and cleaned during survey. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. An audit of all residents' nails was conducted on to identify other residents who may be affected by deficient practice. Any exceptions found were addressed at time of audit. What measures will be put into place or what systemic changes will you make to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95601	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 6 unable to provide care for about 1 to 2 minutes during the event. Interview and observation with the resident were conducted on at 11:17 AM, who stated he would like to get up in a chair, but the chair was a problem because his whole body "hurts" while sitting in the chair. The resident stated he has "cramps" all the time in his left , and that is why he is more comfortable in bed. During this interview, the resident started to have , and stated it was his left cramping. He squirmed in the bed holding the bedrail with his right and pulling up in bed, and his left was in full extension. He started moaning and had grimacing, stating that it was still hurting for 2 to 3 minutes. Resident #42 then pushed the call bell at 11:20 AM. Staff C, Registered Nurse (RN) came in at 11:22 AM, and he stated he had a cramp to his left , at which time she repositioned his left . During an interview on at 2:50 PM with Staff B, CNA, when asked how often Resident #42 has spasms or cramps, and what body part was involved, Staff B stated he complained of left , and called it a cramp. The CNA stated he pushes the call bell several times a day and says his left is cramping. She stated she repositions him and places a pillow under his . When asked what she does next, Staff B stated she reports the complaint of to the nurse. An interview was conducted on at 3:15 PM with Staff C, RN, who was asked if she had ever seen Resident #42 have a left , , she stated, "No" and added the resident has a diagnosis of , , and gets , for it. Staff C, RN, stated today was the first time she had ever heard the resident's described as a	N 201	ensure that the deficient practice does not recur. Nursing staff educated re residents' nail grooming and cleanliness during daily ADL care by Weekly audits x 4 weeks will be conducted, then bi-weekly x 2, then monthly x 1 to identify any deviation from the compliance plan by Guardian angels will do weekly checks of assigned residents' nails during their routine rounding for need of grooming and report need to Unit Managers for care by How the corrective action(s) will be monitored to ensure the deficient practice will not rec, i.e., what quality assurance program will be put into place. The plan will be submitted to the QAPI process for monitoring and review x 3 months or until substantial compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. #4: Quality of Care: care was not completed as ordered; care was documented as done. What corrective action(s) will be implemented for those residents found to have been affected by the deficient practice.	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95601	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 7 cramp. After surveyor intervention, an order for Flexeril, a relaxant, was added on at 3:39 PM by Staff C, RN. 2. Review of the policy "Nail Care" dated documented in part, "...3. routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises. ...7. d. If trimming is allowed, clip nails using nail clippers straight across and even with tops of the .." Review of the record revealed Resident #6 was admitted to the facility on . Review of the Quarterly Minimum Data Set (MDS) assessment dated documented the resident had a ( ) score of 9, on a 0 to 15 scale, indicating severe , . This MDS also documented the resident needed substantial to for personal hygiene. Review of the current care plan initiated on , and revised on , documented Resident #6 had an ADL [Activities of Daily Living] self-care , and instructed staff to check nail length, trim, and clean on bath day, and as necessary. A second care plan initiated on , and revised on , documented, in part, to avoid scratching and keep short. Review of the most current weekly skin assessment, dated , documented the resident's nails were cleaned and trimmed. Observations on at 2:46 PM and on	N 201	The physician was informed by the Unit manager of the order for care not being executed, on /24for resident #61, a new order for PRN obtained and care performed on . The resident's was evaluated by care , on and showed no adverse outcome from missed . How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken. DON and Unit managers completed an audit of all similar residents to identify any other residents affected by the deficient practice on . The audit revealed that no other residents were affected by the deficient practice. What measures will be implemented or what systemic changes will you make to ensure that the deficient practice does not recur. All licensed nurses will be reeducated on care policy and procedures and on following physicians' orders by All licensed nurses will be reeducated on nursing documentation of provision of care in residents' medical records only after the care is completed by Weekly quality review of care provision and documentation will be conducted by DON/designee of 5 residents with x 4 weeks then bi-weekly x 2 then monthly x 1 by . How the corrective action(s) will be monitored to ensure the deficient practice will not rec, i.e., what quality assurance program will be put into place. Results of quality review by DON/ designee will be introduced in the QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95601	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 8 at 12:59 PM revealed Resident #6 was in bed and noted to have excessively long ˘ that had red-brown substance under the nail beds, extending approximately 0.5 cm beyond the ˘ . On at 12:59 PM, the resident was observed scratching an open area on her left cheek using her ˘ and was present on her . During an interview on at 3:00 PM, when asked who was responsible for nail care, Staff D, Certified Nursing Assistant (CNA), stated another CNA, Staff B, who speaks Spanish the resident's primary language, does the resident's nails. On at 3:10 PM, Staff B stated that nails were cleaned as part of bathing, but not trimmed, because all nail trimming was done by the activity department. During an interview on at 11:36 AM, when asked who was responsible for nail care, the Activities Director stated a restorative CNA does nail care that includes trimming, filing, and polishing ˘ for the residents. An interview was conducted on at 1:57 PM, with Staff C, Registered Nurse (RN), who stated the ˘ of Resident #6 were a little long. Observation at this time revealed the resident's ˘ appeared shorter than the previous day but still remained long and beyond the end of the ˘ . During this interview, Staff B stated she had trimmed the resident's nails that morning. 3. Record review revealed Resident #61 was admitted to the facility on . Review of the Quarterly Minimum Data Set (MDS) assessment, dated , documented the resident had a ( ) score of 5, on a 0 to 15 scale, indicating severe ˘	N 201	process for monitoring and review for 3 months or until substantial compliance with care policy. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95601	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 9 , . This MDS also documented the resident needed partial to with personal hygiene. Review of the current care plan initiated on , and revised on , documented Resident #61 had an ADL self-care and instructed staff to check the nail length, trim and clean on bath day, and as necessary. An interview and observation conducted on at 12:46 PM revealed Resident #61 was sitting in his chair digging under his . His lunch tray with the remainder of bar-b-que chicken and sauce were on the over-the-bed table. Nine of the ten nails on both were long, extending beyond the , with reddish-brown substance under the nails. Resident #61 requested a napkin to clean under his nails. The of Resident #61 extended approximately 1cm beyond his , line and were curled under, making it more difficult to remove the debris under his nails. When asked if he likes his nails that length, the resident stated, "No." Resident #61 expressed that he was waiting for a staff member to trim his nails, and that it had been several weeks. On at 10:06 AM, the resident's nails remained long with some residual substance under the nails. On at 12:07 PM, the resident's nails were trimmed and cleaned. Resident #61 stated, "They were just done." 4. Review of the policy, titled, Treatment Management, revised , documented in part, "1. treatments will be provided in	N 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95601	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 10 accordance with physician orders.... 7. Treatments will be documented on the Treatment Administration Record." Review of the record revealed Resident #61 was admitted to the facility on . Review of the Quarterly Minimum Data Set (MDS) assessment, dated , documented the resident had a ( ) score of 5, on a 0 to 15 scale, indicating severe . Review of the current orders documented as of that staff were to provide daily care to the right heel. An order dated instructed nurses to provide daily care to the resident's right . An additional order dated instructed staff to offload Resident #61 right heel while in bed. An observation on at 3:35 PM revealed Resident #61 in bed with two on his right lower . The resident's right heel was directly on the mattress, with no . There were two right : one on the area and one around the heel and ankle. Written on both was the date with the initials of the nurse who completed the care. On at 3:17 PM, an observation revealed the same date and initials as the previous day. On at 3:26 PM, Staff E, Unit Manager, confirmed that the nurse did not change the as ordered, as the initials on the were by the nurse who had worked two days prior. Review of the corresponding Treatment Administration Record (TAR) for , documented the had been completed,	N 201		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	95601	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 11 when it had not been done, as confirmed with the Unit Manager. Staff E was observed doing the change on at 3:42 PM. When the was removed, there was a moderate amount of drainage on the that had seeped through the outermost layer and it was malodorous. Class III	N 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Recertification survey was conducted on through at Vivo Healthcare Fort Pierce. The facility was not in compliance with CFR 42, Part 483, Requirement for Long Term Care Facilities.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the call bell was within reach for 1 of 1 sampled resident, Resident #42, who was capable to use the call bell and needed assistance. The findings included: Review of the record revealed Resident #42 was admitted to the facility on . Review of the current Minimum Data Set (MDS) assessment dated documented the resident needed maximum to total assistance from staff for activities of daily living (ADLs) to include mobility. An interview and observation was conducted on at 11:02 AM. Although the record documented a low score, the resident could answer simple questions and make his needs known. He was able to reveal he had had a that affected his left side. When asked	F 558	F558 Reasonable accommodation of needs Resident #42 call bell out of reach Corrective actions What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #42 call light was placed within reach during survey. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. DON/designee conducted an initial audit of all residents' call lights conducted to identify any other affected residents affected by deficient practice on 2/13/25. There were no other affected residents. What measures will be put into place or	

