STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106038	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexander "sandy" Nininger State Veterans Nursing	8401 W Cypress Dr Pembroke Pines, FL 33025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51663 Based on observations, interviews and record reviews, the facility failed to provide residents' choices consistent with their interest assessments and care plan. Facility failed to honor resident choices regarding scheduled bedtime for 1 of 1 resident (Resident #114). The findings included: A record review showed that Resident #114 was admitted on [DATE] with Quadriplegia, C1-C4 incomplete. The Minimum Data Set (MDS) quarterly dated 12/18/2024 revealed that the Brief Interview of Mental Status (BIMS) score is 15, which indicated no cognitive impairment. A review of the admission MDS dated [DATE] section E showed that Resident #114 answered that it was very important for him to choose his bedtime. In an observation conducted on 01/06/2025 at 11:35 AM Resident #114 was still lying in his bed undressed. In an observation conducted on 01/08/2025 at 12:05 PM Resident #114 was seen in bed underneath the covers. In this observation Resident #114 said that he was waiting to get dressed and get out of bed. In an interview conducted on 01/09/2025 at 1:15 PM Resident #114 stated that he wished to be out of bed earlier than 12:00 PM. An ideal time for him would be at 10:00 AM. Resident #114 further stated that he talked to the staff regarding getting out of bed at 10:00 AM and not after 12:00 PM, but nothing changed. In his last attempt to address the issue he was answered that they have to do what is best for the nursing staff. In an interview conducted on 01/09/2025 at 1:05 PM with Staff O, Certified Nurse Assistant (CNA) Staff O, stated that Resident #114 did mention wanting to be out of bed earlier than 12:00 PM, but she did not have the power to change that. In an interview conducted on 01/09/25 at 2:00 PM, with the Director of Nursing (DON), she was informed of the findings.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025

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F 0585

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50370

Based on observations, interviews and record reviews, the facility failed to address a grievance regarding hearing aids for 1 of 1 sampled resident (Resident #17).

The findings included:

A review of facility's policy titled, State of Florida, Department of Veteran's Affairs, Resident Grievances dated 08/04/2009, revised 10/18/2027, revealed the resident has the right to voice grievances to the facility. Number 1under the filing grievances section revealed that any resident, family member, or appointed resident representative may file a grievance concerning care, treatment, behavior of other staff members, theft of property or any other concerns regarding his or her stay in the facility.

Number 3 revealed that grievance may be submitted orally or in writing and may be filed anonymously.

Number 6 under the investigation and resolution of grievances section revealed that the resident and or resident's representative filing the grievance on behalf of the resident, will be informed of the findings of the investigation within 10 working days of receiving the grievance, and actions taken to correct any identified concerns.

Record review revealed Resident #17 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including Traumatic Subdural Hemorrhage with Loss of Consciousness, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Major Depressive Disorder.

Review of quarterly Minimum Data Set (MDS) assessment, dated 11/12/24, revealed a Brief Interview for Mental Status (BIMS) score of 06, indicating severe cognitive impairment. Section B revealed hearing aids were used by Resident #17 during the assessment.

A review of nursing care plan dated 08/15/23, quarterly reviewed on 11/15/23, 02/14/24, 05/15/24; annually reviewed on 08/14/24 and 11/13/24, revealed to continue the plan of care for communication problem with the Nursing approaches of assisting with hearing aid placement and maintenance prn (pro re nata), or as needed. Additional nursing interventions revealed to check Resident #17's ears for cerumen build up prn, and to refer to Audiologist as indicated.

Additional review of Social Worker's notes dated 11/20/24, revealed impaired hearing, bilateral hearing aid used, potential for decline in understanding.

A further review of care plan edited on 11/21/24 regarding mood and state problem revealed interventions by Nursing and Social Services to involve Resident #17's family in his care.

In an interview on 01/07/25 at 11:19 AM, Resident #17 reported he lost his hearing aids two weeks ago. When asked if he told Staff, he pointed to his right ear and asked this Surveyor to repeat the question. He then responded No! Resident stated he was having a hard time

(continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understanding and asked the surveyor to talk louder. When asked how he lost the pair of hearing aids, he responded with a smile, pointed at his right ear and asked to repeat the question. After the surveyor asked the question in a louder voice, Resident #17 responded, I put them in my right short pocket, then my laundry was taken out of my room with the pair of hearing aids. In an interview with Staff Q, a Certified Nursing Assistant (CNA), on 01/07/25 at 11:30 AM, when asked if she had observed Resident #17 was not wearing both hearing aids for the past few weeks, she responded No. When asked if she is aware resident lost his hearing aids, she responded, she was not. She added she will tell the Charge Nurse right away. In an interview with Staff E, a Charge Licensed Practical Nurses (LPN) on 01/08/25 at 11:46 AM , she stated she has never heard of any resident who lost hearing aids. In an interview with Resident #17's daughter on 01/07/25 at 12:16 PM, she revealed she reported the loss of hearing aids two weeks ago to both laundry and nursing staff but failed to get their names. When asked if any of the facility staff had given her an update regarding the hearing aid search, she responded, No, no one called me back and I want to get an update as soon as possible. She was worried that her father might be having difficulty in communicating and expressing his needs. In another interview on 01/07/25 at 2:30 PM, when asked about his lunch, Resident #17 answered with a smile that he is having hearing difficulty. He kept pointing at his right ear and asking the surveyor to repeat the questions. In an interview with Staff S, a Licensed Social Worker (LSW) on 01/08/25 11:56 AM, when asked who can report the loss of personal property in the facility, she responded, Anybody, including staff, visitors and residents may report a loss or missing personal item. She added that there is no time limit for reporting the loss or missing items. When a resident reports the lost or missing items to a facility staff, the staff completes a Care and Concern form. Once filled, the form is submitted to the Social Services department, which initiates the investigation, and discusses the search event during the next day staff meeting. When the entire facility staff is aware, they all participate in the investigation by searching for the lost or missing item. When asked why there was no completed Care and Concern form and investigation started for Resident #17's hearing aids, she responded, I never heard of anybody who lost a pair of hearing aid!. Staff S, a LSW was made aware that Resident #17 told Staff Q, a CNA yesterday about the lost hearing aids. Furthermore, she was informed that Resident #17's daughter reported the loss to the laundry and the nursing staff a few weeks ago. Staff S responded that there is a break in reporting, but she will talk to the Nurse Supervisor and will personally fill out the report. In another interview on 01/09/25 at 9:02 AM, Resident #17 stated no one has updated him about the hearing aids. In an interview with Staff S on 01/09/25 at 10:23 AM, she stated the hearing aids investigation started, and Resident #17's daughter was updated regarding the search.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51663 Based on observations, interviews and record reviews, the facility failed to provide treatment and care, in accordance with professional standards for practice for 3 of 25 sampled residents (Resident #114, Resident #34, Resident #104). The findings included: 1) Record review showed that Resident #114 was admitted to the facility on [DATE] with Quadriplegia, C1-C4 incomplete. The Minimum Data Set (MDS) quarterly dated 12/18/2024 revealed that the Brief Interview of Mental Status (BIMS) score is 15, which indicates no cognitive impairment. A review of section GG indicated that Resident #114 needs partial to moderate assistance to roll left and right. In an interview conducted on 01/09/2025 at 1:30 PM Resident #114 stated that 3 weeks ago he was left on his bed for 2 hours in fetal position waiting for a suppository to help with defecation. He further stated Staff O, Certified Nurse Assistant (CNA), who starts her shift at 3:00 PM and came into his room and found him in fetal position on his bed sweating with his heart rushing. The CNA obtained the Hoyer lift from the room across, got him in his wheelchair, pushed him into the bathroom and made the necessary arrangement for him to evacuate. In an interview conducted on 01/09/2025 at 4:05 PM with Staff O, she stated that the incident happened 3 weeks ago. She came in at 3:00PM and started rounding when she found Resident #114 lying on one side sweating saying that he needed to use the bathroom, she ran and went to get the Hoyer lift from the opposite room, got him on the chair and pushed him to the bathroom. She further stated that Resident #114 told her that he had spent two hours waiting for the suppository which never got administrated. 50895 2) At the resident council meeting held on 01/08/2024 at 2:30 pm, Resident #34 complained that at a prior resident council meeting he reported the problem that he waits too long for assistance with toileting. He and two other residents agreed that reported problems are not resolved. When asked to describe what happened in the bathroom, Resident #34 said that he waited on the toilet for one and a half hours before he received assistance. At first, he pulled the call bell, and no one came. When he got too tired of waiting, he phoned the front desk and asked for someone to request that a nursing staff member to go to his room and to provide him with assistance in the bathroom. When the surveyor asked how many times this has happened, Resident #34 stated every day of the week. A record review showed that Resident #34 was admitted to the facility on [DATE] with Other Sequelae of Cerebral Infarction, and Diabetes Mellitus Type 2. This resident's Brief Interview for Mental Status (BIMS) score, per the Minimum Data Set (MDS) assessment dated [DATE], was 15. This indicated that Resident #34 was cognitively intact. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) At the resident council meeting held on 01/08/2024 at 2:30 pm Resident #104, said that he waited half of an hour to receive assistance when he was on the toilet. He stated that when he called someone to help, a CNA answered that she was unable to assist him because she was assigned to a different section of residents on the unit. Per record review, Resident #104 was admitted on [DATE] with diagnoses that included Hemiplegia/Hemiparesis following Cerebral Infarction affecting left dominant side, and Spinal stenosis. This resident's Brief Interview for Mental Status (BIMS) score, per the Minimum Data Set (MDS) assessment dated [DATE], was 14. This indicated that Resident #104 was cognitively intact. In an Interview with Staff J, on 01/06/25 at 3:00 PM, the CNA said that she worked at the facility for almost 8 years. When asked how many residents she provided care for on that day, the CNA responded that each CNA on her unit provided care for 7 residents. When asked if she felt like they could provide adequate care for the residents, she answered that with love and cooperation, they could manage it. In a follow-up interview with Staff J on 01/08/25 at 10:00 AM, the surveyor asked if there was enough nursing staff to take care of all of the residents on the unit on that day, Staff J answered, we manage.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews and record review, the facility failed to provide a left hand splint as per Physician's order for 1 of 1 resident reviewed for Limited Range of Motion (Resident #19). The findings included: Record review revealed that Resident #19 was readmitted to the facility on [DATE] with diagnoses of Hypertension and Muscle Weakness. An order dated 11/30/23 revealed the following: apply left hand splint and left elbow protector for 8 hours (as needed) during AM hours and check skin before and after removal. The Quarterly Minimum Data Set(MDS) dated [DATE], showed that Resident #19 has a Brief Interview of Mental Status (BIMS) score of 13, which is low to moderate cognitive impaired. In an observation conducted on 01/06/25 at 11:00 AM, Resident #19 was observed in bed with a contracture (fingers curled and pulled towards the palm) on his left hand, and no left-hand splint in place. In this observation, Resident #19 stated that the left hand splint has not been placed on his left hand and that the staff will get around to do so when they can. In observations conducted on 01/06/25 at 12:35 PM, at 2:00 PM and 3:00 PM, Resident #19 was observed in bed with a contracture on his left hand, and no left-hand splint in place. In an observation conducted on 01/07/24 at 8:30 AM, Resident noted in bed with a contracture to his left hand, and no left-handed splint in place. In an interview conducted on 01/07/24 at 2:35 PM with the facility's Rehab Director, he said that Resident #19 had an order for left hand splint which was dated 11/30/24. He further stated that Restorative oversees making sure that the splints are placed on Resident #19 on a daily basis. In an interview conducted on 01/07/25 at 2:38 PM with Staff D, Registered Nurse, she stated that the Restorative team, oversees the Restorative program. The Restorative treatment is documented in a Restorative binder located in the nurse's station. If a resident has a splint in place, it will be documented in the electronic system indicating whether the splints are on or off. Staff D said that it will also be documented in the progress notes if a resident has splint in place. If a resident has an order for splint that is not placed as per Physicians' order, she will question the Restorative staff as to why it is not followed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on 01/07/25 at 2:53 PM, with Staff C, Restorative Certified Nursing Assistant, she stated that she is given a list of residents who have orders for splints by the Restorative Nurse. She follows Physicians orders for splints and documents in the electronic system. Staff C oversees the placement of splints on her unit and will ask for help from other Restorative staff if needed. When asked about the order for splints for Resident #19, she said that he has knee braces every day between 4-8 hours and was not aware of any other orders for splints. She then said Resident #19 has no more splints that I am aware of. In an interview conducted on 01/07/25at 3:30 PM, with the Staff F, Registered Nurse, she stated that Resident #19 is receiving hip and knee splints that are placed by Restorative staff. She further said that she will document in the electronic system for on and off when the splints are placed on the resident or taken off the resident. A review of the last 14-days Administration History in the electronic system did not show any on or off documented for Resident #19. In an interview conducted on 01/09/25 at 3:00 PM with the facility's Director of Nursing, she was informed of the findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 50895 Based on observations, interviews, record reviews, and policy reviews, the facility failed to provide adequate supervision during a Hoyer lift transfer for 1 of 1 sampled resident (Resident #45). This had the potential to affect 50 residents who used Hoyer lifts. The facility failed to ensure that the oxygen tank was secured for 1 of 1 sampled resident (Resident #44). The findings included: 1) According to the facility's policy and procedure on Safe Resident Handling and Lifting, revised 05/09/2018, employees will use mechanical lifting devices and/or other approved resident handling assistive devices in accordance with instructions and training. At least two people will be present to assist the resident during the use of mechanical lift equipment. Staff should refer to and comply with the resident's care plan prior to transferring or lifting residents. Review of the clinical record for Resident #44 revealed an admitted [DATE]. This resident's diagnoses included Unspecified Dementia, Unspecified Psychosis, Chronic Kidney Disease, Muscle Weakness, Other Lack of Coordination, and Senile Degeneration of the Brain. According to the Minimum Data Set assessment dated [DATE], Resident #44 was rarely/never understood. His functional abilities were coded dependent for chair/bed-to chair transfers. Review of the care plan for Resident #44 showed that he was at increased risk for falls. The care plan revised 12/26/24 listed a goal was to be free of fall related injuries. An intervention listed in the care plan specified the requirement for dependent assistance to be provided with bed/chair to chair transfer. On 01/06/25 at 1:10 PM, Staff J, Certified Nursing Assistant (CNA), was observed using the mechanical lift to lower Resident #45 into his bed. No other nursing staff members were present in the room. Staff J detached the Hoyer pad from the mechanical lift and then she proceeded to answer questions. In an interview with Staff J, on 01/06/25 at 3:00 PM, she stated that she worked at this facility for almost 8 years. When asked how a resident gets transferred from a bed to a wheelchair, Staff J said some residents used a lift and other residents ambulated during the transfer. She explained that nursing and therapy departments communicated about how the resident was to be transferred. When asked how she knew if the resident's transfer required 1 person or 2 people to assist, she answered that when a mechanical lift was used, two people were needed to assist the resident. Staff J was asked if it was easy to find another staff member to provide assistance with mechanical lift transfers. She responded that it was not easy to find someone to help provide assistance, for instance in the morning, at breakfast time, everyone is busy. So, you have to wait. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 01/06/25 at 2:30 PM, with Staff K, Registered Nurse (RN), who oversees the care planning for residents. She was asked what dependent in transfers meant. Staff K answered that dependent meant the resident depended totally on the staff for transfers. When asked to describe examples of total dependence, the RN said it usually means a mechanical lift. Staff K explained that each resident was screened by the therapy department to determine their needs for transfers and mobility. When asked how the nurses know when to use a mechanical lift, the RN said that it's listed on each resident's care plan. Both of the RNs in the room, Staff K, and Staff L, voiced that always, at least two person assistance is needed for mechanical lift transfers. In an interview with Staff K on 01/09/25 at 12:00 PM, the surveyor requested to know how many people were using mechanical lifts. Staff K said she was unable to print out a list of the residents. She said she would ask each charge nurse how many residents used mechanical lifts on 01/09/25 on their unit. At 1:10 PM, Staff K reported that 50 residents were using mechanical lifts for transfers on that day. 41837 2) Review of the facility's policy titled, Oxygen Concentrators/Oxygen Tanks-Maintenance and Inspection with a revised date of 07/19/23 included in part the following: All portable oxygen tanks that are not in use are to be properly secured and stored in the designated oxygen storage room within the appropriate tank holder. Not in use (empty) portable oxygen carts and hand trucks stored within the stored room are also to have appropriate securing mechanism attached. Record review for Resident #44 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on 08/13/24. Diagnoses included in part the following: Acute Respiratory Failure with Hypoxia, Respiratory Syncytial Virus Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Other Asthma, Unspecified Dementia Moderate with Anxiety. Review of the Minimum Data Set for Resident #44 dated 11/20/24 documented in Section C a Brief Interview of Mental Score of 15, indicating a cognitive response. Documented in Section O for Respiratory Treatments included oxygen therapy. Review of the Physician's Orders for Resident #44 revealed an order dated 08/13/24 to check O2 (oxygen) saturation every shift, give oxygen at 3 L/min (Liters per minute) via n/c (nasal cannula) continuous. Review of the Care Plan for Resident #44 dated 08/07/23 with a problem of resident has diagnosis of COPD with continuous oxygen as ordered via nasal cannula and is susceptible to shortness of breath, labored respirations, URI (Upper Respiratory Infection), and increased congestion. The goals were for the resident to breathe comfortably with intervention thru NRD (next review date), and episodes of congestion and URI will be minimized with interventions in place thru NRD. The Approaches included in part the following: Administer medications, respiratory treatments and oxygen as ordered. Pulmonary consult as ordered. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/06/25 at 11:18 AM, an observation was made of Resident #44 sitting up in bed with oxygen on via nasal cannula. Next to the bed was a wheelchair with an oxygen tank in the holder on the wheelchair, behind the wheelchair was an additional oxygen tank standing up next to an empty oxygen holder (Photographic Evidence Obtained). On 01/06/25 at 3:30 PM, an observation was made of Resident #44 sitting up in bed with oxygen on via nasal cannula and an additional oxygen tank standing up next to an empty oxygen holder in same spot as previously observed earlier today. On 01/07/25 at 9:00 AM, an observation was made of Resident #44 sitting up in bed wearing oxygen via nasal cannula. Next to the bed was a wheelchair with an oxygen tank in holder on the wheelchair, behind the wheelchair continued to be an additional oxygen tank standing up next to an empty oxygen holder. During an interview conducted on 01/06/25 at 11:25 AM with Staff A, Registered Nurse (RN) who was asked about the oxygen tanks for the resident, she stated he has an oxygen tank on his wheelchair for when he goes out of his room, she said he also has an additional oxygen tank behind the wheelchair just in case he needs it. Staff A checked both oxygen tanks with a penlight and said yes they both have oxygen in them. During an interview conducted on 01/07/25 at 3:15 PM with Staff B, Certified Nursing Assistant (CNA) who stated she has worked at the facility for 3 years. When asked about oxygen tanks at the bedside, she stated they do not keep additional oxygen tanks at the bedside, if the tank on the back of the wheelchair becomes empty, they take the empty one back to the oxygen room to store it and will get a replacement tank. The oxygen tank is kept in the back of the wheelchair. When asked if there was an additional oxygen tank how it would be stored, she said they are in stored in the holder. During an interview conducted on 01/07/25 at 3:18 PM with Staff C, CNA who stated she has worked at the facility since 2008. When asked about oxygen tanks at the bedside, she stated oxygen tanks are kept in the back of the resident's wheelchair, they do not have extra oxygen tanks at the bedside. She stated that if the oxygen tank becomes empty, they return it to the oxygen room and obtain a full tank. During an interview conducted on 01/08/25 at 8:51 AM with Staff D, RN who stated she has worked at the facility for 7XXX[AGE] years. When asked about oxygen tanks at the bedside, she said they are not supposed to have extra oxygen tanks in the resident's room, if the tank becomes depleted they return the tank to the oxygen room and obtain a new tank. When asked how oxygen tanks are stored, she said in the holder attached to the back of the wheelchair. If there was an extra oxygen tank it would be stored in a roller (stand).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexander "sandy" Nininger State Veterans Nursing	8401 W Cypress Dr Pembroke Pines, FL 33025

