STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106151	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alwyn C Cashe State Veterans Nursing Home	5255 Raymond St Orlando, FL 32803

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview, and record review, the facility failed to implement its policy and procedures for the prohibition of abuse and neglect related to providing staff education, conducting a thorough incident investigation, and protecting residents in response to an allegation of neglect for 1 of 2 residents reviewed for neglect, of a total sample of 4 residents, (#1); and failed to minimize the risk for neglect for residents who had abnormal diagnostic test results. Findings: Review of the facility's policy and procedure for Abuse, Neglect and Exploitation / Misappropriation of Property, revised on 3/01/24, revealed the facility's intent to achieve and maintain an abuse-free environment. The document indicated the seven components of the abuse prohibition program were screening, training, prevention, identification, investigation, protection, and reporting. The procedure defined neglect as the failure to provide necessary goods and services and the .failure to make reasonable effort to protect a resident from abuse, neglect. The policy revealed staff would be educated on occurrences and actions that could be regarded as neglect. The document provided guidance on the elements of a thorough investigation including interviewing staff, obtaining written statements, and describing actions to protect resident(s). The policy revealed residents would be protected from harm during the investigation by reassigning involved staff to duties that did not involve resident contact and agency staff will not be allowed to work during the investigation. Review of the medical record revealed resident #1, a [AGE] year-old male, was admitted to the facility on [DATE] with diagnoses including dementia, hypertension, atrial fibrillation, and a cardiac pacemaker. He was transferred to the hospital on 12/06/24 and readmitted to the facility on [DATE] with a new diagnosis of acute on chronic congestive heart failure (CHF). Resident #1's medical record revealed a laboratory result for a Brain Natriuretic Peptide (BNP) test dated 11/29/24. The document showed a critically high value of 432.10 picograms per milliliter (pg/mL), outside the reference range of 0 to 100 pg/mL. This test measures the amount of BNP hormone made by the heart and released into the bloodstream when it has to work harder than normal to pump blood. It is used to confirm or rule out heart failure in patients with symptoms, (retrieved on 1/29/25 from www.medlineplus.gov/lab-tests/natriuretic-peptide-tests-bnp-nt-probnp/). (continued on next page)

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident Progress Notes revealed on 11/29/24 at 2:27 PM, Registered Nurse (RN) A received telephone notification from a laboratory technician regarding resident #1's critically high BNP level. The note showed she left a message with the physician's answering service and was awaiting a return call. A nursing progress noted dated 11/29/24 at 4:35 PM, indicated RN A called the physician again to report the abnormal lab result and left a voicemail message. The medical record did not show any additional actions by RN A to ensure a physician was notified of the lab result before she left the facility at the end of her shift. There was no evidence she shared the information with a supervisor or the oncoming overnight shift nurse, and no documentation by the night shift nurse to indicate she was either made aware of or addressed the unreported lab result. On 1/23/25 at 12:33 PM, and 1:03 PM, in telephone interviews, RN A stated she did not recall resident #1's critically high BNP laboratory result or her unsuccessful attempts to reach a medical provider. She stated she felt it was appropriate to leave a message if she could not reach a provider, and explained privacy laws prevented her from including the resident's name or specific laboratory result. RN A said, Maybe I would have left a message to call the facility. On 1/23/25 at 4:25 PM, the Interim Director of Nursing (DON) stated her expectation was nurses would immediately notify medical providers of abnormal diagnostic test results to ensure timely and appropriate interventions as indicated. She explained nurses should speak to a provider, not just leave a message, and if a nurse could not contact an attending physician, he/she should escalate the issue to a supervisor who would reach out to the facility's Medical Director. On 1/23/25 at 10:26 AM, during review of the Reportable Tracking Log for December 2024, the Risk Manager (RM) confirmed an allegation of neglect was made by resident #1's daughter on 12/06/24. She explained the resident's daughter reported her father's eyes had milky drainage and his face appeared to be swollen. The RM stated the resident's daughter chose to transport him to an urgent care clinic for evaluation and he was transferred to the hospital and diagnosed with CHF. The RM recalled during review of resident #1's medical record, she noted he had a BNP laboratory test done on 11/29/24 and RN A attempted to report the abnormal result to the physician's answering service. The RM stated RN A misspoke and left a voicemail