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

Electronically Signed /2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 1 how he gets help when needed, he stated he used the call bell. Resident #42 was in bed during the interview and reached for the call bell to his right side. The call bell was looped over the lowest part of the mobility bar with the button part to activate on the floor. Photographic Evidence Obtained. The resident was unable to reach the cord to obtain the call button. During an observation on at 9:02 AM, Resident #42 was sitting up in an adaptive chair, sliding down with his and hanging off the footrest to the right side, and the call bell was on the bed and out of reach. Staff X, Certified Nursing Assistant (CNA), entered the room within a couple of minutes to pick up the breakfast trays. Resident #42 called the CNA by name and told her he was "not okay." The CNA agreed to help him after she removed his breakfast tray. At 9:13 AM, Resident #42 requested the call bell as the CNA had not placed it within his reach. The resident was able to push the call bell once it was within his reach.	F 558	what systemic changes will you make to ensure that the deficient practice does not recur. Weekly audits of all rooms will be conducted by DON or designee to ensure compliance with appropriate call bell placement X 4 weeks, then bi-weekly x 2 weeks then monthly X 1 then PRN. Results will be reviewed for quality by DON or designee. Guardian angels will round in their assigned times weekly x 4 weeks, then bi-weekly x 2 weeks then with their scheduled routine room rounds for appropriate call bell placement. All staff will be reeducated to ensure the call bells are secured within easy reach of residents after provision of care and services before leaving residents' rooms. How the corrective action(s) will be monitored to ensure the deficient practice will not rec, i.e., what quality assurance program will be put into place. DON will present the results of quality review in QAPI for oversight and revision if needed. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 2 CFR(s): 483.10(i)(1)-(7) §483.10(i) 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 safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)( ); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after , must maintain a temperature range of 71 to 81°F; and	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure timely housekeeping and maintenance in 2 of 4 (100 and 300) resident hallways, affecting Resident #224, #42, #23, and #66; and failed to maintain ceiling vents and common area walls on all four resident units and in the central common area. The findings included: 1. The following environmental and housekeeping concerns were observed during the survey: a) On at 10:24 AM, Resident #224 stated the window air conditioner in her room was broken, and had been since her admission on . The panel on the air conditioning unit showed a code of E3, indicating an error, and no air was blowing. b) On at 11:09 AM, the privacy curtains for Resident #42 were noted to be stained on both sides. Photographic Evidence Obtained. There was also a odor noted upon entering the room. On at 10:35 AM and on at 9:29 AM, the odor remained. An observation of the resident's mattress at this time lacked any obvious signs of previous episodes and during a skin check at this time, the resident's skin lacked any skin , which would indicate a lack of care. Upon further investigation, the privacy curtain had an odor as well as the room itself. The baseboard on the wall behind the bed had also	F 584	F-584 Safe/Clean/Homelike Environment 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Ceiling vents have been corrected. Ceiling vents on 100, 200, 300 and 400 Halls, and in the central common area have been removed, sanded & repainted to an acceptable condition, and then replaced in their proper slots. This was completed on . All areas of bubbling and peeling paint were repaired and repainted in Hall 300 and Hall 400, as of . Resident # 42 privacy curtains were replaced with new clean curtains on , , 3/ , , and . Privacy curtains will be examined daily and changed daily, or as needed. Resident # 42 baseboard behind bed was replaced with new, as of Resident # 42 A new bed was provided to this resident as of Resident # 42 Floor was sanitized and cleaned on , , , , , and . This room is inspected daily and will be cleaned daily or as needed. Resident # 23 A new overbed table was provided for this resident, as of . Resident # 23 The recliner was removed from this resident's room, as of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 4 pulled away from wall several inches and the laminate trim from the footboard of the bed was missing. The floors were visibly dirty with debris and darkened stains. Photographic Evidence Obtained. c) On at 11:19 AM, the over-the-bed table for Resident #23 had an open rusted square area on the and the headrest area of the recliner had a worn off, and could no longer be effectively cleaned. Photographic Evidence Obtained. d) On at 10:35 AM, an area of white plaster, approximately 2 by 3 , was noted on the yellow wall located behind the bed of Resident #66. During a supplemental interview on at 9:42 AM, the resident stated it had been there ever since she could remember. When asked if it bothered her, the resident stated, "Well it's not pretty." During an interview on at approximately 10:00 AM, when asked the process for ensuring clean privacy curtains, the Housekeeping Director stated the curtains are taken down and replaced monthly when each room is deep cleaned. When asked specifically about the deep cleaning schedule, the Housekeeping Director stated he makes out a monthly calendar and ensures each room and all common areas are deep cleaned monthly. The Housekeeping Director also identified two "target" rooms that are completed weekly due to odors, but did not include the room of Resident #42. When asked if the staff did any type of rounds to identify new areas of concern, the Housekeeping Director stated managers do daily angel rounds and should be reporting any concerns during their morning	F 584	Resident # 66 The wall behind the bed was repaired to an acceptable condition as of . Resident # 244 A new Air Conditioner has been Installed in this room, on . Resident #42: room where this resident resides has been added to the 'target list' of rooms that are inspected every day (2) How will you identify other residents having potential to be affected by the same practice and what corrective actions will be taken; Maintenance & Housekeeping Department Heads will incorporate a weekly resident room Inspection at the beginning of the week. These Inspections will be documented and discussed upon completion to identify areas of concern. Findings will be addressed and corrected depending on the severity & impact on the residents. Inspections for the room inhabited by resident #42 will be daily. The resident uses the privacy curtains to wipe himself when using the bathroom. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur? Maintenance & Housekeeping staff have been made aware of the additional weekly Inspections. All other staff members have been re-educated regarding reporting Maintenance & Housekeeping issues in the Maintenance logbooks posted at the nurse's stations. All staff members have also been Instructed to verbalize their requests, when possible, in addition to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 5	F 584		

meetings. An additional observation was made at this time and the Housekeeping Director agreed with the concerns for Residents #42 and #23.

During an interview and tour on at 11:12 AM, when asked the process for repairs, the Maintenance Director stated they had a maintenance book to log needed repairs, and many staff just tell him of needed repairs. The Maintenance Director stated, "Remember, I'm the only maintenance person, so I can't always get to things right away. And I do life safety as well." Review of the 100 unit Maintenance Book lacked any entries for 2025. During an observation of the plaster wall in Resident #66's room, with the Maintenance Director, he stated the repair of that wall had been done in or (of 2024), and that he hadn't had a chance to get and paint the area or the wall. Observation of Resident #244's room revealed a temporary air conditioner. The Maintenance Director stated he had just heard about the issue that morning. When told it had not been working since the resident's admission, the Maintenance Director stated he just heard of the issue that day.

2. Observation of the common area and four hallways on beginning at approximately 11:30 AM, with Photographic Evidence obtained, revealed the following:
a) On the 100 hall, 5 of 6 ceiling vents had a rust-like substance and or were dirty.
b) On the 200 hall, 6 of 6 ceiling vents had a rust-like substance and or were dirty.
c) On the 300 hall, 6 of 6 ceiling vents had a rust-like substance and or were dirty. There were multiple areas of bubbling and or pealing paint on the walls.
d) On the 400 hall, 4 of 6 ceiling vents had a

noting them in the Maintenance logs. All staff members have been educated on the escalation process should they feel an environmental issue has not been addressed.
Daily inspections of the 'target rooms' list will continue ongoing.
Facility staff were educated by the Executive Director/Designee on on ensuring a safe, clean, homelike environment, and how to report concerns for maintenance and environmental services.