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews, and record review, the facility failed to address a significant weight loss in a timely manner, failed to provide adequate nutritional supplements to prevent further significant weight loss, and failed to have effective communication between the multidisciplinary staff for 1 of 4 sampled residents reviewed for nutrition (Resident #103). The findings included: A review of the facility's policy titled, Dietitian, dated [DATE], showed the following: The Dietitian will work closely with the Interdisciplinary team, assess the nutritional needs of the residents, and collaborate effectively with other direct care staff and practitioners to assess and address nutritional issues with the facility population. A review of the facility's policy titled Facility Nutrition Program/Resident Nutrition Services dated [DATE] showed the following: the Dietitian will help assess the nutritional needs and risk of all residents and ensure that appropriate meals and other nutritional interventions are provided. A review of the facility's policy titled Standards of Care Meetings dated [DATE] showed the following: the facility will conduct a standards of care meeting weekly to address resident at risk related to significant weight changes. Pull report from electronic health for the weight variances for the past 180 days and review prior to meetings. Each significant weight change must be identified and addressed in the documentation and the care plan. Identifying the root cause of the weight loss and working toward identifying interventions as appropriate. Is the Dietitian consulted and documenting timely on the significant weight change? Are recommendations followed up in a timely manner? The meetings will be held weekly and all residents in all care areas should be discussed at least monthly. Record review revealed that Resident #103 was initially admitted to the facility on [DATE]. He was discharged on [DATE] and readmitted again on [DATE]. He was transferred to the hospital on [DATE] and returned on [DATE]. He was transferred to the hospital on [DATE] and returned to the facility on [DATE]. He was transferred to the hospital from [DATE] and returned [DATE]. He was transferred to the hospital again on [DATE]. A progress note dated [DATE] revealed that Resident #103 expired at the hospital. Resident #103 had diagnoses of right Adrenalectomy, bipolar, dementia, and hypertension. The annual Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview of Mental Status (BIMS) score of 10, which was moderate cognitively impaired. A review of the care plan initiated on [DATE] showed that Resident #103 will not experience weight changes and will consume greater than 75% of meals served. It further showed that Rsident #103 was at risk for decline in nutritional status as evidenced by diagnoses. The Quarterly review dated [DATE] showed to continue with plan of care. The approaches were noted to monitor nutritional status and to monitor weights. A review of the weight log for Resident #103 showed the following: (continued on next page)

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F 0692

Level of Harm - Actual harm

Residents Affected - Few

[DATE], a weight of 182 pounds.

[DATE], a weight of 177 pounds.

[DATE], a weight of 174 pounds.

[DATE] a weight of 170 pounds.

[DATE], a weight of 168 pounds.

[DATE], a weight of 166.5 pounds.

[DATE], a weight of 168 pounds.

[DATE], a weight of 181 pounds.

[DATE], a weight of 178 pounds.

[DATE], a weight of 176 pounds.

[DATE], a weight of 164 pounds.

[DATE], a weight of 157 pounds.

[DATE], a weight of 154 pounds.

[DATE], a weight of 150.8 pounds.

[DATE], a weight of 154.2 pounds.

[DATE], a weight of 145 pounds.

The above weight changes showed that Resident #103 had a significant weight loss of 9.4% from [DATE] to [DATE], a significant weight loss of 6% from [DATE] to [DATE], and an 11.6% significant weight loss from [DATE] to [DATE].

The readmission initial nutritional observation dated [DATE] revealed the following: The Dietitian used a recorded weight of 172.4 pounds taken from [DATE]. No updated weight was taken after Resident #103 was readmitted on [DATE]. Resident #103 estimated calorie needs at ,d+[DATE] a day and ,d+[DATE] grams of protein a day. In this note, the Dietitian deceased the Mighty Shake (nutritional supplements), which the Resident was on from 3 times a day to once daily, stating that Resident #103 ate over 75% of his meals. Monitor intake of meals and weights and follow up as needed.

