STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106006	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baldomero Lopez Memorial Veterans Nursing Home	6919 Parkway Blvd Land O Lakes, FL 34639

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure a complete and thorough investigation for two resident-to-resident abuse incidents (Resident #1/Resident #2 and Resident #5/Resident #6) out of nine resident-to-resident incidents reviewed.Findings included: 1.An interview was conducted on 4/8/26 at 3:25 p.m. with Staff A, Certified Nursing Assistant. He said when the resident-to-resident incident occurred with Resident # 1and #2 on 4/2/26, he was across the hall in another resident room with the door shut providing care. Staff A said he was the only staff member on the hall at the time and tried to keep an eye on everyone but had to close the door of the room he was in for privacy. He said he heard screening from another room, so he dropped everything and ran out. He said he went into Resident #1's room and Resident #1 had Resident #2 pinned to the bed and had his hands around his neck. Staff A said he had to convince Resident #1 to let so of Resident #2. He said Resident #2 was visibly shaking and trembling. Staff A said he could only imaging how Resident #2 felt at the time. Review of admission Records showed Resident #1 was admitted on [DATE] with diagnoses including Alzheimer's disease, cognitive communication deficit, and adjustment disorder with mixed anxiety and depressed mood. Review of Resident #1's Annual Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed a brief interview for mental status (BIMS) score of 12, indicating moderately impaired cognition. Review of Resident #1's Care plan showed a problem area of:Psychiatric: Resident #1 is at risk fluctuations in mood and behavior related to Alzheimer's dementia and post-traumatic stress disorder (PTSD). Review of Resident #1's progress notes showed:4/2/26 7:50 p.m. by Staff B, Licensed Practical Nurse (LPN). Resident involved in resident-to-resident altercation during shift. Immediate staff interventions was implemented, and resident separated without further escalation. Post-incident observations revealed no visible injury or outward sign of acute distress at time of entry. Resident was redirected and remained in stable condition thereafter. Responsible party was notified. RN supervisor and risk manager were notified in accordance with facility protocol. Ongoing monitoring and safety interventions continue. Review of admission Records showed Resident #2 was admitted on [DATE] with diagnoses including Alzheimer's disease with early onset, major depressive disorder, recurrent, mild, other mixed anxiety disorders, and dementia in other diseases classified elsewhere, severe with psychotic disturbance, mood disturbance and anxiety. Review of Resident #2's MDS dated [DATE], Section C, Cognitive Patterns, showed a BIMS score of 3, indicating severely impaired cognition. Section E, Behavior showed resident wandered daily and resident had physical behavioral symptoms directed towards others on one to three of the previous seven days. Review of Resident #2's care plan showed a problem area of:Behavior: the resident is noted with problematic behaviors such as constant pacing and wandering the secured unit. He has cognitive impairment related to dementia and demonstrated impaired awareness of personal space. He may enter other resident's rooms or crowded areas and become anxious or agitated when in close proximity to others, placing him at risk of resident-to-resident conflict or altercations. Dated 3/13/26. Review of Resident #2's progress notes showed:4/2/26 7:38 p.m. by Staff C, LPN. Wife and POA [power of attorney] notified that resident involved in Altercation [sic] with another resident. Resident evaluated by this nurse. No bruising, skin (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tears or redness noted to resident skin. Resident denies pain or discomfort at this time. An interview was conducted on 4/8/26 at 2:05 p.m. with the Risk Manager (RM) and a follow-up interview was conducted on 4/9/26 at 2:00 p.m. She said Staff B, LPN called her on 4/2/26 around 8:00 p.m. and told her there had been a resident-to-resident abuse incident with Residents #1 and #2. She said she was told Resident #1 had his hands around Resident #2's neck. The RM said she was not always in the building and depending on where she was at, she told staff to get her the allegations and the information. The RM said for this incident she didn't have statements but was still investigating it. She confirmed she typically got statements immediately when an event occurred. The RM said, we [staff] aren't good about painting the picture. If I am not here I have to rely on them [staff] to tell me what is going on. She said she only had a verbal statement from Staff B, LPN about what happened with Residents #1 and #2. She said Staff B told her a CNA informed him about the incident, but the RM didn't know who the CNA was. She said she thinks it was Staff A, CNA that said something about witnessing Resident #1 having his hands around Resident #2's neck. The RM said she did not get a statement from Staff A, CNA. She said the way she visualized it the incident happened in front of the bed by the door. She said Resident #1 was up and he met Resident #2 at the door and started screaming at him and then Resident #2 got in Resident #1's personal space and Resident #2 put his hands on Resident #1's neck. The RM said she was assuming this happened by the door but did not get a written statement or clarification from Staff A, CNA to figure out what happened. The RM said she had not heard anything about Resident #2 being pinned to the bed by Resident #1. She confirmed she had already completed the required investigation reports and submitted them. The RM said she could have dug into the incident further and there were no excuses. 