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	05/21/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, it was determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This was observed during 3 of 3 visits conducted in the Main Kitchen. The findings included: 1. A tour of the Main Kitchen was conducted on 05/18/26 at 08:46 AM with the Dietary Manager (DM). The following items were observed: a. In the walk-in refrigerator, a full 6 inch deep, two third-sized hotel pan located on a shelf to the right of the entrance was observed with loosely wrapped raw white mushrooms. The pan was dated 05/08/26 and the mushrooms were observed to be browned and discolored indicative of spoilage. The DM stated mushrooms can be refrigerated for up to 30 days. b. In the food processing area, the convection oven was observed with a large amount of food residue on mainly the interior top and bottom. The bottom of the oven had a metal sheet tray which also had a large amount of food residue that was burnt onto the pan. c. In the cooking prep area, a knife drawer was noted with food residue and debris. There were five knives observed with food residue or buildup in the grooves and handles. d. In the food prep area, a food processor was observed in a corner. Upon disassembling the processor, the blade was observed to have food particles. The DM stated it was not in use. There was no sign or tag identifying the item as not in use. e. In the food prep area, a bug zapper was noted on the wall above a stainless-steel prep table with 2 food processor bases on it. The bug zapper had no collection tray or cover to ensure insects would not fall upon the food prep area and there was a buildup of dust like debris on the appliance. f. In the dish machine area, white dried up liquid splashes and buildup were noted on the shelves above the dish table and the dish table back splash where the clean dishes exited the washer and were placed to dry. g. In the dish machine area, there were broken floor tiles where water accumulated and sat. h. In the steam table area, inside the plate-warmer, two plates were noted with dried food debris and dried up coffee colored liquid stains. 2. Upon returning to the kitchen on 05/18/26 at 10:29 AM to discuss some of the findings from the previous observation that morning with DM, personal items were found on a stainless-steel prep table near the oven. An 8-ounce water bottle and an orange-colored blue tooth speaker were observed next to single use gloves and food equipment. The DM was notified. She acknowledged the findings by stating she would have them removed. 3. On 05/20/26 at 11:10 AM a tray-line observation was conducted. The following was observed: Staff I used plastic-handled portion scoops to serve the food items. Her hands were bare. The scoop for the pureed bread was observed sinking into the food item down to the handle and release mechanism which had been in contact with Staff I's bare hand. This also occurred with the pureed meat, starch, and vegetable food items after it was pointed out by this surveyor. Photographic Evidence was obtained.

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

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

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(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** Based on observations, interviews, and record review, the facility failed to: 1. Follow the approved menu for the lunch meal served to the residents on 05/18/26 with the potential to affect 63 residents with orders for regular texture foods. 2. Failed to provide all the menu items for 1 of 1 resident observed during the breakfast meal on 05/19/26. (Resident #65) 3. Failed to provide all the menu items for 1 of 1 resident observed during the lunch meal on 05/19/26. (Resident #43) 4. Failed to serve the correct portion size for residents on 05/20/26 with the potential to affect 7 residents with orders for bite sized consistency. The findings included: 1. The approved lunch menu on 05/18/26 documented the residents with regular texture diet consistency were to receive a 4-ounce (oz) portion of Chicken Marinated. During an observation on 05/18/26 at 11:51 AM, in the Delta Blue Dining Room, the portion of chicken served to the residents with a regular texture diet was observed to be smaller than 4 oz. On 05/18/2026 at 12:10 PM an observation of the lunch meal performed by a second surveyor on the Alpha Unit and the Main Dining Room revealed chicken portions for the regular texture diet that appeared to be small. On 05/18/26 at 12:14 PM, the regular texture chicken on the steam table was weighed at 2.7 oz. The DM acknowledged it by advising the server to provide two pieces per plate. 