The next follow up nutritional note dated [DATE] showed the following: Resident #103 weight was at 176 pounds and at increased nutritional risk. He was receiving one can on Mighty shake an eating 75% to 100% of his meals. This note did not address that Resident #103 went down from 181 pounds to 176 pounds. No additional nutritional interventions were made at this time.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The next nutritional assessment was dated [DATE] which was 17 days after Resident #103 ' s 9.4% significant weight loss was identified. In this note, the Consultant Dietitian stated that Resident #103 had a 7. 5% weight change in 90 days and reduced his estimated protein needs between 74 grams to 89 grams and his daily caloric needs to 2337. It further showed that Resident #103 was at nutritional risk due to weight loss and ate ,d+[DATE]% of his meals. No new nutritional interventions were made to address the above significant weight loss and the note stated to continue plan of care. The nutritional follow-up note dated [DATE], which was written about 2 weeks after the 6% significant weight loss, was identified from 164 pounds on [DATE] to 154 pounds on [DATE]. In this note, Staff V, Consultant Dietitian stated Resident #103 eats 76%-100% of his meals and occasionally eats 26% to 50% of his meals. Staff V stated that Resident #103 was at nutritional risk with a history of significant weight loss and recommended increasing the Mighty Shake supplements from once a day to twice a day. This nutritional intervention only provides an extra 200 calories and 9 grams of protein a day to aid with significant weight loss. A review of the Medication Administration Record dated [DATE] to [DATE] did not show that Resident #103 received the Mighty Shake nutritional supplements twice a day. A progress note dated [DATE], which was completed by Staff V, current Consultant Dietitian, revealed the following: Resident #103 Ideal Body Weight was 178 pounds, and his current weight was 155.4 pounds. Resident #103 had a 6.2% significant weight loss in 30 days and a significant 11.7% weight loss in 90 days. Resident #103 eats 76%-100% of his meals, and occasionally, he eats 26% to 75% of his meals, which should be sufficient to meet nutritional needs. It further showed that Resident#103 would benefit from a weight gain of 4.6 pounds in two weeks and 1.2 pounds in one week. No nutritional interventions or changes were made at this time to address the weight loss and provide supplements to aid with weight gain. The next nutritional progress dated [DATE] and completed by Staff V showed the following: Resident #103 had 19.8 pounds in 180 days (the RD wrote this in her note which was a mistake), and 11.5% significant weight loss in 90 days. 51% to 75% of the food intake was noted for the last 30 days, which may not be sufficient to meet nutritional needs. In this note, Staff V added a Med pass (nutritional supplement) once a day to provide an extra 240 calories and 10 grams of protein. This note did not show that Staff V contacted Resident #103 ' s Practitioner regarding the severe weight loss of 19.8% from [DATE] to [DATE]. A progress note written on [DATE] by Staff W, Nurse Practitioner, stated that Resident #103 lost 36 pounds in 6 months post Adrenalectomy. It was recommended to consult an endocrinologist for possible adrenal insufficiency. This note was written 2 weeks after the last nutritional note was written by Staff V on [DATE]. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	In an interview conducted on [DATE] at 3:05 PM with Staff W, she stated that she was aware that Resident #103 lost some weight, but she did not suspect more than a normal weight loss associated with dementia. She did not worry about the weight loss because she knew that Dietary was following the Resident. The nursing staff told her that Resident #103 had not been eating well for some time, and when she assessed the Resident on [DATE], she noticed the weight loss on his face and body. Staff W was not aware that Resident #103 had a severe weight loss and was never told by the nutrition department or the nursing staff prior to the week of [DATE]. According to Staff W, she did not see the trending weight loss or the overall picture of the weight loss for Resident #103. She ordered some labs after she noticed the weight loss but would have had Resident #103 see an endocrinologist sooner. Staff W said, I depend on the nursing staff to let me know of any significant weight loss or change in conditions. When asked by this Surveyor if the weight loss for Resident #103 was avoidable or nonavoidable, she could not tell. In an interview conducted on [DATE] at 10:20 AM with Staff V, Current Consultant Dietitian stated that she comes into the facility on ce a week and oversees all high-risk residents and residents with significant weight loss. The weights are taken on admission, every week for four weeks, and monthly thereafter. A nutrition observation assessment on all admissions and readmissions is completed as soon as possible. In an interview conducted on [DATE] at 8:00 AM with the facility's Diet Technician, she stated that she has been working in the facility full time and that the Consultant Dietitian comes in once a week. The residents weights are discussed and reviewed in the weekly risk meetings that are held on Thursdays with the Interdisciplinary team. She and the consultant dietitian are required to attend those meetings. The Consultant Dietitian comes in once a week, usually on Thursdays so that she can attend the meetings. They have had some issues with coverage for some time and difficulties with meeting the workload once a week by the Consultant Dietitians. According to her, all initial assessments and significant weight change notes are completed by a Consultant Dietitian. All weights are taken by Restorative staff and recorded in the electronic system. The monthly weights are placed in the system by the 9th of the month and then emailed to her and the Consultant Dietitian for review. For any weight loss, the Diet Technician will contact the Consultant Dietitian to ensure that she follows up on any nutritional recommendations and interventions. The consultant nutritionist oversees the running of a monthly weight report and addresses any significant weight losses as well as weekly weights. In an interview conducted on [DATE] at 9:26 AM with Staff V, Current Consultant Dietitian, she was asked as to why she only recommended Med pass once a day in her note dated [DATE]. She said that Resident #103 was eating about 75% of his meals, and she wanted to make sure he was receiving the nutritional supplements (Mighty Shake) and that it was enough before throwing more supplements on Resident #103. It was only when she noticed the 10-pound weight loss that she went ahead and added the Med pass. Staff V said that she only attended the last risk meeting but has not been attending the prior ones. She was only told recently that she needed to be part of the risk meetings. When asked if she had contacted Staff W prior to [DATE] to address the significant weight loss for Resident #103, she said no. Staff V stated that she did not address the weight loss with the facility ' s Director of Nursing or the nursing staff on the floor. (continued on next page)

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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 0692 Level of Harm - Actual harm Residents Affected - Few	In an interview conducted on [DATE] at 10:00 AM with the Director of Nursing (DON), she stated that at 10:00 AM, the risk meetings are done weekly with the Consultant Dietitian and the Diet Technician. They addressed the weekly and monthly weights and any significant changes. The DON said that she remembered discussing the weight loss on Resident #103 in the risk meeting but could not recall the date. When asked if she had contacted Resident #103's Practitioner to let her know about the severe weight loss, she said no but that the Practitioner had been notified recently by the nursing team. Usually, she speaks to the nursing team and the nurse supervisor, and they contact the Practitioner. In an interview conducted on [DATE] at 10:07 AM with Staff E, Licensed Practical Nurse, she stated that she remembered Resident #103 and had worked with him in the past. She said that Resident #103 was eating well, that he drank all the Mighty shakes daily, and that he liked them. She did not see any poor intake of meals and was aware that he lost weight because she reviewed the weekly and monthly weights. She reported to Staff W, that Resident #103 lost weight but was not sure as to when she reported the weight loss. According to Staff E, Resident #103 could eat independently and needed very little assistance. Only around the end of [DATE] did she start noticing the weight loss on Resident #103's face and body. A review of the clinical chart did not show any nutritional assessments or notes written after the last one was done on [DATE]. In an interview conducted on [DATE] at 3:00 PM with the DON she was informed of the findings.

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49060

Based on observation, interviews and record review, the facility failed to ensure controlled substance medication reconciliations were accurate for 2 of 9 sampled residents reviewed during the controlled substance record review on the facility's Delta and Alpha wings, for Residents #38 and #44.

The findings included:

1) Review of Resident #38's clinical record documented admission on 10/30/23 and readmission on 07/09/24, and had diagnoses that included: Dementia, Anxiety Disorder, Restlessness and Agitation, Unspecified Psychosis.

Review of Section C of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #38 had a Brief Interview for Mental Status (BIMS) of 04, indicating severe cognitive impairment.

Review of the Physician's Orders showed that Resident #38 had an order dated 12/19/24 for Alprazolam 0.5 mg tablet, give 1 tablet oral every 12 hours for 30 days for Psychosis/Agitation/Anxiety.