(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;
The Maintenance & Housekeeping Departments will conduct a weekly efficiency & quality review of the additional maintenance and housekeeping Inspections & reporting process x 4 weeks, and then every 2 weeks x 2 months then PRN as indicated. The findings of these quality reviews are to be reported to the Quality Assurance/Performance Improvement Committee monthly x 3 months, or until committee determines substantial compliance.
The Administrator/Designee will conduct a quality review of resident rooms, kitchen, to ensure facility is providing safe, clean and comfortable homelike environment 3 times weekly x 4, then weekly x 4 weeks, then monthly x 1 month and PRN as indicated.
The findings of these quality reviews will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 rust-like substance and or were dirty. The walls had areas of bubbling paint. e) In the common central area, 6 of 8 ceiling vents had a rust-like substance and or were dust laden. During an interview on at approximately 1:00 PM, the Maintenance Director agreed with the findings.	F 584	be reported to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is maintained.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on policy review, observation, interviews, and record review, the facility failed to ensure timely ˘ care for 2 of 5 sampled residents, Residents #6 and #61, reviewed for activities of daily living (ADLs) care. The findings included: Review of the policy, titled, Nail Care, dated , documented in part, "... 3. routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises. ... 7. d. If trimming is allowed, clip nails using nail clippers straight across and even with tops of the ˘ ." 1. Review of the record revealed Resident #6 was	F 677	F677 Tag ADL Care : Nail grooming not performed for two residents #6 and #61 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident# 6, nails were cut and cleaned during survey Resident # 61, nails were cut and cleaned during survey. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. An audit of all residents' nails was conducted on to identify other residents who may be affected by deficient practice. Any exceptions found were addressed at time of audit. What measures will be put into place or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 7 admitted to the facility on . Review of the Quarterly Minimum Data Set (MDS) assessment dated documented the resident had a ( ) score of 9, on a 0 to 15 scale, indicating severe , . This MDS also documented the resident needed substantial to for personal hygiene. Review of the current care plan initiated on , and revised on , documented Resident #6 had an ADL [Activities of Daily Living] self-care , and instructed staff to check nail length, trim, and clean on bath day, and as necessary. A second care plan initiated on , and revised on , documented, in part, to avoid scratching and keep short. Review of the most current weekly skin assessment, dated , documented the resident's nails were cleaned and trimmed. Observations on at 2:46 PM and on at 12:59 PM revealed Resident #6 was in bed and noted to have excessively long that had red-brown substance under the nail beds, extending approximately 0.5 cm beyond the , . On at 12:59 PM, the resident was observed scratching an open area on her left cheek using her and was present on her . During an interview on at 3:00 PM, when asked who was responsible for nail care, Staff D, Certified Nursing Assistant (CNA), stated another CNA, Staff B, who speaks Spanish the resident's primary language, does the resident's nails. On at 3:10 PM, Staff B stated that nails were cleaned as part of bathing, but not trimmed, because all nail trimming was done by the activity	F 677	what systemic changes will you make to ensure that the deficient practice does not recur. Nursing staff educated re residents' nail grooming and cleanliness during daily ADL care by Weekly audits x 4 weeks will be conducted, then bi-weekly x 2, then monthly x 1 to identify any deviation from the compliance plan by Guardian angels will do weekly checks of assigned residents' nails during their routine rounding for need of grooming and report need to Unit Managers for care by How the corrective action(s) will be monitored to ensure the deficient practice will not rec, i.e., what quality assurance program will be put into place. The plan will be submitted to the QAPI process for monitoring and review x 3 months or until substantial compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 8	F 677		

department.
During an interview on at 11:36 AM, when asked who was responsible for nail care, the Activities Director stated a restorative CNA does nail care that includes trimming, filing, and polishing for the residents.

An interview was conducted on at 1:57 PM, with Staff C, Registered Nurse (RN), who stated the of Resident #6 were a little long. Observation at this time revealed the resident's appeared shorter than the previous day but still remained long and beyond the end of the . During this interview, Staff B stated she had trimmed the resident's nails that morning.

2. Record review revealed Resident #61 was admitted to the facility on . Review of the Quarterly Minimum Data Set (MDS) assessment, dated , documented the resident had a ( ) score of 5, on a 0 to 15 scale, indicating severe . This MDS also documented the resident needed partial to with personal hygiene.

Review of the current care plan initiated on , and revised on , documented Resident #61 had an ADL self-care and instructed staff to check the nail length, trim and clean on bath day, and as necessary.

