

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2025
NAME OF PROVIDER OR SUPPLIER  Alwyn C Cashe State Veterans Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>50401</p> <p>Based on observation, interview and record review, the facility failed to treat each resident with respect and dignity by failing to recognize each resident's individual preference whether to wear a clothing protector at meals for 31 residents observed on the memory care unit out of a total sample of 25 residents.</p> <p>Findings:</p> <p>On 2/24/25 at 11:59 AM, in the Freedom memory care unit dining room, facility staff were observed putting clothing protectors on all 19 resident without first asking if they wanted to wear one. Staff informed residents they were putting the clothing protector on them, but did not ask the resident their preference.</p> <p>On 2/25/25 at 12:08 PM, Certified Nursing Assistant (CNA) G was observed as she put clothing protectors on residents without first asking them if they wanted to wear one. A short time later at 12:35 PM, a total of twelve residents dining on the Patriot Unit were all wearing clothing protectors over their clothes before lunch was served.</p> <p>On 2/27/25 at 12:01 PM, CNA H was observed while she put clothing protectors on residents without first asking them if they wanted one. CNA H explained she told residents she was putting the protector on but confirmed she didn't ask them if they wanted it, because they were used to wearing them. She stated she was not aware she needed to ask the residents their preference first.</p> <p>On 2/27/25 at 2:05 PM, the Director of Nursing (DON) and the Regional DON indicated they were not aware staff had put clothing protectors on residents without asking their preference first. They confirmed staff should ask the residents before putting a clothing protector on the resident, since getting the resident's preference was their right.</p> <p>The facility's policy entitled, Dining-Assisting Residents with Eating, dated 6/05/20 indicated staff were to offer clothing protectors to residents.</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2025
NAME OF PROVIDER OR SUPPLIER  Alwyn C Cashe State Veterans Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49840</p> <p>Based on interview, and record review, the facility failed to develop a comprehensive person-centered care plan to meet the resident's medical, nursing, mental and psychosocial needs for 2 of 2 residents reviewed for comprehensive care plans out of a total sample of 25 residents, (#10 and #49).</p> <p>Findings:</p> <p>1. Resident #49 was admitted to the facility on [DATE] with diagnoses including dementia, metabolic encephalopathy, obstructive sleep apnea, dysphagia and type 2 diabetes.</p> <p>Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of 12/30/24 revealed resident #49 had short-term and long-term memory problems and had severely impaired cognitive skills for daily decision making. The assessment revealed resident #49 was on a mechanically altered therapeutic diet and was dependent on staff for eating.</p> <p>A care plan initiated 11/19/24 indicated resident #49 had a feeding self-care deficit. Interventions included staff to provide assistance with eating and drinking. The care plan did not indicate the level of assistance resident #49 required for eating and drinking.</p> <p>On 2/24/25 at 1:58 PM, resident #49's wife stated he had lost weight since being admitted to the facility. She expressed concern that the staff were not assisting him with meals.</p> <p>On 2/27/25 at 1:56 PM, the MDS Coordinator acknowledged resident #49's care plan indicated he required assistance with eating but did not specify the amount of assistance required.</p> <p>45646</p> <p>2. Resident #10 was admitted to the facility on [DATE] with diagnoses including cognitive communication deficit, Parkinson's disease without dyskinesia, vascular dementia, neurocognitive disorder with Lewy bodies and unspecified hearing loss.</p> <p>Review of the Minimum Data Set (MDS) admission assessment with assessment reference date (ARD) of 12/12/24 revealed resident #10 had a Brief Interview for Mental Status (BIMS) score of 07 which indicated he had severe cognitive impairment. The MDS indicated resident #10 had moderate difficulty with hearing with use of hearing aids.</p> <p>The Care Area Assessment (CAA) associated with the Admission MDS dated [DATE] indicated resident had conditions which required further evaluation. The identified areas included communication due to hearing impairment. The care planning decision was to address this triggered area through the care planning process.</p> <p>Review of resident #10's electronic medical record (EMR) revealed a comprehensive person-centered care plan was not developed to address his communication deficit related to his hearing loss.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2025