On 01/09/25 at 11:00 AM, a review of Resident #38's Controlled Drug Record sheet received by the facility from the pharmacy on 01/02/25 for Alprazolam 0.5 mg (30 tablets), give one tablet every 12 hours for 30 days for Psychosis-Agitation, was conducted. The inventory sheet documented that one tablet of Alprazolam 0.5 mg was removed from the controlled substances box at 9:00 AM and 9:00 PM on the following days: 01/06/25, 01/07/25, and 01/08/25. Further review revealed that a total of 6 tablets were removed from the controlled substances box.

Review of Resident #38's January 2025 electronic Medication Administration Record (eMAR) documented Alprazolam 0.5 mg was initialed as administered on 01/09/25 at 9:00 AM. The medication was not documented on the resident's controlled drug record sheet as removed from the box. The resident's controlled drug was not reconciled.

On 01/09/25 at 12:25 PM, an interview was conducted with Staff E, Licensed Practical Nurse (LPN), who stated she has worked at the facility for [AGE] years. She stated she first retrieves the controlled drug from the locked box, dispenses it, administers it to the resident and then she documents the medication as administered in the Controlled Drug binder and in the eMAR. A side-by-side review of Resident #38's controlled drug record sheet dated 01/02/25 for Alprazolam was conducted with Staff E. She stated she believed she did administer the medication to Resident #38 because she signed the eMAR. When Staff E reviewed the controlled drug record for Resident #38 she stated she missed it. When asked why she documented prior to administering the Alprazolam, she stated she just missed it. Staff E acknowledged that Resident #38's Alprazolam count (24 tablets) was correct in the controlled substance box.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted 01/09/25 at 11:45 AM with Staff N, Delta Nurse Supervisor. She stated the controlled drugs count is done on every change of shift by the nurses. Staff N stated the protocol for controlled drug administration is to first dispense the medication, administer it to the resident, return to the medication cart and document as given in the Controlled Drug Binder and in the eMAR. An interview was conducted on 01/09/25 at 1:57 PM with the Director of Nursing (DON), who stated she is confused as to why the nurse signed the eMAR and not the controlled drug binder and why the nurse did not dispense the medication accordingly. 41837 2) On 01/09/25 at 10:15 AM, a review of the medication cart 1 on Alpha Yellow with Staff D, Registered Nurse (RN) this included a review of the Controlled Drug Record for Resident # 44 for Oxycodone HCl 5mg. The count was 18, and Staff D acknowledged count was correct and matched the count of 18 on the Controlled Drug Record. Record review for Resident #44 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on 08/13/24, diagnoses included in part the following: Other Fracture of Lower End of Left Tibia Subsequent Encounter for Closed Fracture with Routine Healing, Acute Respiratory Failure with Hypoxia, Respiratory Syncytial Virus Pneumonia, Chronic Obstructive Pulmonary Disease (COPD), Other Asthma, Unspecified Dementia Moderate with Anxiety. Review of the Minimum Data Set for Resident #44 dated 11/20/24 documented in Section C a Brief Interview of Mental score of 15, indicating a cognitive response. Review of the Physician's Orders for Resident #44 revealed an order dated 10/15/24 for Oxycodone 5mg 1 tab oral every 4 hours as needed for pain. Review of the Controlled Drug Record for Resident #44 for the Oxycodone 5mg every 4 hours as needed documented on 01/06/25 6:00 PM the drug was signed out and given. Review of the Medication Administration Record for Resident #44 for 01/06/25 did not have any documentation for Oxycodone 5mg being administered on 01/06/25 at or around 6:00 PM. During the interview conducted on 01/09/25 at 11:20 AM with the Director of Nursing (DON), who was asked when a controlled medication is being administered, where is the nurse to document this, she stated they document the medication on the Controlled Drug Record and in the resident's chart in the Medication Administration Record. During the interview conducted on 01/09/25 at 11:30 AM with Staff H, Registered Nurse (RN), who was asked when a controlled medication is being administered, how do they document, she said you document the medication on the Controlled Drug Record and in the resident's chart in the Medication Administration Record. During the interview conducted on 01/09/25 at 11:28 AM with Staff D, RN, who was asked when a controlled medication is being administered, how do they document, she said you document the medication on the Controlled Drug Record and in the resident's chart in the Medication Administration Record.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49060 Based on observations, interviews and record review, the facility failed to ensure a treatment cart was locked while unattended during facility tour; failed to ensure medication cart and medications were secured during medication administration observation; and failed to dispose of expired over the counter medications (OTC) during medication storage review. The findings included: Review of the facility's policy titled, Storage of Drugs and Biologicals, dated 05/04/16, included the following: In accordance with State and Federal laws, the facility will store all drugs and biologicals in locked compartments/containers Containers/compartments containing drugs and biologicals will be locked when not in use, including medication carts. Review of the facility's policy titled, Medication Administration, dated 12/31/21, included the following: During administration of medications, the medication cart will be kept closed and locked when out of sight of the personnel administering medication. No medications are kept on top of the cart. 1) During the initial tour of the facility conducted on 01/06/25 at 09:25 AM, the surveyor noted an unlocked, unattended treatment cart in the Delta [NAME] unit, in which some of the residents' diagnoses include Dementia, Psychosis, Anxiety and Depression. Further observation revealed in the top-drawer treatment medications labeled with residents' names, and a pair of scissors stored in the second drawer of the treatment cart, photographic evidence obtained. During this observation, multiple staff members and residents were noted walking past the unlocked treatment cart. An additional observation was conducted on 01/06/25 at 10:14 AM which revealed the treatment cart was still unlocked and a few moments later observed the floor nurse lock the cart. 2) A medication administration observation was conducted in the Delta [NAME] unit on 01/07/25 at 9:02 AM with Staff M, Licensed Practical Nurse (LPN) for Resident #96. While dispensing the prescribed medications, Staff M noticed one resident wheeled his wheelchair close to another resident and both residents started to argue. Staff M stated, they are going to fight and walked approximately 25 meters away from the medication cart to where the two residents were arguing. However, she left the medication cart unlocked and the dispensed medication for Resident #96 on top of the medication cart. During this observation, Staff M was away from the unlocked, unattended medication cart and medications for approximately 7 minutes. Staff M returned to the medication cart and continued preparing the medications for Resident #96. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 01/09/25 at 10:58 AM a medication cart storage review in the Delta Yellow unit was conducted with Staff E, Senior LPN, who worked at the facility for [AGE] years. Review of the over-the-counter medication (OTC) drawer in the medication cart revealed the following two expired medication bottles: Almacone double strength Antacid 355 mL bottle with an expiration date of 08/2024 and opened date of 01/07/24. Cough Syrup, Cough and Chest Congestion DM: Dextromethorphan HBr, USP 20mg and Guaifenesin, USP 200mg, 118 mL bottle with an expiration date of 11/2024 and opened date of 10/24/24. An interview was conducted at this time with Staff E, LPN, who stated that the pharmacist and the unit nurse supervisor check the medication carts regularly. She was surprised that there were expired medications in the cart. An interview was conducted on 01/09/25 at 11:45 AM with Staff N, Delta Unit Nurse Supervisor. She stated that all the supervisors do random medication cart checks as well as the pharmacist. She also stated the floor nurses are to check expiration on the medications prior to administering it and any medication that has expired, they are to remove it from the cart.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews and record review, the facility failed to follow their own menu for fresh fruit, for 8 of 8 residents observed during dining (Resident #104, Resident #42, Resident #14, Resident #8, Resident #86, Resident #12, Resident #60, and Resident #35). The findings included: 1. Record review revealed that Resident #104 was admitted on [DATE] with diagnoses of Hypokalemia and Hemiplegia. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 which is cognitively intact. In an interview conducted on 01/07/25 at 8:24 AM in the main dining room, Resident #104 was eating his breakfast meal. Resident #104 stated that they only get bananas twice a week if any, and that the rest of the week they do not get any fresh fruits. He then picked up his meal ticket and said, it says here that we are supposed to get fresh fruit for breakfast. 2. Record review revealed that Resident #42 was readmitted to the facility on [DATE] with diagnoses of Depression and Dysphagia. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15, which is cognitively intact. In an interview conducted on 01/07/25 at 8:32 AM in the main dining room, Resident #42 stated that they only get fresh fruits twice a week and that is usually a fresh banana which they do not have today. 3. Record review showed that Resident #14 was admitted to the facility on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, and Muscle Weakness. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15, which is cognitively intact. In an interview conducted on 01/07/25 at 8:32 AM in the main dining room, Resident #14 stated that they are supposed to get a fresh fruit every day for breakfast and that they do not. 4. Record review revealed that Resident #8 was readmitted to the facility on [DATE] with diagnoses of Type 2 Diabetes, and Hypertension. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15, which is cognitively intact. In an interview conducted on 01/07/25 at 8:32 AM in the main dining room, Resident #8 stated that they only get bananas but not every day and that it is only given once or twice a week. 5. Record review revealed that Resident #86 was admitted on [DATE] with diagnoses of Muscle Weakness and Depressive Disorder. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 which is cognitively intact. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Alexander "sandy" Nininger State Veterans Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE: 8401 W Cypress Dr, Pembroke Pines, FL 33025	