2. An interview was conducted on 4/9/26 at 11:15 a.m. with Staff B, LPN. He said for the incident with Residents #5 and #6 on 2/3/26 he was the first one to arrive in the room. He said he witnessed Resident #6 wander into Resident #5's room and he thought Resident #5 would tell Resident #6 would leave and he would exit the room. Staff B, LPN said he heard Resident #5 tell Resident #6 to leave but they got into it like to macho guys and he ran into the room. He said the two residents were full on punching each other and it was like a [NAME] in the jungle. Staff B said Resident #6 ended up being pushed to the floor and kicked by Resident #5. He said he yelled for Staff A, CNA to help him and they were able to separate the two residents. Staff B said Resident #6 had redness around his eye where he was hit right after the incident happened and later it turned purple. Review of admission Records showed Resident #5 was admitted on [DATE] with diagnoses including Alzheimer's, dementia, and a history of mental and behavioral disorders. Review of Resident #5's MDS dated [DATE], Section C, Cognitive Patterns, showed a BIMS score of 8, indicating moderately impaired cognition. Review of Resident #5's progress notes showed;2/3/26 at 9:43 p.m. Staff reported to this writer that resident had pushed [Resident #6] to the ground. Staff heard yelling and investigated the yelling they observed both residents exchanging punches. According to staff, resident [Resident #6] walked into [Resident #5] room doorway. Then [Resident #5] became agitated at this and began the physical altercation. As staff were walking over to intervene, they observed [Resident #5] push [Resident #6] to the ground. [Resident #6] fell backward and then onto his buttocks with his back against the open door. [Resident #5] cursed at [Resident #6] and then kicked him while on the ground. CNA intervened and redirected [Resident #5] into his room and shut his door. CNA went to get the hall nurse. Hall nurse assessed both residents and no visible injuries were noted to either resident. Both denied pain. [Resident #6] was assisted up into his wheelchair by the hall nurse and 2 CNAs. This writer placed a stop sign on [Resident #5] door and contacted Risk Manager. Review of admission Records showed Resident #6 was admitted on [DATE] with diagnoses including Alzheimer's, cognitive communication deficit, PTSD, and mild neurocognitive disorder due to known physiological condition with behavior disturbances. Review of Resident #6's 1/23/26 admission MDS, Section C, Cognitive Patterns, showed a BIMS score of 4, indicating severely impaired cognition. Review of Resident #6's progress notes showed: 2/3/26 at 9:43 p.m. Staff reported to this writer that resident was pushed to the (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ground by Resident #6. Staff heard yelling and investigated the yelling, when they observed both residents' exchanging punches. According to staff, Resident #6 walked into Resident #5's room doorway. Then, Resident #5 became agitated and began the physical altercation. As staff walked over to intervene they observed Resident #5 pushed Resident #6 onto his buttocks with his back against the open door. Resident #5 cursed at Resident #6 then kicked him while he was on the ground. CNA intervened and redirected Resident #5 into his room and shut the door. Hall nurse assessed both residents and no visible injuries were noted to either resident. Resident #6 was assisted up into this wheelchair. A stop sign was placed on Resident #5's door. RM was notified of the incident. Resident #6 verbalized that he went into the room not knowing it was not his own. An interview was conducted on 4/8/26 at 2:05 p.m. with the Risk Manager (RM). She said Resident #6 was on every 15-minute checks as he was very aggressive and can change mood in a heartbeat. The RM said it was reported to her that Resident #6 went into Resident #5's room and Resident #6 fell on his buttocks after being pushed by Resident #5 then Resident #6 was kicked. The RM said Staff A, CNA was the first person in the room when the incident occurred and he called Staff B, LPN in to help. The RM said she did not have written statements from all staff, but what it sounded like to her was Staff A, CNA walked in and saw Resident #6 on the floor and Staff B, LPN was called into help. She said when she talked to Staff B, LPN the only altercation he mentioned was Resident #5 kicking Resident #6 on the ground. The RM said she had a statement from Staff