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	12/23/2025

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to notify the family representative in writing of a room change for 1 of 3 residents reviewed for Resident's Rights, 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 from another nursing home on 4/03/25 and re-admitted from an acute care hospital on 8/12/25. The record noted the resident changed rooms on 11/26/25 because a private room was no longer medically necessary. In an interview on 12/23/25 at 1:30 PM, the Social Worker said it was the facility's practice to notify the resident/family representative verbally in person or over the telephone of room changes. She said a handwritten log of changes was kept by the Social Services Department. She checked the log and said it indicated on 11/25/25, resident #1's family representative was contacted by telephone and notified of the room change. She said she also recalled discussing it with her the next day and she was not happy about the change. On 12/23/25 at approximately 3:00 PM, the Nursing Home Administrator (NHA) explained she was not aware the resident/representative had to be notified in writing, as well as verbally of room changes. Review of the facility's standards and guidelines titled Resident Rights and Resident Notification, dated 3/22/24 outlined the facility must protect and promote the rights of each resident. Rights concerning living arrangements noted the resident/representative had the right to receive written notice including the reason for the room change before the change was made.

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 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 observation, interview, and record review, the facility failed to develop an individualized comprehensive care plan to include a pacemaker and compression stockings for 1 of 3 residents reviewed for quality of care, 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 from another nursing home on 4/03/25 and re-admitted from an acute care hospital on 8/12/25 with diagnoses that included cognitive communication deficit, dementia, type 2 diabetes mellitus, chronic venous hypertension (high pressure in veins) with inflammation of bilateral (both) lower extremities (legs/feet), atherosclerotic (hardening of arteries) heart disease, chronic atrial fibrillation (abnormal heart rhythm), congestive heart failure (CHF) (ineffective pumping/fluid buildup), and edema (fluid retention/swelling). The most recent Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date of 10/11/25 showed resident #1 scored 10 out of 15 on the Brief Interview for Mental Status that indicated moderate cognitive impairment. The assessment noted the resident was dependent on staff to complete all Activities of Daily Living and he received high-risk anti-coagulant (blood clot prevention), diuretic (fluid removing), and anti-platelet (blood clot prevention), medications during the look back period. Resident #1's active physician's orders included Eliquis (anti-coagulant) 5 Milligrams (MG) twice daily for atrial fibrillation, Lasix (diuretic) 20 MG once daily for edema and CHF, Toprol extended release 50 MG once daily for high blood pressure, compression stockings to be applied when out of bed, and cardiology (heart specialist) consultation. The Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form 3008 from the hospital dated 3/14/25 noted resident #1 had a pacemaker treatment device. On the afternoon of 12/22/25, review of the current comprehensive care plan revealed the care plan did not include edema with compression stockings nor the presence or monitoring of a pacemaker. On 12/22/25 at 2:58 PM, the Interim Director of Nursing (DON) confirmed resident #1 had a pacemaker. She checked the medical record and was unable to locate physician's orders to monitor the pacemaker, care plans for the device or compression stockings for edema. On 12/23/25 at 10:20 AM, the Interim DON explained the MDS Coordinators were responsible for developing and revising comprehensive care plans. On 12/23/25 at 10:26 AM, MDS Coordinator D explained comprehensive care plans were developed and revised by the MDS department who utilized the medical record, new orders, face to face assessments, and daily clinical meeting discussions amongst the Interdisciplinary Team (IDT). She said care plans were revised primarily by the MDS Coordinators during the IDT meetings, and when they were absent, the Unit Manager and DON updated them, mostly for falls. She checked resident #1's medical record and acknowledged the care plan was not updated until the previous evening for a pacemaker and edema with compression stockings. She explained she was informed about the missing problems earlier that morning and updates were made the previous day when they learned those items were missing. The MDS Coordinator stated the items should have been included, since the beginning and did not know how they were missed. On 12/23/25 at 1:10 PM, the Interim DON conveyed she expected MDS to ensure care plans were individualized, comprehensive, and developed timely. Review of the facility's standards and guidelines titled Care Plan Development and dated 11/28/17, outlined that the comprehensive care plan was developed within 21 days of admission, or seven days after completion of a comprehensive assessment. The plan of care described services that were furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being that included measurable objectives, interventions, goals, and timetables that were reviewed and revised.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide expected provision of care and follow physician's orders for compression stockings for 1 of 3 resident reviewed for quality of care, 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 from another nursing home on 4/03/25 and re-admitted from an acute care hospital on 8/12/25 with diagnoses that included dementia, type 2 diabetes mellitus, chronic venous hypertension (high pressure in veins) with inflammation of bilateral (both) lower extremities (legs/feet), atherosclerotic (hardening of arteries) heart disease, congestive heart failure (CHF) (ineffective pumping/fluid buildup), and edema (fluid retention/swelling). The most recent Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date of 10/11/25 showed resident #1 scored 10 out of 15 on the Brief Interview for Mental Status that indicated moderate cognitive impairment. The assessment noted the resident was dependent on staff to complete all Activities of Daily Living and he received high-risk anti-psychotic (psychosis prevention), anti-depressant, anti-coagulant (blood clot prevention), diuretic (fluid removing), anti-platelet (blood clot prevention), and hypoglycemic (blood sugar lowering) medications during the look back period. Resident #1's active physician's orders included Lasix (diuretic) 20 MG once daily for edema and CHF, cardiology (heart physician) consultation, and compression stockings to be applied when out of bed. On 12/22/25, review of the comprehensive care plan revealed no focus or interventions for edema with