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation conducted on 01/07/24 at 8:41 AM, Resident #86 was in his room with the breakfast tray. The breakfast meal ticket dated 01/07/25 showed fresh fruit. The breakfast meal plate provided to Resident #86 did not have fresh fruit. 6. Record review showed that Resident #12 was readmitted to the facility on [DATE] with diagnoses of Muscle Weakness and Dysphagia. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 which is cognitively intact. In an interview conducted on 01/07/24 at 8:50 AM, Resident #12 stated that they do not get fresh fruit for breakfast every day. 7. Resident #60 was readmitted on [DATE] with diagnoses of Parkinson, Dysphagia and Depression. An order dated 12/20/24 for Mechanical Soft (Pureed fruits and vegetables with nectar thick liquids. The Significant change Minimum Data Set (MDS) dated [DATE] revealed that Resident #60 is rarely or never understood. In an observation conducted on 01/07/24 at 8:54AM, Resident #60 was in his room with the breakfast tray. The breakfast meal ticket dated 01/07/25 showed fresh fruit. The breakfast meal plate provided to Resident #60 did not have fresh fruit. 8. Record review showed that Resident #35 was readmitted to the facility on [DATE] with diagnoses of Hemiplegia and Anxiety Disorder. The Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 which is cognitively intact. In an observation conducted on 01/07/24 at 8:39AM, Resident #35 was in his room with the breakfast tray. The breakfast meal ticket dated 01/07/25 showed fresh fruit. The breakfast meal plate provided to Resident #35 did not have fresh fruit. In an interview conducted on 01/09/24 at 11:00 AM with the facility's Diet Technician, she stated that they have bananas coming in on a weekly basis and that they also substitute other fresh fruits. When asked as to why the fresh fruit was not provided to all residents on 01/7/24 for the breakfast meal she did not have an answer.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51663 Based on observations, interviews and record reviews, the facility failed to provide palatable, appetizing and flavorful food for 8 of 8 residents (Resident# 58, Resident# 43, Resident# 59, Resident# 73, Resident# 88, Resident# 17, Resident# 32, Resident# 70). The findings included: 1. A record review showed that Resident #58 was admitted on [DATE] with chronic kidney disease stage 3. The Minimum Data Set (MDS) quarterly dated 11/20/2024 revealed that the Brief Interview of Mental Status (BIMS) score is 13, which indicates mild cognitive impairment. In an interview conducted on 01/06/2025 at 11:45 AM, this surveyor was stopped in the hallway by Resident # 58 who said that the food in the facility is disgusting. He stated that the food did not look appetizing, that he usually asks for his eggs over easy but one day he gets it and the next day he does not. This is because they alternate between pasteurized and unpasteurized eggs. Resident #58 further stated that the unpasteurized eggs are overcooked and have a pancakes texture. The resident said that he doesn't understand what is going on in the kitchen, but the food is terrible. 2. A record review showed that Resident #43 was admitted on [DATE] and readmitted on [DATE] with Amyotrophic lateral sclerosis and muscle wasting and atrophy. The Minimum Data Set (MDS) quarterly dated 10/16/2024 revealed that the Brief Interview of Mental Status (BIMS) score is 12, which indicates moderate cognitive impairment. In an interview conducted on 01/06/2025 at 10:01 AM Resident # 43 stated that his meals are incomplete, and that he never gets what he asks for. 3. A record review showed that Resident #59 was admitted on [DATE]with low vision, atherosclerotic heart disease, and unspecified angina pectoris. The Minimum Data Set (MDS) quarterly dated 12/18/24 revealed that the Brief Interview of Mental Status (BIMS) score is 08, which indicates severe cognitive impairment. In an interview conducted on 01/06/2025 at 10:05 AM Resident # 59 stated that the food is horrible. 4. A record review showed that Resident #73 was admitted on [DATE] and readmitted on [DATE] with cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery and chronic arterial fibrillation. The Minimum Data Set (MDS) quarterly dated10/09/2024 revealed that the Brief Interview of Mental Status (BIMS) score is 15, which indicates no cognitive impairment. In an interview conducted on 01/06/2025 at 12:30 PM in the main dining room Resident # 73 stated that breakfast is okay, but lunch and dinner are terrible. Sometimes they serve popcorn shrimp with a very thick coating and some pieces don't have any shrimp under the coating. Resident #73 further stated that when he says he doesn't like the food the staff gets mad and takes his plate away. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. A record review showed that Resident #88 was admitted on [DATE] with polymyalgia rheumatica and muscle wasting and atrophy. The Minimum Data Set (MDS) quarterly dated 10/16/2024 revealed that the Brief Interview of Mental Status (BIMS) score is 14, which indicates mild cognitive impairment. In an interview conducted on 01/06/2025 at 12:37 PM in the main dining room Resident # 88 stated that the main issue of this facility is that the food is not appetizing and that he does not get what's on the menu even when he orders it. A review of the Fall/Winter week 4, Day 4, lunch showed the following: 3 ounces of baked chicken, sage bread dressing, Harvard beets and black forest cake. At test tray on a Regular consistency diet was conducted on 01/08/24 at 12:10 PM. The following were noted: the baked chicken appeared small and tasted bland with no seasoning. The sage bread stuffing was colorless, with no taste and a dough like texture. The beets had a thick glaze with no taste and tasted like canned beets. The overall lunch plate had a beige and reddish color with no other color variation and lacked any type of colorful garnish. The black forest cake was dry to taste and was served in a plastic throw away container. The lunch meal did no have an appetizing appearance or taste. 50370 6) Record review revealed Resident #17 was admitted on [DATE] with diagnoses including Traumatic Subdural Hemorrhage with Loss of Consciousness, Muscle Weakness, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Major Depressive Disorder, and Malignant Neoplasm of the Prostate. A review of quarterly Minimum Data Set (MDS) assessment dated [DATE], Section C revealed a Brief Interview for Mental Status (BIMS) score of 06, indicating severe cognitive impairment. A review of dietary care plan dated 08/29/24, revealed Resident #17's risk for nutritional status decline, with interventions to monitor and document the intake of food, and to offer food preferences. During an interview on 01/07/25 at 11:25 AM, Resident #17 was sitting in a wheelchair, and waiting for a staff to take him to activities. When asked regarding breakfast, he prompted the surveyor to speak louder, while pointing at his left ear. He stated he barely ate the breakfast served him because of bad food taste. He added he had to eat some of it because he had no other choices. When asked if he requested an alternate meal, he seemed confused, pointing at his right ear, then asked this surveyor to repeat the question. When the surveyor explained that he could ask for a different meal in a louder voice volume, he smiled and stated he did not know that. When asked regarding other previous meals served in the facility, he added all foods had bad taste and not good to eat. 7) Record review revealed Resident # 32 was initially admitted on [DATE], and readmitted on [DATE] with diagnoses including Bullous Pemphigoid (a rare skin condition causing large, fluid-filled blisters), Hemiplegia and Hemiparesis following Cerebrovascular Disease (affecting left non-dominant side), Muscle Weakness, Dementia with Agitation and Diabetes Mellitus. A quarterly MDS dated [DATE], revealed a BIMS score of 12, indicating a moderately good cognition. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of baseline care plan dated 03/02/23, revealed Resident #32 was at risk for nutritional deficit, with the following interventions: dietician to evaluate as needed, provide diet as ordered, assist with meals as needed, and obtain food preferences. Additional review of a quarterly nutrition progress notes dated 09/03/24, revealed the following: Basal metabolic index (BMI) of 27.12, weight of 121 Lbs. (pounds), fluctuating food intake, and known food preferences. During an interview with resident on 01/06/25 at 10:10 AM, when asked regarding meals and food serve by the facility, she responded, Terrible food. When asked to explain what terrible means, she stated, Food does not match menu, and food does not taste good. When asked if she requested a tastier food, she responded All of the foods served here have no flavor. In another interview with Resident #32 on 01/08/25 at 03:49 PM, when asked regarding lunch, she responded, Lunch was tasteless. 8) Record review revealed Resident #70 was admitted on [DATE] with diagnoses including Complete Traumatic Amputation of 2 or more toes, Type 2 Diabetes Mellitus, Essential Hypertension and Depression. A review of quarterly MDS dated [DATE], revealed a BIMS score of 09, indicating moderately impaired mental cognition. Section K revealed no swallowing disorder, while Section L revealed no broken teeth, loose teeth and mouth or facial pain. Additional review of nutrition care plan dated 09/19/24, revealed resident was at risk for nutritional status decline. A quarterly MDS review notes dated 10/29/24, revealed to assist resident with meals as needed, diet as ordered, and monitor food intake. Further review of dietary notes dated 01/08/25 revealed no food intolerances, and resident was at continued nutritional risk. During an interview with Resident #70 on 01/06/25 at 10:36 AM, when asked regarding the meals and food served by the facility, he responded, The food was not flavorful. In another interview on 01/07/25 at 9:30 AM, when asked about his breakfast, he responded, Food was not good. When asked why it was not good, he responded, It had crappy taste. During another interview with resident on 01/08/25 at 9:10 AM, when asked if he is losing weight, because he stated he does not like the taste of food in the facility, he responded his wife brings him food, he is not bothered if he is losing weight but would like to have tasty and flavorful food from the facility. 50895 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9) During an interview with the Food Service Director (FSD) on 01/08/25 at 3:50 PM, in the Dietary Manager's office, the FSD mentioned that she eats the foods served at the facility and that she thinks they taste good. She also said that there were many residents on the No Added Salt diet, and for that reason many of the foods tasted bland. The requested test tray was for the lunch meal served to residents on a Regular diet (with no restrictions).