for the provider regarding a Basic Metabolic Panel (BMP) result rather then a BNP. The RM indicated there was no evidence in the medical record that RN A made an effort to inform the DON or another provider about the critical test result. She stated the attending physician signed off on the laboratory result a few days later without making recommendations, and it was unknown if the physician was aware of the delay in reporting. The RM stated the facility substantiated the allegation of neglect as RN A did not follow up to ensure a critical laboratory test result was reported promptly to the physician. On 1/23/25 at 11:34 AM, the Administrator stated when she was informed of the neglect allegation and the investigative finding related to resident #1's laboratory result that was not reported to the physician timely, she followed up with facility's Medical Director. She explained the Medical Director was supposed to speak with the physician who signed off on the test result to ascertain if there was a need to re-educate her on facility processes. The Administrator stated the Medical Director never got back to her and she had no written statement regarding whether or not an intervention was necessary. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/24/25 at 9:08 AM and 10:36 AM, the Staffing Coordinator explained she met with the Administrator and DON daily to review the facility's staffing needs and followed their instructions regarding schedules and assignments. She stated she had never been told to remove any staff members from the schedule due to an allegation of abuse or neglect. She provided documentation of RN A's completed shifts which showed she worked in December 2024 on on 12/06/24, 12/13/24, 12/17/24, 12/19/24, and 12/21/24. On 1/24/25 at 9:11 AM, and 10:36 AM, the Administrator explained since the Staffing Coordinator was new to the position, removal of staff from the schedule during an investigation in December 2024 would have been done by herself and/or the previous DON. The Administrator stated she did not inform the staffing agency nor remove RN A from the schedule during investigation of the allegation of neglect. She acknowledged the facility had not followed the policy, which required the removal of staff involved in an incident to ensure residents were protected during the investigation period. On 1/24/25 at 9:18 AM, and 9:34 AM, the RM verified she was responsible for the investigation of resident #1's neglect allegation. However, she acknowledged she never obtained statements from RN A, the Medical Director, the resident's attending physician, or Advanced Practice Registered Nurse B who ordered the laboratory test. The RM stated she was informed of the allegation of neglect by email on 12/06/24, but she was not at work that day. She explained she did not identify the concern with the laboratory test result on either 12/10/24 or 12/11/24. The RM was informed RN A continued to work after the concern was discovered as her time sheet showed she worked on 12/13/25, while investigation was ongoing. The RM said, I did not pull her [from the schedule] during the investigation. In hindsight, she should have been pulled at least until the final findings were submitted. The RM verified the facility normally required all staff to participate in education on the abuse and neglect prohibition policy and procedures after any allegation. She acknowledged the facility focused on education related to the clinical aspect of the nurse's failure to report the laboratory result appropriately. The RM said, The neglect allegation was substantiated. We should have done abuse and neglect education with all staff to make sure they understand. On 1/24/25 at 9:15 AM and 10:10 AM, the Staff Developer stated the last all-staff education provided on the topic of abuse and neglect prohibition was done in October 2024. He explained whenever there was an allegation of abuse or neglect, the expectation was all staff would be re-educated. The Staff Developer stated the process was to initiate education immediately when an allegation was received. He said, If the allegation is verified, we definitely do 100% of staff. That is important. He stated he was on leave from 12/05/24 to 12/24/24 and was not involved in the investigation or corrective actions and did not initiate re-education on abuse and neglect. The Staff Developer stated when he returned from leave, he was not informed verbally or by email that there was a verified allegation of neglect, and he vaguely recalled hearing about the issue recently. On 1/24/25 at 9:59 AM, the Interim DON stated she was unable to find evidence that the facility educated all staff on the abuse and neglect prohibition policy and procedures in response to the identification of neglect for resident #1. She stated all staff involved should have been removed from resident care, management should have collected statements and conducted a thorough investigation, and all staff should have be re-educated on the facility's policy and procedures. The Interim DON explained the rationale for these actions was to prevent the same thing from happening again. Review of the Facility Assessment Tool, dated 1/21/25, revealed the facility would provide residents with person-centered social support including the prevention of abuse and neglect.