2. Record review for Resident #65 revealed the resident was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #65 revealed the Resident had a Brief Interview for Mental Status (BIMS) score of 04, which indicated the resident had severe cognitive impairment. On 05/19/26 at 09:05 AM an observation was conducted in resident #65's room. The resident was consuming his breakfast meal. The tray ticket read No Added Salt, Regular Texture, Thin Liquids Diet and included Oatmeal on the list of meal items. The approved breakfast menu on that day documented a 1/2 cup serving of Cereal Oatmeal. There was no documentation found on the ticket indicating the resident did not like hot cereal or oatmeal. There was no oatmeal bowl on the resident's tray. When asked, the resident stated he liked oatmeal. On 05/21/26 at approximately 10:30 AM an interview was conducted with the Dietary Manager (DM) who had been employed by the facility for 10 years. She stated hot cereal was not placed on the breakfast trays. The units were provided with bowls of hot cereal which were passed to the residents by the unit staff. 3. Record review for Resident #43 revealed the resident was admitted to the facility on [DATE]. The following diagnoses were included: Cancer, Autoimmune Gastrointestinal Disease, Diabetes, and Hyperlipidemia. Review of the Quarterly Minimum Data Set (MDS) for Resident #43 dated 05/08/26 revealed the Resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. On 05/19/26 at 12:01 PM an observation was conducted during the lunch meal in resident #43's room. The resident's tray ticket read Regular, Regular Texture, Thin Liquids. At the bottom of the ticket, it read no pork. The approved lunch menu on that date documented the main meal for the Regular Diet had pork thus the alternate meal was provided. The approved Regular Diet, alternate meal was documented as beef Swiss steak tomatoes and potatoes parslied. The resident's tray did not have parslied potatoes. The tray ticket did not indicate the resident did not like potatoes. The resident stated he liked potatoes and would have wanted them. On 05/21/26 at approximately 10:30 AM an interview was conducted with the Dietary Manager (DM). She stated it was Resident #43's preference but was unable to provide documentation that the resident did not want potatoes. 4. The approved lunch menu on 05/20/26 documented residents with Soft and Bite Sized Diet consistency orders were to receive a 3 oz portion of fish tilapia herb and lemon. On 05/20/26 at 11:10 AM an observation of the tray line was conducted. Staff I was observed plating the meals using a 3 oz portion scoop to measure the bite sized portion of fish. It was noted the portion provided was with a scoop that was approximately two thirds to half full. This surveyor stopped the dietary staff from passing the tray down to the meal cart. The DM advised Staff I to fully fill the scoop acknowledging the finding. Photographic evidence was obtained.

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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** Based on observations, interviews and record review, the facility failed to provide pureed foods in a form to meet the needs of a total of 17 residents with orders for pureed foods. The findings included: The facility provided the guidelines from the International Dysphagia Diet Standardization Initiative 2.0 (IDDSI) dated July 2019 which were the guidelines used for the consistency of the pureed diets. The standards described pureed consistency as extremely thick and able to retain its shape. It further stated that it cannot be poured. Recipes for Pureed Sauteed Squash and Pureed Garlic Mashed Cauliflower provided by the facility described the consistency as able to hold its shape on a plate, does not flow easily, and cannot be poured. 1. Record review for Resident #9 revealed the resident was admitted to the facility on [DATE]. The following diagnoses were included: Dementia, Depression, and Chronic Gingivitis. Review of the Significant Change Minimum Data Set (MDS) for Resident #9 dated 02/25/26 revealed the Resident had a Brief Interview for Mental Status (BIMS) score of 01, which indicated the resident had severe cognitive impairment. The resident had a diet order (02/18/26) Puree, Thin Liquids. 2. Record review for Resident #31 revealed the resident was admitted to the facility on [DATE]. The following diagnoses were included: Anxiety, Seizures, and Depression. Review of the Quarterly Minimum Data Set (MDS) for Resident #31 dated 04/07/26 revealed the Resident could not have a Brief Interview for Mental Status (BIMS) due to rarely or never being understood. 