An interview and observation conducted on at 12:46 PM revealed Resident #61 was sitting in his chair digging under his . His lunch tray with the remainder of bar-b-que chicken and sauce were on the over-the-bed table. Nine of the ten nails on both were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 9 long, extending beyond the , with reddish-brown substance under the nails. Resident #61 requested a napkin to clean under his nails. The of Resident #61 extended approximately 1cm beyond his line and were curled under, making it more difficult to remove the debris under his nails. When asked if he likes his nails that length, the resident stated, "No." Resident #61 expressed that he was waiting for a staff member to trim his nails, and that it had been several weeks. On at 10:06 AM, the resident's nails remained long with some residual substance under the nails. On at 12:07 PM, the resident's nails were trimmed and cleaned. Resident #61 stated, "They were just done."	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on policy review, observation, interview, and record review, the facility failed to ensure changes were completed per physician order for 1 of 2 sampled residents, Resident #61, reviewed for care.	F 684	F684- Quality of Care: care was not completed as ordered; care was documented as done. What corrective action(s) will be implemented for those residents found to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10 The findings included: Review of the policy, titled, Treatment Management, revised , documented in part, "1. treatments will be provided in accordance with physician orders.... 7. Treatments will be documented on the Treatment Administration Record." Review of the record revealed Resident #61 was admitted to the facility on . Review of the Quarterly Minimum Data Set (MDS) assessment, dated , documented the resident had a ( ) score of 5, on a 0 to 15 scale, indicating severe . Review of the current orders documented as of that staff were to provide daily care to the right heel. An order dated instructed nurses to provide daily care to the resident's right . An additional order dated instructed staff to offload Resident #61 right heel while in bed. An observation on at 3:35 PM revealed Resident #61 in bed with two on his right lower . The resident's right heel was directly on the mattress, with no . There were two right : one on the area and one around the heel and ankle. Written on both was the date with the initials of the nurse who completed the care. On at 3:17 PM, an observation revealed the same date and initials as the previous day. On at 3:26 PM, Staff E, Unit Manager,	F 684	have been affected by the deficient practice. The physician was informed by the Unit manager of the order for care not being executed, on /24for resident #61, a new order for PRN obtained and care performed on . The resident's was evaluated by care , on and showed no adverse outcome from missed . How will you identify other residents who have the potential to be affected by the same deficient practice and what corrective action will be taken. DON and Unit managers completed an audit of all similar residents to identify any other residents affected by the deficient practice on . The audit revealed that no other residents were affected by the deficient practice. What measures will be implemented or what systemic changes will you make to ensure that the deficient practice does not recur. All licensed nurses will be reeducated on care policy and procedures and on following physicians' orders by All licensed nurses will be reeducated on nursing documentation of provision of care in residents' medical records only after the care is completed by Weekly quality review of care provision and documentation will be conducted by DON/designee of 5 residents with x 4 weeks then bi-weekly x 2 then monthly x 1 by . How the corrective action(s) will be monitored to ensure the deficient practice will not rec, i.e., what quality assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 confirmed that the nurse did not change the ˬ as ordered, as the initials on the ˬ were by the nurse who had worked two days prior. Review of the corresponding Treatment Administration Record (TAR) for , , documented the ˬ had been completed, when it had not been done, as confirmed with the Unit Manager. Staff E was observed doing the ˬ change on at 3:42 PM. When the ˬ was removed, there was a moderate amount of drainage on the ˬ that had seeped through the outermost layer and it was malodorous.	F 684	program will be put into place. Results of quality review by DON/ designee will be introduced in the QAPI process for monitoring and review for 3 months or until substantial compliance with care policy. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law.	
F 697 SS=D	Management CFR(s): 483.25(k) §483.25(k) Management. The facility must ensure that , management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to effectively communicate the resident's complaint of , , failed to evaluate the effectiveness of , interventions, and failed to appropriately treat , for 1 of 5 sampled residents, Resident #42, reviewed for , management. The findings included:	F 697	F697 Tag Management What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The physician was notified of the resident's complaint of ˬ spasms and an order obtained for relaxant on . Resident was referred to Management practitioner and evaluated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 12 Review of the record revealed Resident #42 was admitted to the facility on . Review of the Quarterly Minimum Data Set (MDS) assessment dated documented the resident had a ( ) score of 3, on a 0 to 15 scale, indicating severe , . This MDS documented the resident needed maximum to dependent assistance for Activities of Daily Living (ADL). Review of the care plan, initiated on and revised on , documented the resident had , related to a , , , (,), , , and left , . This care plan instructed "staff to evaluate the effectiveness of , interventions as needed." It documented to "review for compliance, alleviating symptoms, dosing schedules and resident satisfaction with results, impact on functional ability, and impact on cognition. Staff instructed to monitor, record, and report to the nurse any signs and symptoms of non-verbal , , such as changes in breathing (noisy, deep / shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); /behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); , (wide open/narrow slits/shut, glazed, tearing, no focus); (, crying, worried, scared, clenched , grimacing) Body (tense, rigid, rocking, curled up, thrashing)." Review of physician progress notes dated revealed in part that a significant was present in the left arm and with