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview, and record review, the facility failed to conduct a thorough medication regimen review and ensure adequate monitoring of a high-risk drug to minimize adverse consequences for 1 of 3 residents reviewed for laboratory test results, of a total sample of 4 residents, (#3). Findings: Review of the medical record revealed resident #3, an [AGE] year-old male, was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including traumatic brain injury, dementia, repeated falls, major depressive disorder, and persistent mood disorders. Review of the Minimum Data Set Discharge-Return Anticipated assessment, with assessment reference date of 12/24/24 revealed resident #3 had an unplanned discharge to the hospital. The document indicated the resident took medications in high-risk drug classes in the 7-day look back period, including an antidepressant and an anticonvulsant. Resident #3 had a care plan dated 3/13/24 for risk for adverse consequences related to medications prescribed for the treatment of depression and a mood disorder. The goal was the resident would not exhibit signs of drug related side effects or adverse drug reaction. The approaches included monitor mood and response to medications, psychiatry and psychology consultations as needed, and pharmacy consultant review. A care plan for signs and symptoms of mood distress, dated 4/30/24, indicated the resident's primary mood disorder would be treated according to psychiatry recommendations. Review of the Physician Order Report revealed resident #3 had an order dated 2/27/24 for Divalproex delayed release sprinkle capsule 250 milligrams (mg) twice daily for mood disorder. Divalproex or Depakote is an anti-seizure drug that is also used to treat other conditions including migraine headaches and manic episodes. The manufacturer's instructions indicate the drug can cause severe liver damage and patients may need to have frequent blood tests, (retrieved on 2/06/25 from www.drugs.com/mtm/divalproex-sodium.html). On 3/21/24, the physician ordered laboratory tests to check the resident's Depakote levels every three months, on the 21st of March, June, September, and December. Review of resident #3's medical record revealed his Depakote level was checked only when initially ordered in March 2024. There was no evidence the laboratory tests were done in June, September, and December 2024 as ordered by the physician. Review of the monthly Consultant Pharmacist's Reports from March 2024 to January 2025 revealed recommendations in July and December 2024 to attempt a gradual dose reduction for resident #3's Divalproex 250 mg. The physician declined the recommendations and noted the resident experienced positive outcomes from the current dosage and no adverse effects. The reports did not include recommendations regarding monitoring of resident #3's Depakote level. (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/24/25 at 12:35 PM, and 12:55 PM, the Interim Director of Nursing (DON) reviewed resident #3's medical record and validated laboratory tests to determine his Depakote levels were not done every three months as ordered by the physician. She stated the resident was hospitalized a few times over the past ten months and his Depakote level was checked there. She provided hospital laboratory results dated [DATE] and 12/24/24 and explained the Psychiatric Advanced Practice Registered Nurse (APRN) had access to and reviewed those results. The Interim DON stated the resident's Depakote levels were therefore checked at the approximate intervals they were due. She acknowledged the tests should have been done 6/21/24, 9/21/24, and 12/21/24; therefore they were not done at the required intervals. She stated the DON and Unit Managers were responsible for ensuring orders were accurately transcribed and implemented, and should follow up on results. The Interim DON was informed the monthly medication regimen review for resident #3 did not identify the absence of laboratory tests to monitor his Depakote level. She verified the missing lab should have been caught during monthly reviews by the consultant pharmacist. On 1/24/25 at 12:56 PM, in a telephone interview, the Psychiatric APRN confirmed resident #3 was on her caseload and she saw him at least every other week in the facility. She stated since resident #3 was admitted with an order for Depakote, the attending physician would have ordered laboratory tests to monitor his drug levels. The Psychiatric APRN explained if she either ordered that medication or adjusted the dose for a resident, she automatically gave orders for laboratory tests every three months to ensure Depakote levels were not outside safe and/or