B that said the residents were in an altercation and then Resident #6 fell on the ground and was kicked. She said she assumed the altercation was Resident #6 being pushed to the floor and kicked. The RM said, I guess I could have probed a little more of what happened. The RM read the nursing progress note in Resident #5's medical record and said she had not read it previously. She said she didn't know about punches being thrown. The RM said, it is like herding cats to them [staff] to give a statement and I should have probed more. An interview was conducted on 4/9/26 at 2:48 p.m. with the Nursing Home Administrator (NHA). The NHA said she expected statements to be taken, and each incident fully investigated. The NHA said the facility policy for investigating resident-to-resident abuse was to follow the federal regulations. Review of a facility policy titled Adverse Incident Investigation and Reporting Guideline, effective 1/8/26, showed:StandardAs part of the facilities risk management and quality assurance program, the Risk Manager or designee will initiate an internal investigation of incidents/accidents within I business day after the Risk Manager or designee has received a report.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the development, revision, and/or implementation of comprehensive care plans was completed for four (Resident #1, #2, #4, and #7) of seven sampled residents.Findings included:1.Review of the resident face sheet for Resident #1 revealed an admission date of 2/20/2025 and a recent admission of 4/1/2026 with diagnoses to include: Alzheimer's disease, dementia without mood disturbance, adjustment disorder with mixed anxiety and depressed mood, post-traumatic stress disorder (PTSD), hypertension, and other co-morbidities. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. The MDS revealed the resident had no identified moods or behaviors. During an interview on 4/8/2026 at 2:05 p.m. the facility Risk Manager (RM) stated on 2/24/2026 Resident #1 was involved in a verbal altercation where he was pushed to the floor and hit his head and had skin tears on both hands. The RM stated during the investigation it was determined that Resident #1 was yelling at another resident from his room. Resident #1 routinely yells at other residents who push on the exit door and the alarm on the door beeps. Resident #1 will yell at the other residents for this. There have been a couple of episodes of this verbal exchange, on 2/24/2026, 3/30/2026 and again on 4/2/2026. The RM stated requesting the care plan approaches to be updated on each of these occasions.Review of Resident #1's Care Plan revealed a problem area Behavioral Symptoms dated with a start date of 4/22/2025 and edited date 2/27/2026 revealing: Behavior: Resident #1 is noted with problematic behaviors such as refusing care at times. Resident #1 verbally resists needed assistance from staff to shower and/or assist with incontinence care and peri-care. The goal reviewed Resident #1 will have fewer episodes of problematics by the next review. Approaches to accomplish this goal are as follows: 4/22/2025 as cognitively able to understand, discuss behaviors with Resident #1. Reinforce why behavior is inappropriate and/or unacceptable. Praise, any indications of progress/improvement in behavior. 4/22/2025 assist Resident #1 in developing appropriate methods of coping and interacting. Encourage him to express his feelings appropriately, letting staff know when he is upset or agitated. 4/22/2025 if Resident #1 becomes resistant/combative to cares, stop and attempt a slower or different approach. Return at a later time as safety and hygiene allows or ask another care giver to attempt approach when possible.4/22/2025 intervene as needed to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and assist to another location as needed. 4/22/2025 Resident is ordered psychotropic medication: Administer as ordered and as appropriate for condition. Monitor for side effects, effectiveness and appropriateness of continued administration.4/22/2025 Monitor behavior episodes and attempt to determine underlying causes. Consider pain, personal beliefs, location, time of day, persons involved and situations. Document behavior and potential causes. 4/22/2025 Monitor for and document presence of mood and behaviors. If noted, document triggers, need for control and outcome of behaviors. 4/22/2025 Problematic behaviors are often noted to occur/worsen with presence of infection: Monitor for signs and symptoms of infection. Obtain/Monitor labs and diagnostic testing as ordered. Report results to the physician as indicated. 4/22/2025 Referral to psychiatry as indicated.4/22/2025 Social services to complete a trauma informed care assessment annually and as needed. No other updates were located related to behaviors in Resident #1's care plan. Review of Resident #1's Care Plan revealed a problem area Falls dated with a start date of 3/6/2025 and edited date 4/9/2026 revealing: Safety: Resident #1 is at risk for injury related to potential falls due to unsteady gait related to diagnosis Alzheimer's Dementia and chronic low back pain. He also has history of stroke, bilateral ankle pain and falls prior to admission. He is at further risk for falls/injury due to daily administration of psychotropic medications and is at risk for excessive bleeding due to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	daily administration of antiplatelet therapy. Prior to survey entrance no approaches were listed after 3/6/2026 for falls. 