significant , , consistent with prior history of . The record lacked any other documentation related to spasms or cramps. Review of the recent daily skilled nursing	F 697	on and an as needed order for , was obtained. How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. An audit of all residents was done to verify they have active orders for , assessment on . Nursing staff will be reeducated to report all , symptoms to primary physicians and Management provider when identified by . What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur. Residents will have , assessment by licensed nurse every shift to identify incidence of , for timely intervention by . CNAS reeducated to immediately report any complaints by residents of , or discomfort to the floor nurse and immediately by . How the corrective action(s) will be monitored to ensure the deficient practice will not rec, i.e., what quality assurance program will be put into place. Weekly quality review will be conducted by DON or designee weekly x 4, then bi-weekly X 2 then monthly X1. Quality reviews will be entered by DON in QAPI for monitoring x 3 months or until substantial compliance. Preparation and/or execution of this plan does not constitute admission or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 13 notes documented inconsistency with the location of , documenting on right , on left , on left , level 5, on , on right , on right , and on right . Further review of the record documented an order dated for (a medication for and) but lacked any medication order for cramps or spasms. An observation of personal care by Staff B, Certified Nursing Assistant (CNA), was made on at approximately 9:45 AM for Resident #42. During the care, Resident #42 experienced left rigidity and extension, with the left involuntarily pulling inward and crossing over right , with the resident expressing and calling it a "cramp." The CNA gave verbal instructions to relax and on breathing exercises. The CNA was unable to provide care for about 1 to 2 minutes during the event. Interview and observation with the resident were conducted on at 11:17 AM, who stated he would like to get up in a chair, but the chair was a problem because his whole body "hurts" while sitting in the chair. The resident stated he has "cramps" all the time in his left , and that is why he is more comfortable in bed. During this interview, the resident started to have and stated it was his left cramping. He squirmed in the bed holding the bedrail with his right and pulling up in bed, and his left was in full extension. He started moaning and had grimacing, stating that it was still hurting for 2 to 3 minutes. Resident #42 then pushed the call bell	F 697	agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 14 at 11:20 AM. Staff C, Registered Nurse (RN) came in at 11:22 AM, and he stated he had a cramp to his left ⌣, at which time she repositioned his left ⌣. During an interview on at 2:50 PM with Staff B, CNA, when asked how often Resident #42 has spasms or cramps, and what body part was involved, Staff B stated he complained of left ⌣, and called it a cramp. The CNA stated he pushes the call bell several times a day and says his left ⌣ is cramping. She stated she repositions him and places a pillow under his ⌣. When asked what she does next, Staff B stated she reports the complaint of , to the nurse. An interview was conducted on at 3:15 PM with Staff C, RN, who was asked if she had ever seen Resident #42 have a left ⌣ , , she stated, "No" and added the resident has a diagnosis of , , and gets , for it. Staff C, RN, stated today was the first time she had ever heard the resident's , described as a cramp. After surveyor intervention, an order for Flexeril, a relaxant, was added on at 3:39 PM by Staff C, RN.	F 697		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug , ,); or	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 15 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on policy review, interview, and record review, the facility failed to ensure adequate monitoring of side effects and behaviors for residents receiving , , , medications, for 1 of 5 sampled residents reviewed for unnecessary meds, Resident #16. The findings included: Review of the policy, titled, Use of , , , Medication, dated , indicated "Residents are not given , , , drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication (s). A , , , drug is any drug that affects activities associated with mental processes and behavior. , , , drugs include but are not limited to the following categories: , , , , , , ,	F 757	F757 Drug Regimen is Free from Unnecessary Drugs (1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident #16 had a new order for behavior monitoring was added to the resident's chart on and revised on , documentation scheduled for every shift. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken. An audit was conducted of the medical records of all patients on , , medication to identify any without behavior	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 16 , , and , , . The resident's response to the medication (s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record." Clincial record review revealed Resident #16 was admitted to the facility on , and again on , with diagnoses that included Non- , and a , , . Review of the physician orders, dated , revealed , 25 mg was prescribed to be administered orally at bedtime to address , , . Another order, dated , outlined behavior monitoring for the , , with a specific behavior code system: - 0: None - 1: /agitation - 2: Paranoia/ / - 3: Screaming/yelling - 4: Biting/kicking/hitting/pinching - 5: Danger to self/others - 6: Smearing feces/ Extreme fear - 7: non-pharmacological interventions were to be recorded with a specific code system included: -0: None -1: Activities -2:1:1 -3: Redirection -4: Repositioning -5: food/fluids -6: rest period -7: quite environment -8: Medication -9: PN Intervention Outcome: I=Improvement S=Same W=Worsen N/A=Not Applicable.	F 757	monitoring on by DON/ designee. Any found without were corrected. Weekly audits will be conducted X 4 by DON or designee then monthly x 3 or until substantial compliance. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur. Education provided to licensed nurses by DON by on the components of this regulation with emphasis on adequate monitoring associated , , medication use per physician's order requiring monitoring and the residents plan of care. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place. The DON /designee will conduct quality review of 5 residents' receiving , , medications weekly x 4 weeks for appropriate behavior monitoring as indicated, and then every 2 weeks 2, then monthly x1 then PRN as indicated. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 17 On , another physician ordered monitoring for side effects, and to place a number corresponding with the side effects, if other-document nurse's note. Outlined monitoring for the with a specific side effect code system: - 0: None - 1: Stiffness/lack of movement - 2: Tardive Dyskinesia - 3: - 4: - 5: gain - 6: - 7: - 8: - 9: Restlessness - 10: retention - 11: Dry - 12: Vision changes - 13: Other. Review of the care plan, revised on , indicated Resident #16 utilized medication for and . Interventions included monitor, document and reporting any adverse effects from the medication, such as unsteady gait, tardive dyskinesia, (EPS) symptoms, , refusal to eat, loss, difficulty swallowing, , social isolation, fatigue, blurred vision, loss of appetite, dry , , , cramps, loss, any symptoms not usual to the resident. Additionally, it documented to monitor and record occurrence for targeted behaviors that included: , combativeness, and any verbal or physical aggression toward others.	F 757	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 18 Review of the Medication Administration Record (MAR) indicated that behavior monitoring was recorded three times daily from , to . The documentation did not include specific codes as mandated to indicate observed behaviors; instead, they were noted by check marks. On at 8:36 AM, an interview with the Director of Nursing (DON) who clarified that behavior monitoring should include coding entries as directed. The DON stated that Resident #16 had not exhibited any concerning behaviors. When asked about using check marks, the DON affirmed that nurses should record a zero if no exhibited behaviors were noted, emphasizing that check marks do not effectively communicate the required information. Upon reviewing the MARs, the DON acknowledged the presence of check marks for behavior monitoring and confirmed the necessity of adhering to the documented coding system.	F 757		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 19 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure a clean and sanitary kitchen and failed to maintain food that was not past it's use-by or expired date. This could potentially affect 72 of 75 residents who consume an oral diet. The findings included: An observation of the kitchen was made on beginning at 8:54 AM with the Kitchen Manager / Certified Dietary Manager (CDM). Upon entering the kitchen, the breakfast service was completed, the kitchen had been cleaned after the meal, and staff were in the process of doing the breakfast dishes. The following concerns were noted and confirmed by managerial staff, with Photographic Evidence Obtained: a) A table in the food preparation area had peeling paint on all the ⌄ and shelf. b) A table in the food preparation area had ⌄ and shelves with rust-like surfaces. c) Pitchers filled with juice to be used that day had leftover sticker debris that had not been cleaned off. d) A plastic serving cart with two shelves was marred, scratched, and with grey-black staining. e) The floor around the cooking appliances was visibly soiled with debris and a black liquid-like	F 812	F812 Food Procurement, Store/Prepare/Serve- Sanitary 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A. Table in food preparation area with peeling paint on ⌄ and shelf has been sanded and painted on . B. Table in food preparation area with rust-like surfaces have been sanded and painted on . C. Dissolvable stickers are being used for dating the pitchers and thoroughly cleaned when removed. D. Plastic serving cart with scratches and staining has been discarded. E. Staff have been educated to thoroughly clean floor at the end of each meal. F. Plate warmer has been thoroughly cleaned, sanitized, and added to the weekly cleaning schedule. G. The juice machine has been replaced, and the hoses are secured. H. Condiment bins are being cleaned and sanitized after each use prior to restocking. I. Oven is being wiped down after each use and thoroughly cleaned weekly. J. Refrigerator gaskets are being wiped	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 20 substance. f) The plate warmer had visible dried brown substance or corrosion. g) The dispensing hose and nozzle to the juice bin was lying directly on the floor. h) A plastic bin with individual syrup containers was visibly soiled with a sticky substance. i) The oven handle was slippery and greasy with dried debris and a build-up. j) The walk in refridgerator had a brownish-black debris around the frame where the seal meets the frame. k) A plastic bin with "clean" utensils stored in it was on a large utility cart with dirty items. The plastic bin was visibly dirty with debris. l) Water was pooling on the floor, appoximately 10 to 12 inches from the wall, along the entire wall that contained the ovens and steamer. The following expired items, as evidenced by the best-by-dates, use-by-dates, and or expired dates marked on the item, were identified in the dry storage area: m) Twelve large cans of chicken and dumplings expired , . n) Twelve large cans of chili expired . o) A case of jelly expired on . p) A six , can of beef stew expired . It had been delivered on . q) A large can of chili con carne expired /224. It had been delivered on . r) A large jar of Skippy peanut butter expired . s) A case of butterscotch pudding, a case of pinto beans, a case of carrots, and a case of peanut butter, all dated as delivered in , of 2023 and unable to read the used by dates. t) Four packages of walnuts with written	F 812	down daily. K. Separate areas designated for clean and dirty items to avoid cross-contamination. L. Water pooled along the wall was cleaned on the spot. Steamer has been serviced with new gasket in place to prevent leaks. M. Chicken and dumplings discarded 2/10/2025. N. Canned chili discarded 2/10/2025. O. Case of jelly discarded 2/10/2025. P. Case of beef stew discarded 2/10/2025. Q. Can of chili con carne discarded 2/10/2025. R. Jar of Skippy peanut butter discarded 2/10/2025. S. Case of butterscotch pudding, case of pinto beans, case of carrots, and case of peanut butter all labeled with "Use by" dates. T. Four packages of walnuts discarded on 2/10/2025. (2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken; CDM completed a sanitation audit of the kitchen on 2/17/2025 to include but not limited to the doors, door seals, floors, juice machine, dish racks, can opener, kitchenware, food storage, sanitation solution, and equipment function. No negative findings. CDM completed a food storage audit on 2/17/2025 to ensure all food items are dated, labeled and packaged properly to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 21 dates that were not able to be read and lacked use-by-dates. The CDM was asked to provide the use-by-dates by the lot number, but failed to do so.	