3. Record review for Resident #53 revealed the resident was admitted to the facility on [DATE]. The following diagnoses were included: Diabetes and Cerebral Vascular Accident with Hemiplegia. Review of the Quarterly Minimum Data Set (MDS) for Resident #53 dated 04/15/26 revealed the Resident had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. On 05/19/26 at about 12:00 PM Residents #9 and #31 were observed eating lunch in the Unit Dining Room. The meal for the pureed diet was pork loin with noodles, sauteed mushrooms, and bread. They were both fed by staff and the meals appeared thin and runny. The food items did not hold their shape and were pooled on the plate. On 05/20/26 at 11:10 AM an observation of the tray line was conducted. The pureed food items were not thick and holding shape. The scoops placed inside the pureed bread, fish, cauliflower garlic mash, and squash medley sank into the food. The pureed items were poured onto the plates, and the scoops were covered in a liquid residue that had an ice cream shake consistency. On 05/20/26 at about 12:00 PM the Dietary Manager, who had been employed by the facility for 10 years, was alerted to the pureed consistency. She stated the year prior, the facility was cited because the pureed food items were too thick. On 5/20/26 12:26 PM Resident #53 was observed eating his meal in the Main Dining Room. The resident's meal ticket read regular, pureed consistency, thin liquids. The pureed meal was fish, garlic cauliflower mashed, and squash medley. The food items did not hold their shape and puddled on the plate. On 05/20/26 at 12:28 PM during a dining room observation in the Main Dining Room, the Dietary Manager and the Speech Language Pathologist approached this Surveyor and provided the IDDSI guidelines. They stated the facility follows these guidelines for pureed food consistency. This surveyor suggested to look at Resident #53's plate to compare it to the guidelines but they chose not to. Photographic evidence was obtained.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on Interview and record review, the facility failed to obtain informed consent for the use of Psychoactive medications for 1 of 4 residents reviewed for Dementia Care, Resident #98. The findings included:On 05/21/26 at 11:51 AM, a record review was conducted for the Dementia Care investigation for Resident #98. Resident #98 was determined to have been prescribed the following Psychoactive medications:Quetiapine 25 mg (Seroquel) 25 mg 1 tablet by mouth at bedtime for hallucinations. Duloxetine (Cymbalta) 30 mg 1 capsule by mouth at bedtime for depressionDuloxetine (Cymbalta) 30 mg 2 capsule (60mg) by mouth once a day at 9:00 AM for depression. Psychoactive medications require informed consent prior when ordered by the Physician, Nurse Practitioner, or Physician's Assistant. Resident #98's records only have Informed Consent for Duloxetine (Cymbalta) 30 mg 1 capsule by mouth at bedtime for depression. On 05/21/26 at 3:43 PM, an interview was conducted with the Administrator regarding Quality Assurance Performance Improvement (QAPI) initiatives for the facility. During the meeting a review of Performance Improvement Programs (PIP) was conducted. The facility had developed a PIP for Informed Consent for Psychoactive Medications. This PIP was completed on 5/1/26.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accuracy of diagnoses included on the PASARR (Preadmission screening and record review) for individuals with a mental disorder, for 3 of 4 residents reviewed (Residents #33, #34, and #7). The findings include: 1.) On 05/19/26 at 2:59 PM, during record review for Resident #33 a determination was made that the primary diagnosis for Resident #33 was identified on the PASARR as Dementia. The Admitting Diagnoses listed for Resident #33 included Chronic combined systolic (congestive) and diastolic (congestive) heart failure.Resident #33 had a Psychiatric evaluation after admission which identified the following psychiatric diagnoses:Major Depressive Disorder recurrent moderate;Post Traumatic Stress Disorder unspecified;Insomnia unspecified.None of these diagnoses were identified as a primary admitting diagnosis. On 05/20/26 at 10:41 AM, an interview was conducted with the Social Services Director (SSD) who is a Licensed Clinical Social Worker (LSCW). The SSD explained that when a resident is admitted to the facility from another facility the sending facility is expected to send the completed PASRR at the time of admission. The SSD explained that an admission from home would need to have a PASSR completed by the facility at the time of admission. The SSD stated that she or one of the nurses trained to complete a PASSR is supposed to review the PASSR and correct discrepancies when they are identified. The SSD explained that if a new psychiatric diagnosis is determined then the facility is supposed to update the resident's record to reflect that new diagnosis. The SSD stated that if a new diagnosis is determined to be a Serious Mental Illness or an Intellectual Disability then a PASRR Level two evaluation becomes necessary. The SSD identified examples of when a Level Two PASSR was required. The examples included Schizophrenia, Autism Spectrum and Downs Syndrome. On 05/20/26 at 11:53 AM, an interview was conducted with the MDS Coordinator. The MDS Coordinator indicated she collects the diagnoses from the 3008 form, the hospital records, and the doctor's notes. The MDS coordinator explained that she had a conversation with the SSD regarding Resident #33's PASRR. The MDS Coordinator agreed with the conclusion that the PASSRR for Resident #33 was coded incorrectly as dementia was not the primary admitting diagnosis based upon the documentation she used from the hospital. The MDS coordinator stated the SSD was correcting the PASARR as we spoke. 