2. Review of the resident face sheet for Resident #2 revealed an admission date of 10/24/2025 and a recent admission of 10/30/2025 with diagnoses to include: Alzheimer's disease with early onset, dementia with psychotic disturbance and mood disturbance and anxiety, and other co-morbidities. Review of the MDS dated [DATE] revealed Resident #2 had a BIMS score of 3 out of 15, indicating severe cognitive impairment. The MDS revealed the resident had physical behavioral symptoms directed toward others occurred at one to three days of the seven day period and the resident wanders daily. Review of the progress notes for Resident #2 the following was revealed: 4/2/2026 at 7:38 p.m. wife notified that resident was involved in altercation with another resident.3/31/2026 at 4:22 p.m. resident continues to have excessive wandering and exit seeking behaviors. Not easily redirected. During an interview with the facility RM on 4/8/2026 at 2:05 p.m. the RM stated Resident #2 has been involved in five resident to resident altercations from 2/24/2026 to 4/2/2026. The altercations were all related to Resident #2's wandering. Review of Resident #2's Care Plan revealed a problem area Behavioral Symptoms dated with a start date of 11/11/2025 and edited date 2/11/2026 revealing: Wandering/Elopement secured Unit: Resident #2 has wandering behavior and is at risk for elopement. He is noted with excessive pacing behaviors. No resident to resident behaviors are mentioned in this care plan. Review of Resident #2's Care Plan revealed a problem area Behavioral Symptoms dated with a start date of 11/11/2025 and edited date 3/13/2026 revealing: Behavior: Resident #2 is noted with problematic behaviors such as constant pacing and wandering the secured unit. He has cognitive impairment related to dementia an demonstrates impaired awareness of personal space. He may enter other resident's rooms or crowded areas and becomes anxious or agitated when in close proximity to others, placing him at risk for resident to resident conflict or altercations. Approaches to accomplish this goal are as follows: 3/10/2026 edited 3/13/2026 Staff will provide frequent observation when Resident #2 is in common areas and will redirect him away from other resident room or crowded areas. If he enters a confined or crowded space and becomes anxious, staff will provide calm reassurance and assist him to exit the area safely and redirect to another area or activity.11/18/2025 provide and encourage the use of a sensory chew for redirection and safety.11/11/2025 as cognitively able to understand, discuss behaviors with Resident #2. Reinforce why behavior is a risk. Praise, any indications of progress/improvement in behavior. 11/11/2025 Assist in developing appropriate methods of coping and interacting. Encourage him to express his feelings appropriately, letting staff know when he is upset or agitated. 111/11/2025 if Resident becomes resistant/combative to cares, stop and attempt a slower or different approach. Return at a later time as safety and hygiene allows or ask another care giver to attempt approach when possible.11/11/2025 intervene as needed to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and assist to another location as needed. 8/29/2024 Resident #4 is ordered psychotropic medication: Administer as ordered and as appropriate for condition. Monitor for side effects, effectiveness and appropriateness of continued administration. 11/11/2025 Monitor behavior episodes and attempt to determine underlying causes. Consider pain, personal beliefs, location, time of day, persons involved and situations. Document behavior and potential causes. 11/11/2025 Monitor for and document presence of mood and behaviors. If noted, document triggers, need for control and outcome of behaviors. 11/11/2025 Problematic behaviors are often noted to occur/worsen with presence of infection: Monitor for signs and symptoms of infection. Obtain/Monitor labs and diagnostic testing as ordered. Report results to the physician as indicated. 11/11/2025 Referral to psychiatry as indicated.11/11/2025 Social services to complete a trauma informed care assessment annually and as needed. No other updates were located related to behaviors in Resident #2's care plan. 3. Review of the resident face sheet for Resident #4 revealed an admission date of 8/28/2024 and a recent admission of 2/12/2026 with diagnoses to include: Alzheimer's disease, dementia with mood disturbance, adjustment disorder, hypertension, atrial fibrillation, and other co-morbidities. Review of the Minimum Data Set (MDS) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated [DATE] revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, indicating severe cognitive impairment. The MDS revealed the resident had no identified moods or behaviors. Review of the progress notes for Resident #4 the following was revealed: 3/27/2027 at 11:25 a.m. resident to resident noted. 