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	09/05/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from neglect by not ensuring the staff maintained a secure environment and implemented measures to mitigate the risks to prevent elopement for 1 of 7 residents reviewed for elopement, of a total sample of 11 residents, (#1). These failures contributed to the elopement of resident #1 and placed him at risk for serious injury/impairment/death. While resident #1 was outside the facility unsupervised, there was reasonable likelihood he could have fallen, become lost, been accosted/harmed by a stranger or been hit by a car. On 8/07/25 at approximately 4:32 AM, the facility failed to prevent a resident with severe cognitive impairment from exiting the facility unsupervised. The facility was unaware of resident #1's whereabouts until day shift staff coming to work found him in the front vestibule at approximately 6:00 AM. The facility failed to ensure the unit was secured and that resident #1 was adequately supervised to ensure vulnerable residents did not exit the facility without staff knowledge. Review of information provided by the facility revealed a total of 23 residents were identified as at risk for elopement on the first day of survey. The facility's failure to provide adequate supervision and a secure environment contributed to resident #1's elopement and threatened all residents who were at risk of elopement. This failure resulted in Immediate Jeopardy which started on 8/07/25 and was removed on 8/11/25 after verification of the immediate actions implemented by the facility. The scope and severity was decreased to a D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. Substandard Quality of Care was identified at F600 and F689. A partial extended survey was conducted on 9/05/25. The noncompliance at F600 was determined to be past noncompliance as of 8/20/25. The census at the start of the survey was 89.Findings: Cross reference F689. Review of the medical record revealed resident #1, an [AGE] year-old male, was admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease, muscle weakness, difficulty in walking, unspecified dementia, cognitive communication deficit, brief psychotic disorder, major depressive disorder and need for assistance with personal care. Review of the Minimum Data Set quarterly assessment with assessment reference date of 6/19/25 revealed resident #1 had a Brief Interview for Mental Status score of 4/15 which indicated he had severe cognitive impairment. The assessment indicated resident #1 exhibited wandering behavior and walked independently up to 150 feet. A care plan initiated 4/21/25 and revised 8/07/25 indicated resident #1 exhibited wandering behavior and moved with no rational purpose, seemingly oblivious to needs or safety. The care plan included that resident #1 was identified as an elopement risk. Interventions included placement of an electronic wander alert bracelet on resident #1 and hourly rounding. Review of physician orders revealed an active order dated 10/23/24 for an electronic wander alert bracelet to be applied to resident #1's left lower leg. In a phone interview on 9/02/25 at 2:25 PM, Certified Nursing Assistant (CNA) C verified resident #1 was on her assignment on 8/07/25. She recalled there were two CNAs and one nurse assigned to the unit for the shift. She stated while she monitored the resident in the common area, resident #1 fell asleep in a chair nearby and she requested he move closer, but he refused. She explained the other CNA on the unit asked her for help, so she asked the nurse to keep an eye on the residents including resident #1 when she left the area. CNA C reported when the nurse agreed she went to help the other CNA. She recalled that later as she was coming out of a resident's room with the other CNA, they were approached by another nurse from Administration who told them resident #1 had gotten outside of the facility. She said she was not aware he was missing until that time. CNA C explained the exit doors were equipped with alarms, but she did not recall hearing any alarms go off during the shift. On 9/04/25 at 6:07 AM, CNA D stated she worked on the secured unit the night resident #1 got outside the building. She confirmed there were two CNAs and one nurse assigned to work on the unit that night. CNA D explained she was not resident #1's assigned CNA and did not know him very well. She recalled seeing him wandering in the hallways, going to the doors leading to other units and the fire exit door during the shift. CNA D remembered she asked CNA C to assist her with other residents at approximately 4:30 AM. She explained she thought the nurse was supposed to be watching the residents in the common area. CNA C stated she later learned resident #1 had left the facility while she and CNA C were getting other residents out of bed. She said she was unaware resident #1 was missing until a staff member informed them. CNA D recalled she never heard an alarm sound. In a phone interview on 9/02/25 at 3:56 PM, License Practical Nurse (LPN) B recalled working 8/07/25. She explained she was not very familiar with the residents as she was an agency