2) Resident #35 was admitted to the facility on [DATE] with diagnoses that included Diabetes Mellitus, Psychotic Disorder, Hypertension and Depression. A Brief Interview for Mental Status (BIMS) was done, and Resident #25's score was 4 on the quarterly Minimum Data Set, dated [DATE]. This indicated he had severely impaired cognition. Record review of Resident #35's Preadmission Screening and Resident Review (PASARR) dated 08/02/23 prior to the resident's admission revealed no diagnoses were checked on the PASARR Screen Decision Making relating to Mental Illness or suspected Mental Illness. Diagnoses of Depressive Disorder and Psychotic Disorder are listed as examples of Mental Illness. An interview with the Social Service Director on 05/21/2026 at 11:55 AM revealed the Social Service Director or Admissions look to see if the PASARR is a part of the admissions file. If it is not, they request it from the hospital or they do it on admission. If the resident comes from home, they do the PASARR. Social Services and any Registered Nurse can review the PASARR. The PASARR for Resident #35 did not have any diagnoses. The Social Service Director reviewed this PASARR and stated this PASARR was not filled out correctly and it should have been filled out with his diagnoses of Depression and Psychotic Disorder. She stated she will fill out a new PASARR today. 3). Record review for Resident #7 revealed an admission date of 12/20/23. A Level one PASRR with a (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reference date of 12/14/23 – prior to being admitted to the facility - that was completed by a facility that the resident came from documented diagnoses that included Bipolar disorder and Depressive disorder, with no other diagnoses indicative of MI or suspected MI. Resident #7's face sheet documented diagnoses that included: PTSD - 11/14/24, Anxiety disorder - 11/14/24, Major depressive disorder - 11/06/24, Bipolar disorder - 0/04/25, Dementia - 04/03/25, Psychosis - 03/20/26, Adjustment disorder with mixed anxiety and depressed mood - 01/23/24. Resident #7's most recent complete assessment, a Quarterly MDS with a reference date of 03/18/26, documented diagnoses that included: Anxiety disorder, Depression, Bipolar disorder, Post Traumatic Stress Disorder (PTSD), Vascular dementia, Major depressive disorder, and Dementia. Resident #7's care plan for Mood State, initiated on 01/02/25 and most recent revised on 03/19/26, documented: Resident is at risk for exhibiting symptoms of depression such as crying, tearfulness, worried facial expressions related to diagnosis of Major Depressive Disorder with psychotropic medications treatments. Resident has a history of depression, anxiety, PTSD (Post Traumatic Stress Disorder) and insomnia as per records history of being treated for depression, psychosis and anxiety. Resident is being monitored by Psychologist, Psychiatry ARNP, Pharmacist, nursing staff and Social Services for psychotropic meeting to evaluate current dosages, adverse effects and GDR (Gradual Dose Reduction) if appropriate. Resident #7's Most recent psychiatric note, with a reference date of 04/16/26, documented: Chief complaint: follow up for history of depression, anxiety, PTSD, Bipolar, dementia and insomnia History of present illness: Patient is seen for follow up psychiatric assessment. Patient has hx of depression, anxiety, Bipolar, PTSD, dementia and insomnia per records .Patient reports that she feels depressed sometimes .Duloxetine was reduced in GDR attempt. No self-harm, SI, hallucinations reported. Depakote was d/c due to tremors. Patient has chart hx of violence, paranoia and suspicious behavior. Current meds: Duloxetine 30 mg po once daily Duloxetine 60 mg po qHS Donepezil 10 mg q HS During an interview, on 05/20/2026 at 10:45 AM, with the Admissions Coordinator, when asked about the resident's PASSAR, the Admissions Coordinator stated that the Admissions Nurse does the pre-admission visit when the resident is coming from the home. When the resident is coming from the hospital or another facility, the Admissions Nurse will request the PASSAR and that she (the Admissions Coordinator) reviews it to make sure that it is correct and psychiatrist will come to the facility and find new diagnoses.