3/25/2026 at 11:58 a.m. Resident sitting in open area watching television (TV) when writer witnessed this resident stick his foot out in attempt to trip another resident. Redirected resident to please no stick his foot out like that. Resident advised this writer that resident keeps pacing in front of his view of the TV. Redirected the other resident. 3/16/2026 at 9:31 a.m. altercation occurred between this resident and another resident. Resident was redirected by staff. No injury was noted. 1/8/2026 at 7:49 p.m. resident standing over another resident (his roommate) yelling at roommate you better stop making all that noise. Review of Resident #4's Care Plan revealed a problem area Behavioral Symptoms dated with a start date of 8/29/2024 and edited date 2/18/2026 revealing: Behavior: Resident #4 has diagnosis of dementia and adjustment disorder. He is noted with increased confusion and agitation at the end of the day that may lead to verbal aggression. The goal revealed Resident #4 will have no episodes of problematic behaviors by the next review date. Approaches to accomplish this goal are as follows: 8/29/2024 as cognitively able to understand, discuss behaviors with Resident #4. Reinforce why behavior is inappropriate and/or unacceptable. Praise, any indications of progress/improvement in behavior. 8/29/2024 assist Resident #4 in developing appropriate methods of coping and interacting. Encourage him to express his feelings appropriately, letting staff know when he is upset or agitated. 8/29/2024 if Resident becomes resistant/combative to cares, stop and attempt a slower or different approach. Return at a later time as safety and hygiene allows or ask another care giver to attempt approach when possible.8/28/24 intervene as needed to protect the rights and safety of others. Approach/speak in a calm manner. Divert attention. Remove from situation and assist to another location as needed. 8/29/2024 Resident #4 is ordered psychotropic medication: Administer as ordered and as appropriate for condition. Monitor for side effects, effectiveness and appropriateness of continued administration. 8/29/2024 Monitor behavior episodes and attempt to determine underlying causes. Consider pain, personal beliefs, location, time of day, persons involved and situations. Document behavior and potential causes. 8/29/2024 Monitor for and document presence of mood and behaviors. If noted, document triggers, need for control and outcome of behaviors. 8/29/2024 Problematic behaviors are often noted to occur/worsen with presence of infection: Monitor for signs and symptoms of infection. Obtain/Monitor labs and diagnostic testing as ordered. Report results to the physician as indicated. 8/29/2024 Referral to psychiatry as indicated.8/29/2024 Social services to complete a trauma informed care assessment annually and as needed. No other updates were located related to behaviors in Resident #4's care plan. 4. Review of the resident face sheet for Resident #7 revealed an admission date of 5/13/2021 and a recent admission of 12/12/2024 with diagnoses to include: Alzheimer's disease, dementia with agitation and other behavioral disturbance and psychotic disturbance and anxiety, psychotic disorder with delusions due to known physiological condition - PTSD related psychosis, hypertension, and other co-morbidities. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #7 had a BIMS score of 0 out of 15, indicating severe cognitive impairment. The MDS revealed the resident had physical behavioral symptoms directed towards others four to six days per week and verbal behavioral symptoms towards others one to three days per week. Review of the progress notes for Resident #7 the following was revealed: 4/1/2026 at 10:57 p.m. resident observed on floor. 3/27/2026 at 5:23 p.m. resident was pushed by another resident when resident took off another resident's hat and this resident was trying to push another resident out of his wheelchair. 3/18/2026 at 6:34 p.m. resident observed on floor2/21/2026 at 6:03 p.m. observed on floor2/18/2026 at 5:31 p.m. resident had fall in common area.Review of Resident #7's Care Plan revealed a problem area Falls dated with a start date of 6/4/2021 and edited date 4/3/2026 revealing: Safety: Resident #7 is at risk for falls due to expected continual declines in physical function, and daily administration psychotropic medication related to diagnosis of PTSD. He (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is at further risk for falls/injury due to resistance/combativeness. Resident #7 is also at risk for excessive bleeding due to daily administration of antiplatelet therapy. Approaches to accomplish this goal were updated on 5/9/2025, 11/6/2024, 4/12/2024. No recent updates had been made to Resident #7's care plan. During an interview on 4/9/2026 at 11:46 a.m. MDS Registered Nurse (RN) confirmed responsibility for updating and developing care plans along with the MDS for each resident. MDS RN stated the care plan for Resident #1, #4 did not reveal being updated with any new approaches after the problem behavior(s) occurred. The MDS RN stated Resident #4's care plan should have been reviewed and revised. The MDS RN stated an internal note is entered into