recommended limits. She was informed although the resident's attending physician ordered the test to be done every three months, the drug level was checked only once in the facility, in March 2024, and not monitored over the following ten months. She confirmed she expected all physician orders to be followed. The Psychiatric APRN denied the Interim DON's claim that she accessed and reviewed resident #3's hospital laboratory results. When asked if she reviewed the resident's medical record during her visits to the facility, she said, It was probably an oversight on my part and I should have probably noticed and ordered the lab. On 1/24/25 at 2:04 PM, in a telephone interview, the facility's Consultant Pharmacist verified she conducted monthly medication regimen reviews for all the facility's residents. She was informed resident #3 had physician orders for Depakote 250 mg twice daily and Depakote level laboratory tests every three months. She was not aware the requested tests had not been done by the facility for almost one year and explained laboratory tests were the responsibility of the facility's nursing department. The Consultant Pharmacist stated the monthly review task did not include laboratory tests as she did not see physician orders. When asked if she ever checked to ensure common laboratory tests usually associated with high-risk drugs were ordered or done, she said, I try to do the labs on residents yearly. On 1/24/25 at 2:11 PM, the Interim DON expressed surprise that the Consultant Pharmacist did not review laboratory tests used to monitor high-risk drugs in her monthly medication regimen review. She stated the Consultant Pharmacist should have access to orders and lab results and her expectation was that the facility would receive recommendations for appropriate laboratory tests as indicated. The Interim DON reiterated nursing management was responsible for review of physician orders to ensure accurate transcription and timely implementation. She stated the pharmacy review process involved chart review by members of the interdisciplinary team including the Consultant Pharmacist, clinical providers, and the DON. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedures for Medication Regimen Review, effective 10/06/17, revealed the Consultant Pharmacist would conduct a medication regimen review for each resident, at least once a month, to identify concerns including potential adverse consequences which may result from, or be associated with medications. The procedures indicated the medication regimen review was to include all drugs ordered for the resident. The document read, The review is also to include other information such as but not limited to the resident's medical diagnosis, the medication administration record, physician's progress notes, nursing notes, laboratory test results, vital signs and other pertinent information.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview, and record review, the facility failed to promptly report a critical result to the ordering physician for 1 of 3 residents reviewed for laboratory test results, of a total sample of 4 residents, (#1). Findings: Review of the medical record revealed resident #1, a [AGE] year-old male, was admitted to the facility on [DATE] with diagnoses including dementia, hypertension, atrial fibrillation, and a cardiac pacemaker. He was transferred to the hospital on 12/06/24 and readmitted to the facility on [DATE] with a new diagnosis of acute on chronic congestive heart failure. Review of the Minimum Data Set Discharge-Return Anticipated assessment, with assessment reference date of 12/06/24, revealed resident #1 had an unplanned discharge to the hospital. The document indicated the resident received diuretic medication or water pills during the 7-day look back period. Review of a care plan for return to the community, dated 10/31/24, revealed resident #1 required a higher level of care that was unable to be met in the community. The goal was he would remain in the long-term care setting to receive supportive services. A care plan for cognitive loss, dated 12/02/24, revealed the resident had impaired decision-making related to dementia. A nursing progress note dated 11/28/24 at 4:04 PM, revealed Advanced Practice Registered Nurse (APRN) B increased the dosage of resident #1's diuretic medication Lasix from 10 milligrams (mg) to 20 mg daily for seven days to treat edema or swelling of his legs. A nursing progress note dated 11/29/24 at 6:06 AM, read, Resident labs collected and result pending. Review of resident #1's medical record revealed a laboratory result for a Brain Natriuretic Peptide (BNP) test dated 11/29/24. The document showed a critically high value of 