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 reviews, the facility failed to develop and implement a care plan with measurable goals and interventions for 1 of 5 residents reviewed for Behavior, Resident #7; and failed to follow care plan interventions for 1 of 2 residents reviewed for falls, Resident #65. The findings included: 1). Record review for Resident #7 revealed an admission date of 12/20/23. According to the resident's most recent complete assessment, a Quarterly Minimum Data Set (MDS) with a reference date of 03/18/26, Resident #7 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. The MDS documented that the resident displayed behaviors that included little interest in doing things 2-6 times during the 14-day look back period, feeling down, depressed, or hopeless 2-6 days of the 14-day look back period, and feelings of loneliness or isolations 'sometimes'. The assessment documented Resident #7 had psychiatric mood disorders at the time of the assessment that included: Anxiety disorder, Depression, Bipolar, and Post Traumatic Stress Disorder (PTSD). Further review of the resident's record revealed that there were no care plans, with measurable goals and interventions for symptoms related to diagnosis of PTSD, including triggers and behaviors. During an interview, on 05/18/2026 at 1:55 PM, Resident #7 stated that her PTSD was related to witnessing a sibling being abused and beaten by a parent. When asked about triggers, Resident #7 replied, touching me, even just a little. The hospital rule is that only women can provide care to women (referring to not being provided care by male staff). When asked about reactions to the trigger, the resident motioned that it made her feel uneasy and unsafe by shrugging and shivering. During an interview, on 05/20/2026 at 10:41 AM, with the Social Services Director, the Social Services Director was made aware of the findings. 2). Review of the facility's policy titled, Falls and Fall Risk Managing, last revised on 09/05/24, stated the staff will identify interventions and implement a resident-centered fall prevention plan related to the resident's specific risks and causes to try to prevent the resident from falling. Record review for Resident #65 revealed the resident was admitted to the facility on [DATE]. The following diagnoses were included: Dementia, Benign Prostatic Hypertrophy, Chronic Kidney Disease Stage 3, Colon and Prostate Cancer. Review of the Quarterly Minimum Data Set (MDS) for Resident #65 dated 04/07/26 revealed the Resident had a Brief Interview for Mental Status (BIMS) score of 04, which indicated the resident had severe cognitive impairment. The resident was dependent when toileting and used a wheelchair or walker to ambulate. Per the facility's Report, Resident #65 fell on [DATE] and 03/16/26. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	As per the event assessment dated [DATE] at 03:48 AM, Resident #65 fell in his room and stated he was coming from the bathroom when he fell. As per the event assessment dated [DATE] at 03:00 AM, Resident #65 was found on the bathroom floor and stated he fell while urinating. Review of the Care Plan for Resident #65 dated 01/07/26 with a focus on falls was updated after a fall on 03/16/26. The approach documented a Toileting Schedule before meals (AC), after meals (PC), at bedtime (HS), and as needed (PRN). This was a minimum of 7 times a day. A review of the Point of Care History Report during the dates of 04/21/26 through 05/21/26 documented how often the resident was offered to use the restroom. The report revealed Resident #65 was offered to use the restroom on average 3 times a day instead of 7 times a day and they were not during the times specified in the approach. On 05/21/26 at 12:12 PM an interview was conducted with the Risk Manager (RM), who had been employed by the facility for about 1.5 years. She stated that when a resident has a fall incident, a full assessment was completed, it was discussed by the Falls Committee to determine the cause, and interventions such as staff education and toileting schedules were put in place. She provided a printout of the Point of Care History Report for the month and acknowledged the resident was not offered assistance to the bathroom [ROOM NUMBER] times daily. She stated it was possibly documented in the physical chart. On 05/21/26 at 2:08 PM, an interview was conducted with Staff G, Senior Licensed Practical Nurse, who had been employed by the facility for 3 years and Staff H, Senior Certified Nursing Assistant who had been employed for 10 years. Both were familiar with Resident #65 since the resident was part of their usual assignment. They were unable to provide any written documentation regarding the resident's toileting schedule. Staff H stated the resident usually needs to use the restroom during morning care and will ask when he needs to use the restroom. She did not state that the resident is offered to use the restroom before and after meals and was unaware of the toileting approach and specific times. Photographic evidence was obtained.