F 812	prevent contamination and growth of , organisms. No negative findings. (3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur; On LNHA initiated ongoing education with CDM and dietary staff on the components of this regulation with emphasis of following proper sanitation, kitchen/ nourishment room cleaning schedules, safe food handling to prevent the outbreak of foodborne illness, proper food storage including labeling and dating food items. On LNHA initiated ongoing education with CDM and dietary staff on proper notification to the maintenance staff when issues or concerns are identified. (4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place; CDM/Designee to conduct a sanitation audit of the kitchen 5 days weekly x 2 weeks, 2 days weekly x 2 weeks and then weekly x 2 months or until substantial compliance is met ensuring the kitchen is meeting the sanitation requirements as per federal guidelines. CDM/Designee to conduct a food storage audit 5 days weekly x 2 weeks, 2 days weekly x 2 weeks and then weekly x 2 months or until substantial compliance is met to ensure all food items are dated, labeled and packaged properly to prevent contamination and growth of , organisms.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 22	F 812	The findings of these quality reviews are to be reported to the Quality Assurance/Performance Improvement Committee monthly x 3 months, or until the committee determines substantial compliance.	
F 880 SS=D	Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Control The facility must establish and maintain an prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable and §483.80(a) prevention and control program. The facility must establish an prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling and communicable for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable or before they can spread to other	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23 persons in the facility; (ii) When and to whom possible incidents of communicable or should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of ; ( )When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable or skin from direct contact with residents or their food, if direct contact will transmit the ; and (vi)The hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of . §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to use appropriate hygiene practices and personal	F 880	F880- Tag Control What corrective action(s) will be accomplished for those residents found to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24 protective equipment (PPE) when providing and care for 2 of 3 sampled residents observed for direct care, Residents #65 and #61. The findings included: Review of the policy, titled, Enhanced Barrier Precautions (EBP), implemented on documented, in part," Definitions: 'Enhanced barrier precautions' refers to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or with a multidrug-resistant organism (MDRO) as well as those at increased risk of MDRO acquisition (e.g., residents with or medical devices.) ... Policy Explanation and Compliance Guidelines:... 1.b) Clear signage will be posted on the door or wall outside of the resident room indicating the type of precaution, required (PPE), and the high contact resident care activities that require the use of gown and gloves... 2. Initiation of Enhanced Barrier Precautions b.) An order for enhanced barrier precautions will be obtained for residents with any of the following: i.) (e.g., such as , , unhealed surgical , and statis) and/or medical devices (e.g., central lines, , , , , tubes) even if the resident is not known to be or colonized with a MDRO... 4.) High-contact resident care activities include: a.) b.) Bathing c.) Transferring d.) Providing hygiene e.) changing linens f.) changing briefs or assisting with toileting g.) Device care or	F 880	have been affected by the deficient practice. Resident# 65 was observed for sign or symptoms of , none discovered. DON was educated by Corporate Chief Clinical Director on Enhanced Barrier Precautions (EBP) during survey and an action plan presented to survey team CNA who demonstrated deficient washing and gloving practice received a 1:1 in-service on by DON All staff educated on EBP and the need for wearing gloves and gowns while providing care by How will you identify other residents having potential to be affected by the same deficient practice and what corrective action will be taken. A review of all residents was done to identify those who meet criteria for EBP. Signage was posted on the doors of all residents with EBP status and supplies placed in containers in hallway or on residents' doors on . Goal of 95-100% of all staff are reeducated by on handwashing and glove donning / doffing and changing is compliant with control procedures for . What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The ongoing EBP in-service will occur weekly for new employees Bins with PPE have been placed in hallways for easy access by staff effective	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25 use: central lines, , , , , / tubes h.) care... 7. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the heals or medical device is removed for the high-risk residents." 1. Record review revealed Resident #65 was admitted to the facility , with a primary diagnosis of of native of extremities with of the right (an accumulation of in the walls of the causing obstruction to flow leading to tissue.)". Other diagnoses included: "acquired absence of right below , acquired absence of left below , Type 2 with , and need for assistance with personal care." Review of the current Minimum Data Set (MDS) assessment dated documented Resident #65 had a ( ) score of 15, on a 0 to 15 scale, indicating intact cognition. This same MDS also documented the resident had an unhealed and was receiving . Review of the active orders revealed there were no Enhanced barrier precaution orders from - . An interview was conducted on at 9:05 AM with Resident #65, who when asked if the staff usually wore a gown and gloves when care was provided, the resident stated he had never seen them wear a gown. The resident was asked	F 880	How the corrective action(s) will be monitored to ensure the deficient practice will not rec, i.e., what quality assurance program will be put into place. The DON /designee will conduct quality review observations of ADL care for 5 residents dependent on ADL care weekly x 4 weeks, bi-weekly for every 2 weeks x 2 months then PRN as indicated. The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 3 months or until substantial compliance is achieved. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 26	F 880		