432.10 picograms per milliliter (pg/mL), outside the reference range of 0 to 100 pg/mL. This test measures the amount of BNP hormone made by the heart and released into the bloodstream when it has to work harder than normal to pump blood. It is used to confirm or rule out heart failure in patients with symptoms (retrieved on 1/29/25 from www.medlineplus.gov/lab-tests/natriuretic-peptide-tests-bnp-nt-probnp/). Review of Resident Progress Notes revealed on 11/29/24 at 2:27 PM, Registered Nurse (RN) A received telephone notification from a laboratory technician regarding resident #1's critically high BNP level. The note showed she left a message with the physician's answering service and was awaiting a return call. A nursing progress noted dated 11/29/24 at 4:35 PM indicated RN A called the physician again to report the abnormal lab result and left a voicemail message. The medical record did not show any additional actions by RN A to ensure a physician was notified of the lab result before she left the facility at the end of her shift. There was no evidence she shared the information with a supervisor or the oncoming overnight shift nurse, and no documentation by the night shift nurse to indicate she was either made aware of or addressed the unreported lab result. (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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 11/30/24 at 11:45 AM revealed Licensed Practical Nurse (LPN) C verbally notified the on-call physician of resident #1's critical laboratory test result, almost 24 hours after it was reported to the facility. On 1/23/25 at 12:33 PM, and 1:03 PM, in telephone interviews, RN A stated she did not recall resident #1's critically high BNP laboratory result or her unsuccessful attempts to reach a medical provider. She stated her usual practice was to notify the physician, inform the nursing supervisor, and write a nursing progress note regarding every laboratory result. RN A stated she felt it was appropriate to leave a message if she could not reach a provider, and explained privacy laws prevented her from including the resident's name or specific laboratory result. RN A said, Maybe I would have left a message to call the facility. On 1/23/25 at 1:34 PM, APRN B recalled she assessed resident #1 and noted both his legs were swollen. She confirmed she increased his diuretic medication and ordered laboratory tests including a BNP level. She acknowledged the resident's BNP result was over 400, which was a critically high level, and she would have expected the nurse to promptly notify a provider in the practice. APRN B was informed RN A's documentation showed that she made two attempts to contact a physician in the practice on 11/29/24. APRN B stated she was not sure why the nurse had a hard time reaching a provider as their practice maintained physician coverage at all times, including after standard working hours and on the weekend. She explained the floor nurses and nurse managers regularly communicated with her by text or direct phone calls. APRN B stated she could not be sure whether the nurse called, or what number she called. On 1/23/25 at 2:07 PM, LPN C stated she was at work on 11/28/24, the day APRN B ordered laboratory tests for resident #1. She recalled she returned to work two days later, on 11/30/24, and after reviewing progress notes in the resident's medical record, she discovered there was no documentation to show a physician was notified of the critical BNP laboratory result. LPN C explained she followed up by contacting the on-call physician to report the BNP result. She validated an abnormal or critical laboratory result should have been reported to the physician immediately. On 1/23/25 at 4:25 PM, the Interim Director of Nursing (DON) stated her expectation was nurses would immediately notify medical providers of abnormal diagnostic test results to ensure timely and appropriate interventions as indicated. She explained nurses should speak to a provider, not just leave a message, and document details regarding the notification in the resident's medical record. The Interim DON stated if a nurse could not contact an attending physician, he/she should escalate the issue to a supervisor who could reach out to the facility's Medical Director. Review of the facility's policy and procedure for Nursing Shift Communication and 24-Hour report, effective 8/27/19, revealed communication between members of the clinical team was an important component of quality of care. The document indicated the shift-to-shift communication process between nurses would involve a complete oral report on topics such as new physician orders, changes in condition, and laboratory values or diagnostic studies.