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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** Based on observations, interviews and record review, the facility failed to investigate and update interventions to care plans to prevent additional falls for 1 of 2 residents reviewed for falls (Residents #65). The findings included: Review of the facility's policy titled, Falls and Fall Risk Managing, last revised on 09/05/24, stated the staff will identify interventions and implement a resident-centered fall prevention plan related to the resident's specific risks and causes to try to prevent the resident from falling. Record review for Resident #65 revealed the resident was admitted to the facility on [DATE]. The following diagnoses were included: Dementia, Benign Prostatic Hypertrophy, Chronic Kidney Disease Stage 3, Colon and Prostate Cancer. Review of the Quarterly Minimum Data Set (MDS) for Resident #65 dated 04/07/26 revealed the Resident had a Brief Interview for Mental Status (BIMS) score of 04, which indicated the resident had severe cognitive impairment. The resident was dependent with toileting and used a wheelchair or walker to ambulate. Review of the Care Plan for Resident #65 dated 01/07/26 with a focus on falls was observed with approaches which included encouraging out of room activities to increase supervision, bilateral 1/4 upper side rails while in bed to assist with bed mobility, keep pathways dry and clear of clutter, keep bed in lowest position and locked, and review of medications. There were no interventions added until 03/16/26 apart from a pommel cushion in wheelchair ordered on 03/03/26. Per the facility's Report, Resident #65 fell on [DATE] and 03/16/26. As per the event assessment dated [DATE] at 03:48 AM, Resident #65 fell in his room and stated he was coming from the bathroom when he fell. As per the event assessment dated [DATE] at 03:00 AM, Resident #65 was found on the bathroom floor and stated he fell while urinating. On 05/21/26 at 12:12 PM an interview was conducted with the Risk Manager (RM), who had been employed by the facility for about 1.5 years. She stated that when a resident has a fall incident, a full assessment was completed, it was discussed by the Falls Committee to determine the cause, and interventions such as staff education and toileting schedules were put in place. She stated Resident #65 had not fully acclimated when his first fall occurred and he was grieving his wife's death and needed more time. The RM later provided the notes for the Falls Committee Meeting dated 01/30/26. Neuro checks and monitoring were ordered for 3 days. No other interventions were ordered. The RM provided a Fall Review form for the fall dated 03/16/26 where the fall action team response was documented but was unable to provide the form for the 01/30/26 fall. The RM agreed that no new approaches were added to address the fall. Photographic evidence was obtained.

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	106038	A. Building B. Wing	05/21/2026

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

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide care and services to meet the needs and prevent re-traumatizing of 2 of 5 residents reviewed for Behavior, (Residents #7, and #9). The findings included:1.) The Facility Assessment, most recently reviewed and revised on 03/27/26, documented:Services and care we offer based on our residents' needs:Mental health and behavior - Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities. During an interview, on 05/21/2026 at 9:14 AM, with Staff C, Unit Clerk, when asked about training provided related to providing care to a resident with PTSD Staff C replied, We have in-services and we learn how to remain calm with them. When asked, Staff C could not recall the most recent training provided. During an interview, on 05/21/2026 at 9:51 AM, with Staff L, Nursing Supervisor 7-3 shift, when asked about training related to providing care to a resident with PTSD, Staff L replied, in-service training on FDVA (Florida Department of Veterans Affairs) learning portal a couple of weeks or a couple of months ago. During an interview, on 05/21/2026 at 1:01 PM, with Staff E, CNA, when asked about training related to providing care to a resident with PTSD, the CNA gave no response after several minutes. During an interview, on 05/21/2026 at 12:58 PM, with Staff F, CNA, when asked about training related to providing care to a resident with PTSD, Staff F stated that there was no training for PTSD, mental stress. During an interview, on 05/21/2026 at 3:11 PM, with Staff M, RN/7-3 supervisor, the RN confirmed that she completed competencies of the nursing and CNA staff. Staff M further stated that the assessments did not include providing care to residents with PTSD and behaviors. When asked about training related to providing care to residents with PTSD, Staff M stated that the Staff education nurse does in-services, she had one last year where she showed videos that were about symptoms of PTSD. When asked how it was determined that staff were understanding of the training, Staff M referred to Staff Development Coordinator (SDC). During an interview on 05/21/2026 at 3:21 PM, with the SDC, when asked about training for providing care to residents with PTSD, the SDC replied, they watched a video and signed a sheet. When asked how to ensure that the staff that took the training and watched the videos understood the material, the SDC stated that there was no assessment to ensure understanding. 