the electronic record attached to the incident resulting from the problematic behavior. During an interview on 4/8/2026 at 2:05 p.m. the Director of Nursing (DON) stated the care plan should be updated and adjusted as needed. Review of the facility's policy and procedure titled: Care Plan Development with a revised date of 11/28/2017 revealed: The care plan will be reviewed and revised as needed, when a significant change in condition is noted, when outcomes were not achieved or when outcomes are completed. All team members are responsible for reporting any changes to the resident's condition to the primary/charge nurse and of any goals or objectives not being met. Any changes must be reported to the MDS coordinator for review. Documentation must be consistent with resident's plan of care and revisions will be done on an as needed basis and can be done by any member of the Interdisciplinary team.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent a residentˆtoˆresident altercation for 6 of 7 residents reviewed (Resident #s 1, 2, 3, 4, 5, 6, and 7). This failure resulted in eight resident-to-resident physical altercations on one of two units. Cross reference F656Findings included:1. During an interview on 4/8/26 at 2:05 p.m. the facility Risk Manager (RM) stated on 2/24/26 Resident #1 was involved in an altercation with another resident (Resident #2) where he was pushed to the floor and hit his head and had skin tears on both hands. The RM stated Resident #1 has been involved in three altercations with Resident #2 (3/30/26 and again on 4/2/26). Review of admission Records showed Resident #1 was admitted on [DATE] with diagnoses including Alzheimer's disease, cognitive communication deficit, and adjustment disorder with mixed anxiety and depressed mood.Review of Resident #1's Annual Minimum Data Set (MDS), dated [DATE], showed a brief interview for mental status (BIMS) score of 12, moderately impaired cognition.Review of Resident #1's Care plan showed a problem area of:Psychiatric: Resident #1 is at risk fluctuations in mood and behavior related to Alzheimer's dementia and post-traumatic stress disorder (PTSD).An interview was conducted on 4/8/26 at 3:25 p.m. with Staff A, CNA. He said when the resident-to-resident incident occurred with Resident # 1 and #2 on 4/2/26, he was across the hall in another resident room with the door shut providing care. Staff A said he was the only staff member on the hall at the time and tried to keep an eye on everyone but had to close the door of the room he was in for privacy. He said he heard screening from another room, so he dropped everything and ran out. He said he went into Resident #1's room and Resident #1 had Resident #2 pinned to the bed and had his hands around his neck. Staff A said he had to convince Resident #1 to let so of Resident #2. He said Resident #2 was visibly shaking and trembling. Staff A said he could only imagine how Resident #2 felt at the time.Review of admission Records showed Resident #2 was admitted on [DATE] with diagnoses including Alzheimer's disease with early onset, major depressive disorder, recurrent, mild, other mixed anxiety disorders, and dementia in other diseases classified elsewhere, severe with psychotic disturbance, mood disturbance and anxiety.Review of Resident #2's MDS dated [DATE], showed a BIMS score of 3, indicating severely impaired cognition The MDS revealed the resident had physical behavioral symptoms directed toward others occurred at one to three days of the seven-day period and the resident wanders daily. Review of Resident #2's care plan showed a problem area of:Behavior: the resident is noted with problematic behaviors such as constant pacing and wandering the secure unit. He has cognitive impairment related to dementia and demonstrated impaired awareness of personal space. He may enter other resident's rooms or crowded areas and become anxious or agitated when in close proximity to others, placing him at risk of resident-to-resident conflict or altercations. Dated 3/13/26.Review of the resident supervision list showed Resident #2 was on every 15-minute checks.During an interview on 4/8/2026 at 2:05 p.m. the RM stated Resident #2 wanders all the time and invades other residents' personal space, including touching them. This sometimes leads to issues. The RM stated Resident #2 has been involved in five resident-to-resident altercations (2/24/26, 3/7/26, 3/27/26, 3/30/26 and 4/2/206). 2. During an interview on 4/8/2026 at 2:05 p.m., the RM stated Resident #3 was in the common area watching television and had another resident hit him with a walker. Both residents were examined and no injuries were noted.Review of admission Records showed Resident #3 was admitted on [DATE] with diagnoses including Alzheimer's disease, major depressive disorder and other co-morbidities.Review of Resident #3's MDS dated [DATE], showed a BIMS score of 4, indicating severely impaired cognition.Review of Resident #3's care plan showed a problem area of:Behavior: the resident is noted with problematic behaviors expected continual declines in cognition and physical function due to dementia by rejection of care; combative with staff; refuses to get out of bed or attempts to get out of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106006	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baldomero Lopez Memorial Veterans Nursing Home	6919 Parkway Blvd Land O Lakes, FL 34639