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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 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview, and record review, the facility failed to promptly report an abnormal chest x-ray result to the ordering physician for 1 of 4 residents reviewed for diagnostic test results, of a total sample of 4 residents, (#1). Findings: Review of the medical record revealed resident #1, a [AGE] year-old male, was admitted to the facility on [DATE] with diagnoses including dementia, hypertension, atrial fibrillation, and a cardiac pacemaker. He was readmitted to the facility on [DATE] with a new diagnosis of acute on chronic congestive heart failure (CHF) and transferred to the hospital on 1/17/25. Review of the Minimum Data Set Discharge-Return Anticipated assessment, with assessment reference date of 12/06/24, revealed resident #1 had an unplanned discharge to the hospital. The document indicated the resident received diuretic medication or water pills during the 7-day look back period. Resident #1 had a care plan for excess fluid volume related to CHF, dated 12/11/24, that instructed nursing staff to assess him for signs and symptoms of excess fluid including shortness of breath, a moist cough, and abnormal lung sounds caused by fluid in the lungs. Review of Resident Progress Notes revealed a nursing note dated 1/14/25 at 1:54 PM, that showed resident #1 was observed coughing at lunchtime and, bits of food observed came out of his mouth. A note dated 1/14/25 at 3:28 PM, indicated Licensed Practical Nurse (LPN) C notified Advanced Practice Registered Nurse (APRN) B, who ordered a chest x-ray to rule out aspiration or accidental inhalation of food and liquids into the lungs. A nursing note dated 1/15/25 at 6:59 AM, revealed the chest x-ray was pending and still to be performed. Review of resident #1's medical record revealed a physician order dated 1/14/25 for a chest x-ray due to coughing. A Radiology Report indicated a date of service of 1/15/25, and the x-ray result was reported on 1/15/25 at 1:37 PM. The document showed resident #1 had patchy bibasilar infiltrates, worse than prior, when compared to a chest x-ray done on 12/24/24. This abnormal finding describes inflammation or fluid build up in the bases of both lungs, (retrieved on 1/29/25 from www. radiopaedia. org/articles/pulmonary-infiltrates). Review of Resident Progress Notes for 1/15/25 and 1/16/25 revealed no documentation to indicate nursing staff notified the ordering physician of resident #1's abnormal chest x-ray result. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated 1/17/25 at 11:52 AM, revealed resident #1 complained of shortness of breath. On evaluation, the nurse discovered his oxygen saturation level was 68% on room air, and increased to 72% after administration of supplemental oxygen at 5 liters per minute (L/min) via nasal cannula. A normal blood oxygen level is between 95% and 100% and low levels may be caused by heart and/or lung conditions (retrieved on 1/29/25 from www.my.clevelandclinic.org/health/diagnostics/22447-blood-oxygen-level). The document indicated the resident's lung sounds were absent in the upper lobes and diminished in the bases, and nursing staff had to increase his oxygen flow rate to 10 L/min via non-rebreather mask. The note indicated the nurse received an order for an antibiotic medication to treat his bibasilar infiltrates prior to the resident's change in condition. However, when she notified APRN B of the resident's chest x-ray results, condition, and oxygen needs, she was given a new order to send him to the hospital Emergency Department for evaluation and treatment. Review of resident #1's Physician Order Report revealed an order dated 1/17/25 for the antibiotic Doxycycline Hyclate 100 milligrams, twice daily for bibasilar infiltrates. On 1/23/25 at 4:25 PM, the Interim Director of Nursing (DON) stated her expectation was nurses would immediately notify medical providers of abnormal diagnostic test results to ensure timely and appropriate interventions as indicated. She explained nurses should speak to the provider and document details regarding the notification in the resident's medical record. On 1/23/25 at 4:41 PM, during review of resident #1's medical record with the Assistant DON, he confirmed the physician order for the chest x-ray was entered on 1/14/25 and the radiology report was completed on 1/15/25. He validated there was no documentation to show nurses notified the physician or APRN of the abnormal result until two days later, on 1/17/25. Review of the facility's policy and procedure for Nursing Shift Communication and 24-Hour report, effective 8/27/19, revealed communication between members of the clinical team was an important component of quality of care. The document indicated issues such as abnormal x-rays would be documented in the medical record, and reported to the physician for initiation of new orders if necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106151	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alwyn C Cashe State Veterans Nursing Home	5255 Raymond St Orlando, FL 32803