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to maintain a secure environment to ensure vulnerable residents did not exit the facility without supervision for 1 of 7 residents reviewed for elopement, of a total sample of 11 residents, (#1). These failures contributed to the elopement of resident #1 and placed him at risk for serious injury/impairment/death. While resident #1 was outside the facility unsupervised, there was reasonable likelihood he could have fallen, become lost, been accosted/harmed by a stranger or been hit by a car. On 8/07/25 at approximately 4:32 AM, the facility failed to prevent a resident with severe cognitive impairment from exiting the facility unsupervised. The facility was unaware of resident #1's whereabouts until staff located him in the front entrance hall outside the facility at approximately 6:00 AM. The facility failed to ensure resident #1 was adequately supervised to ensure vulnerable residents did not exit the facility without staff knowledge. Review of information provided by the facility revealed a total of 23 residents were identified as at risk for elopement on the first day of survey. The facility's failure to provide adequate supervision resulted in Immediate Jeopardy starting on 8/07/25 and was removed on 8/11/25. The scope and severity of the deficiency was decreased to a D, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy. The noncompliance at F689 was determined to be past noncompliance as of 8/20/25.Findings: Cross reference F600. Resident #1, an [AGE] year-old male, was admitted to the facility on [DATE]. His diagnoses included Alzheimer's disease, muscle weakness, difficulty in walking, unspecified dementia, cognitive communication deficit, brief psychotic disorder, major depressive disorder and need for assistance with personal care. Review of the Minimum Data Set quarterly assessment with assessment reference date of 6/19/25 revealed resident #1 had a Brief Interview for Mental Status score of 4/15 which indicated he had severe cognitive impairment. The assessment indicated resident #1 exhibited wandering behavior and walked independently up to 150 feet. A care plan initiated 4/21/25 and revised 8/07/25 indicated resident #1 exhibited wandering behavior and moved with no rational purpose, seemingly oblivious to needs or safety. The care plan detailed resident #1 was identified as an elopement risk. Interventions included placement of an electronic wander alert bracelet on resident #1 and hourly rounding. Review of physician orders revealed an active order dated 10/23/24 for an electronic wander alert bracelet to be applied to resident #1's left lower leg. In a phone interview on 9/02/25 at 2:25 PM, Certified Nursing Assistant (CNA) C verified resident #1 was on her assignment on 8/07/25. She recalled providing him with a snack at some point during the night while he sat at a table across from where she was monitoring residents in the dayroom. CNA C explained there were two CNAs on the unit that night. The other CNA asked her for help, so she asked the nurse to keep an eye on the residents in the dayroom. She conveyed the nurse agreed to help watch the residents so she went to help the other CNA. CNA C recalled as she was coming out of a resident's room with the CNA D, they were approached by another nurse who worked in Administration who told them resident #1 had gotten outside of the facility. She said she was not aware he was missing until that time. CNA C explained the exit doors were equipped with alarms, but she did not hear any alarms go off during the shift. On 9/04/25 at 6:07 AM, CNA D stated she worked on the secured unit the night resident #1 got outside the building. She confirmed there were only two CNAs and one nurse working that night. CNA D explained she was not his assigned CNA. She did recall seeing resident #1 wandering in the hallways and that he had gone to the fire exit door during the night. She had last seen him in the common area at some point during the early hours of the morning but could not recall exactly what time. CNA D did recall she asked CNA C to assist her with getting some of the residents up around 4:30 AM. She stated the nurse was supposed to watch the residents. CNA C stated she later learned resident #1 had left the facility while her and CNA D assisted other residents out of bed. She was unaware he was missing until a staff member informed them. She stated she never heard an alarm sound. In a phone interview on 9/02/25 at 3:56 PM, License Practical Nurse (LPN) B recalled working on 8/07/25. She stated she monitored the residents in the common area while the two CNAs worked together but had to start her medication administration, so she left. LPN B explained she was the only nurse on the unit for that shift and had to use two different medication carts to pass medications. She stated she never heard any alarms go off and was not aware resident #1 had left the facility until he was returned by another staff member which she believed was around 6:30 AM. On 9/02/25 at 3:10 PM, LPN A stated she normally worked in the Admissions department and usually worked 8:00 AM to 4:30 PM. She explained she came in early and