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bed without assistance at times. He has been noted to be sexually inappropriate at times. Dated: 5/18/21.3. Review of the resident face sheet for Resident #4 revealed an admission date of 8/28/24 and a recent admission of 2/12/26 with diagnoses to include: Alzheimer's disease, dementia with mood disturbance, adjustment disorder, hypertension, atrial fibrillation, and other co-morbidities.Review of the MDS dated [DATE] revealed Resident #4 had a BIMS score of 4, indicating severe cognitive impairment. The MDS revealed the resident had no identified moods or behaviors.Review of Resident #4's Care Plan revealed a problem area Behavioral Symptoms dated with a start date of 8/29/24 and edited date 2/18/26 revealing: Behavior: Resident #4 has diagnosis of dementia and adjustment disorder. He is noted with increased confusion and agitation at the end of the day that may lead to verbal aggression. During an interview on 4/8/26 at 2:05 p.m. the RM stated Resident #4 and Resident #7 were in the common area watching television and had a resident-to-resident altercation. Resident #4 pushed Resident #7 and tried to pull him out of his wheelchair.Review of the resident face sheet for Resident #7 revealed an admission date of 5/13/21 and a recent admission of 12/12/24 with diagnoses to include: Alzheimer's disease, dementia with agitation and other behavioral disturbance and psychotic disturbance and anxiety, psychotic disorder with delusions due to known physiological condition - PTSD related psychosis, hypertension, and other co-morbidities.Review of the MDS dated [DATE] revealed Resident #7 had a BIMS score of 0, indicating severe cognitive impairment. The MDS revealed the resident had physical behavioral symptoms directed towards others four to six days per week and verbal behavioral symptoms towards others one to three days per week.4. Review of admission Records showed Resident #6 was admitted on [DATE] with diagnoses including Alzheimer's, cognitive communication deficit, PTSD, and mild neurocognitive disorder due to known physiological condition with behavior disturbances.Review of Resident #6's 1/23/26 MDS, showed a BIMS score of 4, indicating severely impaired cognition.Review of Resident #6's Care Plan revealed a problem area Behavioral Symptoms dated with a start date of 1/29/26 and edited date 2/6/26 revealing: Behavior: Resident #6 is at risk for disturbed sensory perception due to trauma triggers, resistive/combativeness, impaired social interaction related to anxiety and hypervigilance due to diagnosis of PTSD. He has been noted wandering into other residents' rooms thinking it is his own and or looking for the toilet.An interview was conducted on 4/9/26 at 11:15 a.m. with Staff B, LPN. He said for the incident with Residents #5 and #6 on 2/3/26 he was the first one to arrive in the room. He said he witnessed Resident #6 wander into Resident #5's room and he thought Resident #5 would tell Resident #6 would leave and he would exit the room. Staff B, LPN said he heard Resident #5 tell Resident #6 to leave but they got into it like to macho guys and he ran into the room. He said the two residents were full on punching each other and it was like a [NAME] in the jungle. Staff B said Resident #6 ended up being pushed to the floor and kicked by Resident #5. He said he yelled for Staff A, CNA to help him and they were able to separate the two residents. Staff B said Resident #6 had redness around his eye where he was hit right after the incident happened and later it turned purple.Review of admission Records showed Resident #5 was admitted on [DATE] with diagnoses including Alzheimer's, dementia, and a history of mental and behavioral disorders.Review of Resident #5's MDS dated [DATE], showed a BIMS score of 8, indicating moderately impaired cognition.Review of Resident #5's Care Plan revealed a problem area Behavioral Symptoms dated with a start date of 7/22/24 and edited date 2/6/26 revealing: Behavior: Resident #5 is noted with problematic behaviors such as paranoia and delusions. He occasionally incorporates information heard on television into his own life. He has a history of verbal behaviors when informed he is wrong and during times of correction/redirection. He is territorial, has poor impulse control and does not like loud noises.5. An interview was conducted on 4/8/26 at 2:05 p.m. with the Director of Nursing (DON) and Risk Manager (RM). The DON said residents tend to gravitate toward certain rooms and it isn't something staff encourage. The RM said, we redirect them constantly, but they continue to do it. The DON said residents also gather in the common area and some get mad when others walk in front of the television. She said, there is always (continued on next page)

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Baldomero Lopez Memorial Veterans Nursing Home	6919 Parkway Blvd Land O Lakes, FL 34639