compression stockings. On 12/22/25 at 1:40 PM, resident #1 was observed sitting in a reclining wheelchair outside. Both of his feet were resting on the footrests, and bare skin of both lower legs was visible from the end of the resident's trousers approximately 10 inches down, to the top of his socks at the ankle. Both of his legs were discolored (red/dark red) and visibly swollen. He was not wearing the compression stockings. On 12/22/25 at 1:42 PM, resident #1's assigned Certified Nursing Assistant (CNA) A explained resident #1 wore Thrombo-Embolic Deterrent (TED) compression stockings daily. She said the stockings were normally applied by the night shift CNAs when they got residents out of bed in the morning. The CNA said she came in late that morning and hadn't noticed the resident wasn't wearing his stockings. The CNA said she was aware the resident should have the stockings on when he was out of bed however, the previously assigned CNA had not put them on when he was assisted out of bed earlier that morning. On 12/22/25 at 1:48 PM, assigned Licensed Practical Nurse (LPN) B said the resident was supposed to wear TED compression stockings daily. She said earlier in the shift, CNA A told her the resident's feet were swollen, and she told the CNA that was because he was supposed to be wearing the TED compression stockings. She said she had documented in the medical record the task had been completed that morning and stated, I assumed they took care of it. On 12/22/25 at 1:51 PM, the Freedom Unit Manager (UM) checked the medical record and confirmed that morning, LPN B documented that resident #1's compression stockings were on. She explained she expected nurses to document completion after confirming orders were implemented. She said compression stockings (TED hose) were ordered to prevent blood clots and promote circulation to prevent complications. A few minutes later, in a joint observation, the UM checked resident #1 and said his legs were red and swollen and the compression stockings should have been applied. On 12/22/25 at 2:58 PM, the Interim Director of Nursing (DON) explained nurses were expected to ensure physician's orders were followed and to document confirmation in the medical record after orders were completed. She checked resident #1's medical record and acknowledged LPN B signed off that the compression stockings were applied the same morning. The DON said she was informed by the Unit Manager the stockings were not applied to resident #1 that morning. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She did not explain why LPN B documented in the record that the task was completed. Review of the Facility Assessment Tool dated 7/23/25 outlined the facility provided nursing services with monitoring/management to prevent problems/deterioration for residents with chronic cardiac conditions.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Cardiology services were provided per physician's orders for 1 of 3 residents reviewed for administration, 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 from another nursing home on 4/03/25 and re-admitted from an acute care hospital on 8/12/25 with diagnoses that included dementia, type 2 diabetes mellitus, chronic venous hypertension (high pressure in veins) with inflammation of bilateral (both) lower extremities (legs/feet), atherosclerotic (hardening of arteries) heart disease, chronic atrial fibrillation (abnormal heart rhythm), congestive heart failure (CHF) (ineffective pumping/fluid buildup), and edema (fluid retention/swelling). The most recent Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date of 10/11/25 showed resident #1 scored 10 out of 15 on the Brief Interview for Mental Status that indicated moderate cognitive impairment. The assessment noted the resident was dependent on staff to complete all Activities of Daily Living and he received high-risk anti-coagulant (blood clot prevention), diuretic (fluid removing), and anti-platelet (blood clot prevention), medications during the look back period. Resident #1's active physician's orders included Eliquis (anti-coagulant) 5 Milligrams (MG) twice daily for atrial fibrillation, Lasix (diuretic) 20 MG once daily for edema and CHF, Toprol extended release 50 MG once daily for high blood pressure, compression stockings to be applied when out of bed, and cardiology (heart specialist) consultation. The Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form 3008 from the hospital dated 3/14/25 noted resident #1 had a pacemaker treatment device. On 12/22/25 at 1:40 PM, resident #1 was observed sitting in a reclining wheelchair outside. Both of his feet were resting on the footrests; the bare skin of both lower legs was visibly discolored red/dark red and swollen. On 12/22/25 at 2:58 PM, the Interim Director of Nursing (DON) explained information about consultations were obtained from the hospital records, admissions, and providers when they initiated an order. She checked resident #1's medical record and found an active physician's order for a cardiology consultation over three months prior on 9/18/25. She said the resident had a pacemaker and needed monitoring by a specialist. The DON said the Nurse Scheduler was responsible for making outside appointments. She said she was unaware of the status of the consult and was unable to locate any Cardiology provider notes in the resident's medical record. On 12/22/25 at 10:02 AM, the Nurse Scheduler explained she was responsible for arranging specialist appointments outside the facility. She said she relied on the Admissions Nurse, physicians, and nurses to alert her for scheduling and planning purposes. She said resident #1 had an outside vascular physician's appointment over the summer and she thought a cardiology consultation appointment wasn't needed after that. She recalled in early December 2025, the facility received notice from resident #1's previous cardiologist who requested the name of the resident's local provider because he was overdue for a visit and the pacemaker device transmissions were being sent to their office in New York. The scheduler confirmed the appointment request for the cardiology consult had not been completed yet. In a follow up interview on 12/23/25 at 3:05 PM, the Nurse Scheduler explained she checked the records and confirmed there was a physician's order for a cardiology consult since September 2025. She stated the physician order, . fell by the wayside. Review of a progress note completed by the Nurse Scheduler on 12/23/25 at 1:46 PM, noted information was obtained from resident #1's cardiology provider that the last consultation was more than a year ago, on 12/10/24. On 12/23/25 at 1:10 PM, the Interim DON confirmed resident #1 should have had a cardiology consult for his pacemaker shortly after (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/18/25 when it was ordered by the physician. She could not explain how it was missed for over three months. Review of the Facility Assessment Tool dated 7/23/25 outlined the facility provided nursing services with management to prevent problems/deterioration for residents with chronic cardiac conditions.