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50895 Based on observations, record reviews, interviews, and policy review, the facility failed to provide the correct diet consistency for 9 residents on the Pureed consistency diet (Residents #41, #65, #25, #53, #11, #16, #45, #60 and #22). This had the potential to affect 14 residents that were prescribed the pureed consistency diet. The findings included: 1) During an observation of residents eating lunch in the Delta Blue dining area, on 01/06/25 at 12:10 PM, Resident #16, Resident #45, and Resident #11 were served the pureed entree consisting of ham, brussel sprouts, and corn. The food appeared lumpy. 2) In an observation and interview with the FSD on 01/06/25 at 12:25 PM, the surveyor approached the Food Service Director (FSD) who was behind the steam table in the main dining room. Concerns about the pureed consistency were voiced by the surveyor. The surveyor requested a sample of the pureed lunch meal and the FSD asked a dietary aide to prepare a pureed meal plate. The FSD carried the pureed meal tray to her office accompanied by the surveyor. At the Food Service Director's desk, the surveyor tasted the pureed meal and observed that the pureed corn, the pureed ham, and the pureed brussel sprouts had small pieces in them that required chewing. They were not smooth. The FSD agreed that the consistency of the pureed foods was not smooth. 3) During an observation of residents eating lunch in the Delta Blue dining area on 01/07/25 at 12:14 PM, Resident #16, Resident #45, and Resident #11, received the pureed entree consisting of pureed Goulash, pureed mixed vegetables, and pureed white bread. The Goulash, mixed vegetables, and bread appeared lumpy. The surveyor approached the FSD and expressed concern about the pureed meal plates and requested a written description of the mechanically altered diets that the cooks follow. 4) Observation of the lunch meal served on the Delta [NAME] unit 01/08/25 at 12:03 PM showed that the pureed diet was served to Resident #41, Resident #65, Resident #25, and Resident #53. The pureed chicken had visible strands of chicken. It was not a uniform consistency. 5) A review of the facility's diet roster printed on 01/06/2025 showed that Resident #16, Resident #45, Resident #11, Resident #41, Resident #65, Resident #25, and Resident #53, were on pureed consistency diets. 6) A review of the State of Florida Department of Veteran's Affairs policy on Facility Diets-Food Consistencies, revised 11/07/2017, described the pureed food consistency. The pureed consistency is designed to provide soft smooth foods. The pureed diet is indicated for individuals with chewing or swallowing problems. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7) In an interview conducted on 01/08/25 at 3:39 PM with Staff G, the Speech Language Pathologist (SLP), she stated that for the pureed consistency, the food needs to be cooked in a way that is it not too liquid and that it should have no solids particles. Sometimes when they process the food in the blender it may have some food particles in it. The Pureed food should have a smooth consistency, with one solid uniform consistency. When the Speech Language Pathologist was shown a picture of the strand of chicken on the spoon from the pureed lunch meal served on 01/08/25, she said that if she saw that pureed chicken served to the residents, she would have sent it back to the kitchen and requested that it be pureed until it was smooth. Photographic evidence obtained 40153 8) Resident #60 was readmitted on [DATE] with diagnoses of Parkinson's, Dysphagia, and Depression. An order dated 12/20/24 for Mechanical Soft (Pureed fruits and vegetables) with nectar thick liquids. The Significant Change Minimum Data Set (MDS) dated [DATE] revealed that Resident #60 is rarely or never understood. In an observation conducted on 01/06/25 at 12:09 PM, Resident #60 was in his room with his lunch meal. Closer observation showed a meal ticket: regular mechanical soft diet with pureed fruits and vegetables, mechanical soft baked ham, creamed corn, soy milk, bread, and thick nectar liquids. The lunch plate was noted with mechanical soft ham and pureed corn that was lumpy, with visible pieces of corn that did not have a uniform consistency. 9) Resident #22 was readmitted on [DATE] with diagnoses of Dysphagia and Psychotic disorder. The diet order dated 08/12/24 was for a pureed thin liquids diet. The Quarterly MDS dated [DATE] showed a Brief Interview of Mental Status (BIMS) score of 09, which was moderate cognitive impairment. In an observation conducted on 01/06/25 at 12:40 PM, Resident #22 was in his room eating his lunch tray. A closer observation showed a meal ticket noted with the following: pureed diet with pureed ham and pureed buttered corn. The lunch plate was noted with pureed corn that was lumpy, with visible pieces of corn that did not have a uniform consistency.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50895 Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety, sanitary conditions, and to ensure the prevention of foodborne illnesses for 106 of 112 residents. The findings included: During the initial tour of the kitchen on 01/06/25 at 9:30 AM, accompanied by the Food Services Director (FSD): 1. The walk-in refrigerator had a black plastic bag with a knot in it located on a shelf. When asked what was in the bag the FSD opened the bag and revealed that it was someone's personal food. It looked like it was chicken and vegetables in a plastic container. On the shelf below that there was transparent, white plastic wrap crumpled up into a ball. 2. The Arctic walk-in freezer had pieces of rubber on the floor. When asked what it was, a food service employee said that it fell off a pipe. 3. The metal backsplash connected to the Vulcan oven had streaks of black and brown debris on the area rising approximately 14 above the level of the stove top. 4. A clear plastic bin had white dried on residue on the interior walls of the bin. The FSD said it must be cleaning solution. 5. Two frying pans had burned on black debris. 6. A large stock pot had black debris surrounding the areas where both handles were connected. 7. The meat slicer had rusty colored markings and brown residue on the blade and the surrounding areas. A follow-up tour of the kitchen on 01/08/25 at 12:00 PM was conducted. The following was observed: 1. The temperature of chocolate pudding that was taken out of the reach in refrigerator was 48' F. The temperature of the puree Black Forest Cake was 54' F. The temperature should have been 41' F or below to meet professional standards for food safety. The FSD was present during this temperature reading and she agreed with the finding. She said that she didn't know why the temperature was so high. During a tour of the nourishment rooms on 01/08/25 at 4:00 PM, accompanied by the FSD, the following was observed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. The Alpha nourishment room refrigerator had brown residue on the highest plastic shelf on the inside of the refrigerator door. Drops of brown colored dried on liquid was on the inside of the freezer close to where the ice packs were stored. There was brown residue on the door handle. 2. The microwave had brown residue on the interior surfaces of the microwave, including the lower and the upper sides of the interior. 3. The temperature of the refrigerator in the Delta Yellow nourishment room was 44' F. The temperature should have been 41' F or below to meet professional standards for food safety. 4. An interview with the nurse supervisor for the Delta Yellow unit, Staff I, on 01/08/25 at 4:32 PM, revealed that to the best of her knowledge, housekeeping does not clean inside the refrigerator. If someone uses the microwave and spills something they should clean it up right then. She added that if someone spills something in the refrigerator, they should clean it up. Photographic evidence obtained.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370 Based on observations, interviews, and record reviews, the facility failed to implement CDC (Center for Disease Control and Prevention) guidelines and recommendations for Enhanced Barrier Precautions for 2 residents with wounds (Resident #61, and Resident #101). The findings included: According to CDC, Enhanced Barrier Precautions revealed the following: Everyone must clean their hands including when both entering and leaving the room. Providers and Staff must also; wear gloves and a gown for the following high-contact resident care activities: dressing; bathing-showering; transferring; changing linens; providing hygiene; changing briefs or assisting with toileting; device care or use: central line, urinary catheter, feeding tube, tracheostomy; Wound Care any skin opening requiring a dressing. https://www.cdc.gov/long-term-care-facilities/media/pdfs/EBP-KeepResidentsSafe-Poster-508.pdf. 1). Record review revealed Resident #61 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses including status post Open Reduction Internal Fixation of Left Femur, Closed Fracture with Routine Healing, Acute Respiratory Failure, Chronic Kidney Disease, and Type 2 Diabetes Mellitus. A record review of Minimum Data Set (MDS) assessment, Section C, dated 11/11/24, revealed a Brief Interview for Mental Status score of 12, indicating moderately good cognition. A review of orders dated 11/05/24 revealed directions to dress the right heel wounds. Additional review of physician orders dated 12/30/24, were in place for resident's wound. Review of nursing care plan dated 11/11/24 revealed no EBP guidelines were included for Resident #61's interventions. During observation on 01/06/25, 01/07/25, and 01/08/25, revealed no EBP signpost on resident's door. There was a metal shelf containing Personal Protective Equipment (PPE) gowns, and gloves. During an observation on 01/09/25 at 10:30 AM, no EBP signpost was observed, and a hanging metal shelf did not contain PPE gowns, and gloves. The only item present was a plastic bottle of a hand sanitizer. During observation and interview on 01/09/25 at 09:28 AM, two Certified Nursing Assistants (CNAs) were inside the bathroom and assisting resident #61with toileting. Staff R, a CNA stated the resident had a bowel movement, before they could transfer him from wheelchair to toilet. Both CNAs were wearing gloves, but not wearing gowns. When asked why they were not wearing gowns, Staff P, a CNA stated, There were no gowns on the metal shelf, and they were in a hurry to assist Resident #61with toileting. When asked who was responsible for replenishing PPE on the metal shelf, she did not respond. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Alexander "sandy" Nininger State Veterans Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 8401 W Cypress Dr Pembroke Pines, FL 33025	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Staff A, a wound care Registered Nurse (RN) on 01/08/25 10:27 AM, she stated the resident was re- admitted to facility from hospital on 11/04/24. During skin assessment she observed right and left heel wounds, left hip surgical wounds with 21 staples, skin scab on left arm was healing, and dark sacral area with sheering (approximately 6x6 cm in size). In an interview with Staff K, an MDS Director, when asked about the absence of EBP guidelines on Resident #61's care plan approach for wounds, she responded, she did not include it. 2). Record review revealed Resident #101 was admitted on [DATE] with diagnoses including End Stage Renal Disease, Dependence on Renal Dialysis, and Pressure Ulcer of Sacral Region (unspecified stage). A record review of quarterly MDS assessment Section C, dated 11/12/24, revealed a BIMS score of 12 indicating moderately good cognition. A review of orders dated 12/30/24, revealed internal tunneled catheter on the right chest area. Additional review of orders initiated on 12/31/24 revealed processes to address the sacral wounds. A further review of orders dated 01/08/25, revealed updated processes to dress the sacral wounds. Additional review of orders from 12/30/24 until 01/08/25, revealed no EBP guidelines related to sacral wounds. During observations on 01/06/25, 01/07/25, and 01/08/25, no EBP signpost and PPE metal shelf were observed on Resident #101's door as compared to other facility doors with different types of skin wounds. During another observation on 01/08/25 at 11:25 AM, Staff A, a wound care RN was asking Staff E, a Licensed Practical Nurse for a PPE gown before entering Resident #101's room. In an interview with Staff A, a wound care RN on 01/08/25 at 09:23AM, she stated Resident #101 came back to the facility on [DATE] with hospital acquired sacral wounds. During an interview with Staff E, an LPN on 01/08/25 at 11:40 AM, when asked who put the PPE metal cart containing gowns and gloves on Resident #101's door today, she responded, The wound care RN did. When asked why there is no EBP signpost on resident's door, she did not respond. When asked how Staff would know EBP guidelines must be followed during resident's care, she responded During report.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106038	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexander "sandy" Nininger State Veterans Nursing	8401 W Cypress Dr Pembroke Pines, FL 33025