what type of , site he had and stated he had both a right upper port, (also known as a central / CVC, a tube inserted into a in the , or , to provide access for ,) and a ( ) to his left arm that was still maturing (a surgical connection between an , and a that allows patients to receive , treatments). At the time this interview was conducted, there was no (EBP) sign and no PPE was observed outside or inside the resident's room.

An care observation was conducted on at 10:15 AM on Resident #65 with Staff A, CNA. Before the care, Staff A washed her , gathered water in a basin and placed it on the bedside table and donned gloves; no PPE was used. With her gloved , Staff A pulled the curtain and provided privacy. She cleansed the upper body first and continued to the lower half. She then proceeded to provide perineum care and discovered the resident was soiled when she observed feces on the washcloth. While using the same gloves, Staff A turned the resident to their side to cleanse his bottom. She removed the soiled brief and continued with perineum care without changing her gloves. When Staff A proceeded to dress Resident #65, she changed out her gloves without performing hygiene. Staff A stated, "I am going to find the lift to transfer the resident to the chair." She was observed to remove her gloves and again not perform any hygiene as she left the room.

When Staff A walked out of the resident's room, an interview was conducted at10:50 AM with the aide. Staff A was made aware of her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 27	F 880		

hygiene and care practices, and stated she did not even notice she had not performed hygiene or changed her gloves during and after the care was provided. Staff A stated, "I did wash my in the beginning". She acknowledged the importance of hygienic performance. When asked if the resident was on any precautions or if they usually used gowns when care was provided, she stated the resident was not on any precautions and if there was no sign on the door they didn't have to wear a gown.

On at 12:14 PM, an interview was conducted with the Director of Nursing (DON) regarding the (EBP) and care observation findings with Staff A. The DON stated, "It breaks my to hear that because we just did an in-service training last week about handwashing and her signature is on it." She agreed care should not have been performed that way and stated Staff A was nervous. The DON admitted she misunderstood the guidelines and criteria regarding the residents that should have been placed on (EBP). The DON stated, "I take full accountability, and we are currently working on fixing it by placing the orders and precautions in place for those residents."

2. Record review revealed Resident #61 was admitted to the facility on .

Review of the current physician's order, dated , documented for daily care to the open area of the resident's right heel. A physician's order, dated , documented for daily care to the open area of the resident's right _. The record lacked any order or care plan related to Enhanced Barrier

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105804	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIVO HEALTHCARE FORT PIERCE	700 S 29TH STREET FORT PIERCE, FL 34947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 28 Precautions (EBP). During the initial pool process on , there was no EBP signage on or at the door or in the room of Resident #61. There was no PPE set up on or at the resident's door, as observed on the doors of the other residents who were on EBP. An observation of care was done on at 3:42 PM with Staff E, Unit Manager. Staff E did not wear a protective gown during the change. Staff E completed care on both open . An interview was conducted on at 10:12 AM with Staff E, who when asked of her understanding of EBP, the Unit Manager stated she did not understand the implementation of EBP until this week. The Unit Manager confirmed she did not wear a gown during the change that she had completed for Resident #61 on . An interview was conducted on at 8:50 AM with the Director of Nursing (DON) that revealed she misunderstood EBP. She stated she thought it was for Multi-Drug Resistant Organisms (MDROs), , (,) , and Vacs. She stated that she instructed the staff to remove all EBP signs on other room doors. The DON stated she had reread the Centers for Control and Prevention (CDC) recommendations last night and stated she was wrong.	F 880		