2). Record review for Resident #7 revealed an admission date of 12/20/23. According to the resident's most recent complete assessment, a Quarterly Minimum Data Set (MDS) with a reference date of 03/18/26, Resident #7 had a Brief Interview for mental Status (BIMS) score of 14, indicating the resident was cognitively intact. The assessment documented that over the 2-week look back period, Resident #7 displayed the following mood symptoms:Little interest or doing things 2-6 days.Feeling down, depressed, or hopeless 2-6 days. Feeling lonely or isolated 'sometimes.' Resident #7s diagnoses included: Anxiety disorder, Depression, Bipolar disorder, PTSD. Psychiatric/Mood disorders at the time of the assessment included: Anxiety disorder, Depression, Bipolar disorder, PTSD. Resident #7's care plan for Mood State, most recently reviewed/revised 03/23/26, documented, Resident is at risk for exhibiting symptoms of depression such as crying, tearfulness, worried facial expressions related to diagnoses of major depressive disorder with psychotropic medications. Has a history of depression, anxiety, PTSD and insomnia as per records history of being treated for depression, psychosis and anxiety. Resident is being monitored by psychologist, Psychiatry ARNP, Pharmacist, nursing staff and Social Services for psychotropic medications. Monthly Psychotropic meeting to evaluate current dosages, adverse effects and GDR if appropriate. A ?Trauma Informed Care Screening' assessment with a reference date of 12/21/23 (upon admission) documented: Did not experience an event that was frightening, horrible or upsetting.Has never served in active combat or in a combat zone. Has (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	never been in a serious accident.Has experience Hurricanes, severe weather in Florida.No trauma during childhood.Has never been attacked, beaten or mugged.Has never been pressured or forced to engage into unwanted sexual activity.Has not had a close family member die violently.Care plan developed yes. During an interview, on 05/18/2026 at 1:55 PM, Resident stated that her PTSD was related to witnessing her sister being abused and beaten by their father. When asked about triggers, Resident #7 replied, touching me, even just a little When asked about reactions to the trigger, the resident motioned that it made her feel uneasy and unsafe by shrugging and shivering. During an interview, on 05/20/2026 at 1:36 PM, with Staff A, CNA, when asked about Resident #7's PTSD, Staff A referred to Physical Therapy. When asked about PTSD, Staff A stated that she was not aware of trauma. During an interview, on 05/20/2026 at 1:47 PM, with Staff B, RN, since 2002, when asked about Resident #7's behaviors and PTSD, Staff B replied, sometimes she gets or has a tendency to get verbally aggressive, sometimes she will burst out crying. Her husband comes and sits with her and watches television and that helps manager her. She said to me in the past that it was from being in the service. When asked about the resident's triggers, Staff B replied, There is no behavior that I do that would trigger her. My actions do not trigger her. On 05/21/2026 at 9:03 AM, Resident#7 was observed in bed with breakfast partially eaten on an overbed table. Resident #7 was crying and appeared to have been for several minutes based on dried tears on her cheek/face. Resident was unable to verbalize why she was crying and motioned that she was hot and needed a fan. During an interview, on 05/21/2026 at 9:10 AM, with Staff K, RN/nurse manager, when asked about the fan, Staff K replied, we had to remove her fan so that Maintenance could make sure that it is grounded and safe. We told her that it would be 15 minutes and that was 8:53 AM. During an interview, on 05/21/2026 at 9:14 AM, with Staff C, Unit Clerk, when asked about Resident #7's behaviors, Staff C replied, she is mostly calm, she likes to be by herself. We get her up as often as we can and her husband is here two times a week and is very supportive of her and he calls her very often - good man. When asked about Resident #7's diagnosis of PTSD, Staff C replied, I don't know, She was in the Miami VA for a long time and we got her after that. During an interview, on 05/21/2026 at 9:51 AM, with Staff L, Nursing Supervisor 7-3 shift, when asked about Resident #7's fan, Staff L replied, Maintenance and Risk manager determined that the fan was not safe as it could very easily fall or be knocked from the headboard as it is a clamp fan. During an interview, on 05/21/2026 at 10:02 AM, with Staff D, LPN providing care to Resident #7, when asked about the resident's behaviors, Staff D replied, she has depression and doesn't like to interact with other people, she lies in her bed and watches TV and listens to music. She states that she would rather be home with her spouse and that adds to her depression. When asked about the resident's PTSD, Staff D replied, I have never heard her complain of nightmares like others do. Another resident has nightmares - he is the only one with PTSD that has nightmares and he is medicated for them. Sometimes she gets upset when we go in and provide care and she is frustrated and she will yell and scream if you go in and she is sleeping and you wake her up. I noticed the fan on Monday, it wasn't there before. During an interview, on 05/21/2026 at 12:36 PM, with Resident #7's spouse, when asked about the resident having PTSD, the spouse replied, not that I am aware of. I have never heard anybody say that about her. When asked about Resident #7's siblings, the spouse replied, There were 3 of them all together and she was the youngest. All girls/sisters. The oldest sister passed from a heart attack 15 years ago. She was born in San [NAME] and then Atlanta and there is no family in South Florida and no kids. When asked about the resident's fan, the spouse replied, about a month or so for the fan, she was always getting so hot. They took one away from her a long time ago and then they said that she could have one again. 