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837 Based on observations and interviews, the facility failed to ensure it was adequately equipped with functioning emergency call device in 2 of 12 bathrooms on the Alpha Unit. The findings included: On 01/06/25 10:25 AM, an observation was made of the emergency call device pull cord in the bathroom for room [ROOM NUMBER], which was wrapped around grab bar (Photographic Evidence Obtained). On 01/06/25 11:38 AM, an observation was made of the emergency call device pull cord in the bathroom for room [ROOM NUMBER], which was wrapped around the grab bar and dragging on the floor (Photographic Evidence Obtained). During an interview conducted on 01/07/25 at 3:15 PM with Staff B, Certified Nursing Assistant (CNA) who stated she has worked at the facility for 3 years. When asked about call devices, she said each resident has one by their bed and there is one in each bathroom. When asked if the emergency call device pull cord in the bathroom should be wrapped around the grab bar she said no. During an interview conducted on 01/07/25 at 3:18 PM with Staff C, CNA who stated she has worked at the facility since 2008. When asked about emergency call devices, she said there is one for each bed and one in each bathroom. When asked if the emergency call device pull cord should be wrapped around the grab bar, she said no. During an interview conducted on 01/08/25 at 8:51 AM with Staff D, Registered Nurse (RN) who stated she has worked at the facility for 7XXX[AGE] years. When asked about the emergency call devices, she said each resident has a call bell with their bed and there is a pull cord in each bathroom. When asked if the emergency call device pull cord in the bathroom should be wrapped around the grab bar, she said no. During an interview conducted on 01/08/25 at 10:25 AM with Staff I, Registered Nurse Supervisor 7:00 AM-3:00 PM who did a side by side observation with the surveyor of the emergency call device in the bathroom for room [ROOM NUMBER] and she acknowledged the emergency call device was wrapped around the grab bar and was non-functional in this manner. The Registered Nurse Supervisor unwrapped the emergency call device cord and the cord was long and laid on the floor. A second side by side observation was made with the Registered Nurse Supervisor of the emergency call device in the bathroom for room [ROOM NUMBER]. During an interview conducted on 01/09/25 at 1:10 PM with the Director of Nursing (DON) who was asked for a policy on call devices, she said they have no policy.