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	somebody there at the nurses' station to observe residents in the common area.An observation was conducted on the locked unit on 4/8/26 at 10:05 a.m. upon entrance to the locked unit a group of four residents were sitting watching television in the common area. No staff were insight of the area. Residents were seen wandering up and down hallways, staff were in and out of resident rooms providing care. An observation was conducted on the locked unit on 4/8/26 at 5:09 p.m. dinner was being served in the dining room to 10 residents. One staff member was in the far corner of the dining room sitting in a chair observing the room and another staff member was delivering trays to the residents. An observation was conducted on the locked unit on 4/8/26 at 5:14 p.m. of three residents in the common area and no staff were at the nurses' station or insight of the area. At 5:19 p.m. it had increased to five residents in the common area with no staff in sight providing supervision.During an interview on 4/8/26 at 5:37 p.m. Staff H, Certified Nursing Assistant (CNA) stated working in the locked unit on a regular basis. Staff H said the residents can get very physical at times with each other. We (the staff) try our best to watch everyone, but it is just so busy, especially around mealtimes and in the afternoon the residents can become more confused. During an interview on 4/8/26 at 5:40 p.m. with Staff I, CNA stated mealtimes are especially difficult, everyone is everywhere, the residents' eat at different times and in different places, we (staff) are trying to pass out the meals, provide care, and try to keep an eye on everyone it is just a lot. During an interview on 4/8/26 at 5:47 p.m. with Staff J, CNA stated the residents on the locked unit do get physical with each other. The residents are everywhere it is hard to keep an eye on them and get what you need to get done accomplished. An interview was conducted on 4/9/26 at 9:40 a.m. with Staff F, Registered Nurse (RN). Staff F said locked unit needs 6 or more CNAs on each shift plus the CNAs that are one to one with residents. She said most days they have enough put not really on weekends. Staff F said the unit had several residents with increased supervision and she would provide a list.Review of the provided supervision list showed on the locked unit there are five residents with every 15-minute checks, five residents with every 30-minute checks, and one resident that is 1:1 supervision.An interview was conducted on 4/9/26 at 11:21 a.m. with Staff G, CNA. Staff G confirmed her resident assignment and said she did not have any residents on increased supervision that she was checking on more frequently or documenting checks on. Comparing Staff G, CNA's assignment to the supervision list, it revealed she had two residents that should have been on every 30-minute checks.An interview was conducted on 4/9/26 at 1:15 p.m. with Staff E, CNA. Staff E confirmed her resident assignment and said she had one resident on increased supervision that she was checking on every 30 minutes and documenting checks on.Comparing Staff E, CNA's assignment to the supervision list, it revealed she had two residents on every 30-minute checks.An interview was conducted on 4/9/26 at 12:57 p.m. with Staff D, CNA. Staff D confirmed her assignment and said she had one resident on increased supervision that she was checking and documenting every 15 minutes. Staff D said during change of shift the CNAs should have been given the supervision documenting sheet for each resident with increased supervision. Staff D was observed pulling out the sheet for her resident and noting she had documented every 15 minutes from the start of her shift at 7:00 a.m. She said the CNAs documented the time of the check and what the residents were doing or where they were at the time. Staff D showed that from 4/9/26 at 12:00 a.m. until 7:00 a.m. there was no documentation completed for her resident. She said when she came on shift, she asked the CNA and nurse, but no one had a sheet that had been completed for her resident, and she had to start a new one.An interview was conducted on 4/9/26 at 2:38 p.m. with the DON. The DON said all staff should know which residents are on increased supervision. She said that information if given at change of shift and each resident had a sheet that needed to be documented on every 15 or 30 minutes depending on their supervision level. The DON said she expected the supervision sheets to be completed and did not understand how staff were not aware they had residents on increased supervision. The DON confirmed Resident #2 was on every 15-minute checks on 4/2/26 when the incident occurred with Resident #1. She said there were always more than one staff member on a hall (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and she had not heard Staff A, CNA was the only staff member on the hall at the time of the incident between Residents #1 and #2.During an interview on 4/8/26 at 2:05 p.m. the RM stated this is a very busy unit and as we are not able to restrain them due to regulations, these incidents are still going to happen.During an interview on 4/9/26 at 2:00 p.m. the RM stated she had not tracked or trended the incidents on the unit to see if there was a pattern.