3). Record review for Resident #9 revealed an admission date of 08/03/22. According to the resident's most complete assessment, a Quarterly MDS with a reference date of 03/25/26, Resident #9 had a BIMS score of 15, indicating the resident was cognitively intact. The assessment documented that Resident #9 displayed feeling down, depressed or hopeless 2-6 days during the 2-week look back period. Resident #9's diagnoses included: Parkinson's disease, PTSD, Insomnia, (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Major depressive disorder, Depression, unspecified psychosis. Resident #7's care plan for psychosocial well-being, most recently reviewed/revised 04/28/26, documented, resident experiences symptoms of distress/PTSD related to history of trauma as evidenced by feelings triggered by loud noises and fireworks. The goal of the care plan was documented as, Episodes of distress symptoms will be alleviated quickly without harm to resident or others. Interventions of the care plan included: Acknowledge experiences as trauma and address as such.Identify what triggers stressful episodes and avoid as able. Maintain consistency in daily routine, care givers, and avoid changes when possible. Provide safe environment. During an interview, on 05/18/25 at 11:18 AM, with Resident #9, when asked about his PTSD, Resident #9 replied, Combat in Vietnam, I killed people, I carried the radio and sent information to the platoons. I was the first one in of my platoon. They sent me to a hospital for 6 weeks in Titusville. They gave me instruction on how to react. When asked about triggers to the PTST, Resident #9 stated explosions, loud noises. I gotta close in. I can be very obnoxious. During an interview, on 05/21/2026 at 10:07 AM, with Staff D, LPN providing care, when asked about Resident #9's PTSD, the LPN replied, he has never complained about nightmares. He has never complained to me about his PTSD. He was in the Vietnam war. He gets aggressive when you don't get things done in a certain order. He does not like the lights being left on and doors being left open. During an interview, on 05/21/2026 at 12:58 PM, with Staff F, CNA providing care to Resident #9, when asked about Resident #9's PTSD, the CNA replied, sometimes he will want something, and he will want it right now.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview, and record review, the facility failed to document behavior monitoring for 1 of 4 residents reviewed for Dementia Care, (Resident #98).The findings include:On 05/21/26 at 11:51 AM, a record review was conducted for Resident #98 related to antipsychotic medications prescribed for a resident with a diagnosis of Dementia. The following medications were ordered for the reason provided:Quetiapine 25 mg (Seroquel) 25 mg 1 tablet by mouth at bedtime for hallucinations. Duloxetine (Cymbalta) 30 mg 1 capsule by mouth at bedtime for depression.Duloxetine (Cymbalta) 30 mg 2 capsule (60mg) by mouth once a day at 9:00 AM for depression.A review of the Medication Administration Record (MAR) for May 2026 revealed monitoring for the antipsychotic medication Quetiapine (Seroquel) but no monitoring was found for the Duloxetine (Cymbalta) an antidepressant. A review of progress notes revealed there were no notes found that identified behavior and/or mood changes related to depression or the use of the antidepressant Duloxetine.On 05/21/26 at 2:17 PM, an interview was conducted with Staff D, a Licensed Practical Nurse (LPN) who works in the Alpha Unit and was assigned to care for Resident #98. Staff D was asked if the facility had a protocol for monitoring antidepressants and to explain the protocol. Staff D stated that the facility had a protocol to monitor behaviors and mood changes for antidepressant medication. Staff D stated that monitoring is included on the MAR. Staff D looked at the orders for Resident #98 and found no orders for monitoring the antidepressant Duloxetine. Staff D stated that the nursing staff is trained to monitor for signs of depression and signs of worsening depression, citing examples that included increased sadness, being withdrawn or seeking to be isolated. Staff D confirmed that behavior monitoring for the antipsychotic Quetiapine was found on the MAR.On 05/21/26 at 2:45 PM, an interview was conducted with Staff J, a Registered Nurse (RN), who works on the Alpha unit where Resident #98 resides.Staff J stated if a resident has dementia and antidepressants, and/or antianxiety medications, and/or antipsychotic medications are ordered then behavior and mood monitoring is supposed to be ordered and documented in the MAR. Staff J stated the nurses do not need to get a doctor's order for monitoring because it is understood that monitoring is required. Staff J stated that even if monitoring was not ordered for a medication, she would at least document mood and behavior in the progress notes. Staff J stated she would document no changes if the resident was stable.