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 36489 Based on interview, and record review, the facility failed to utilize its Quality Assurance and Performance Improvement (QAPI) program to monitor a Performance Improvement Project (PIP) and determine the effectiveness of selected interventions related to preventing recurrence of deficient practices for 1 of 4 residents reviewed for diagnostic test results, of a total sample of 4 residents, (#1); and failed to implement the QAPI policy and procedures to maintain adequate oversight of a PIP to ensure all residents with abnormal diagnostic test results received timely and appropriate care and services. Findings: On 1/23/25 at 10:26 AM, the facility's Risk Manager (RM) discussed an allegation of neglect, made by resident #1's daughter, on 12/06/24. She explained during the investigation, she reviewed his medical record and discovered a critically high laboratory result, indicative of heart failure, had not been promptly reported to the physician. The RM stated the resident was hospitalized approximately one week later with a new diagnosis of congestive heart failure. She stated the facility initiated a PIP on 12/12/24 for Critical lab results are not being followed up and addressed timely. The RM stated the root cause analysis showed the resident's assigned nurse failed to follow up on a critical lab result. She explained the facility's monitoring process involved daily use and review of the 24-hour report. The RM indicated nurses did not document the critical test result on 24-hour report and there was no communication at the change of shift to ensure continuity of care. She stated the QAPI committee developed an audit tool to ensure all critical and abnormal laboratory test results were noted and reported. The RM indicated the audits were ongoing and the previous Director of Nursing (DON) was responsible for collecting and reviewing the 24-hour reports and comparing them to residents' medical records. When asked if additional concerns were identified by auditing, the RM stated she did not have access to the completed audit forms. She explained the DON was no longer on staff at the facility, but she would check her office for the audit forms. On 1/23/25 at 11:15 AM, the Administrator and Assistant Director of Nursing (ADON) presented the facility's QAPI binder and prepared to discuss the PIP for critical and abnormal laboratory test results. The Administrator stated they contacted the previous DON a few minutes ago and she informed them she might have shredded the audits. She stated management staff were in the process of searching the previous DON's office and inspecting the contents of the shred bin for the missing audit forms, but as of now, they were unable to find the paperwork. The Administrator provided an attendance sheet for an Ad Hoc QAPI meeting held on 12/13/24 and confirmed the PIP was initiated at that time. Review of the PIP revealed the DON was responsible for reviewing the 24-hour report and ensuring all abnormal and critical laboratory test results were addressed. The PIP read, Audits will be reviewed in the QAPI meeting monthly times for 3 months or until substantial compliance is achieved. The Administrator stated the next scheduled monthly QAPI meetings were held on 12/18/24 and 1/15/25. However, she had no documentation related to the PIP for the meeting in December and although Critical Lab Monitoring was listed as New in January, there was no associated documentation. The ADON stated he was never involved in completing the audit forms as the DON was solely responsible for that task. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106151	A. Building B. Wing	01/24/2025

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/23/25 at 11:53 AM, the RM stated the search of the shred bin and the previous DON's office was unsuccessful. She explained they contacted the previous DON again and she said she might have thrown the audit forms in the trash. The RM stated she got the key to the dumpster and searched that location too, but did not find any audit forms for the PIP. On 1/23/25 at 4:04 PM, the RM was informed that during the complaint investigation survey, review of resident #1's medical record revealed he had a chest x-ray that showed an abnormal result, but the provider was not notified for two days. She was told the x-ray was done on 1/15/25, approximately six weeks after the incident with the resident's critical laboratory result, and the agency nurse who failed to make appropriate notification in the first incident was one of the staff assigned to care for him after the chest x-ray was done and not reported. The RM provided a 24-hour report that showed documentation for the night shift on 1/15/25 that read, Xray still pending, lab collected, result pending. The RM acknowledged if the 24-hour report had been reviewed according to the auditing process she described, the DON or the Unit Manger should have followed up. On 1/24/25 at 9:30 AM, the Administrator stated the QAPI committee discussed the concern related to the critical laboratory test result for resident #1. She explained the facility's PIP and interventions were developed to prevent the situation from occurring again, mainly by reviewing orders and results in daily clinical meetings. The Administrator acknowledged the review process did not catch resident #1's abnormal x-ray or that it was not reported promptly to the physician. She verified that without documentation of audits and review of the findings by the QAPI committee, it was not possible to evaluate the effectiveness or success of the existing PIP. Review of the facility's policy and procedures for the Quality Assurance / Risk Management Program, revised on 3/01/24, revealed the facility would develop, implement, and maintain an ongoing facility-wide program designed to monitor, evaluate, and improve the quality of care for residents and to resolve identified problems. The policy indicated the facility would develop PIPs to gather information, clarify issues, design and implement interventions, assess results, and sustain improvements. The document revealed a qualified staff member would be selected to lead the PIP, and findings from audits would be reported to the QAPI committee every month and noted in the minutes.