NAME OF PROVIDER OR SUPPLIER  Alwyn C Cashe State Veterans Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/27/25 at 9:14 AM, the MDS Coordinator reviewed resident #10's admission MDS, CAA triggers and care plan. She verified no care plan was developed to identify resident #10's hearing loss. She explained a care plan should have been developed to address the triggered area.</p> <p>Review of the job description for MDS Coordinator revealed the coordinator's duties and responsibilities included actively participating with clinical assessment team to assure prompt and accurate update of resident care plan to maximize resident outcome.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2025
NAME OF PROVIDER OR SUPPLIER  Alwyn C Cashe State Veterans Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840</b></p> <p>Based on observation, interview, and record review the facility failed to provide appropriate care and services to maintain and clean a Continuous Positive Airway Pressure (CPAP) machine for 1 of 1 residents reviewed for respiratory services, of a total sample of 25 residents, (#49).</p> <p>Findings:</p> <p>Resident #49 was admitted on [DATE] with diagnoses including dementia, metabolic encephalopathy, dysphagia, obstructive sleep apnea (OSA), Diabetes Mellitus (DM) Type II, and was assessed to be dependent for all activities of daily living (ADL).</p> <p>On 02/26/25 at 12:39 PM, resident #49's spouse stated the CPAP machine was working fine but the distilled water used in the machine was still in the cannister and staff needed to empty it daily, then leave the canister to dry.</p> <p>On 2/26/25 at 12:41 PM, Registered Nurse (RN) C was asked to come into resident #49's room to observe the CPAP machine. Observations at that time noted water remained in the cannister and it was not clean. RN C stated it was everyone's responsibility to remove the cannister and clean the machine but that the night shift staff was responsible for putting the machine on and off in the morning.</p> <p>Review of physician orders dated 9/24/24 noted apply CPAP and check setting with auto CPAP setting 11-18 centimeters (cm) water (h2o), and if the resident refused CPAP, to monitor oxygen saturation and document result. There were no physican orders regarding the cleaning of the machine.</p> <p>Review of the 9/24/24 admission care plan for resident #49 noted a revision date of 1/14/25 to reflect resident had an ineffective breathing pattern related to OSA and noted he/she refused to use CPAP with the intervention to apply CPAP machine as ordered. Care plan did not reflect interventions to provide and maintain a clean CPAP machine for use.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2025
NAME OF PROVIDER OR SUPPLIER  Alwyn C Cashe State Veterans Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840</b></p> <p>Based on observation, interview, and record review the facility failed to prevent medication errors greater than 5 percent (%) for 3 of 4 residents sampled for medication administration, (#29, &amp; #18), of a total sample of 25 residents. There were 4 errors in 30 opportunities by 2 of 3 nurses observed, for a medication error rate of 13.3 %.</p> <p>Findings:</p> <p>1. Resident #29 was most recently admitted to the facility on [DATE] with diagnoses that included unspecified dementia, stroke, chronic leg ulcer, rash and pruritic (itchy skin).</p> <p>Review of physician orders for February 2025 revealed an order for Lidocaine adhesive patch, medicated 5 per cent (%), administer 5%, topically. Special instructions included apply patch daily for 12 hours on lower back, then remove. Other orders included Resident #29 had an additional physician order for Lac-Hydrin (ammonium lactate) lotion, 12% administer 12% topically which was to be administered twice a day at 10:00 AM and 2:30 PM for dryness of bilateral extremities.</p> <p>On 2/25/25 at 9:58 AM, agency Licensed Practical Nurse (LPN) A was observed as she prepared 10:00 AM medications for resident #29. She prepared resident #29's medications including his 5% Lidocaine patch. When LPN A applied the patch to the resident's back, another Lidocaine patch was seen on resident #29's back from the previous day. LPN A removed the old patch and replaced it with the new one. She acknowledged the patch should have been removed previously. LPN A did not apply the Lac-Hydrin lotion as ordered at that time, but stated she administered her medications first then returned later to administer the treatments like lotion.</p> <p>Review of the Medication Administration Record for February 2025 revealed Registered Nurse (RN) C documented she had removed the Lidocaine patch the night before, 2/24/25. LPN A did not administer the Lac-Hydrin lotion until 12:00 PM, 2 hours late.</p> <p>2. Resident #18 was most recently admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, hypertension, atrial fibrillation and peripheral venous disease.</p> <p>Review of physician orders for resident #18 revealed an order for Eliquis (Apixaban) tablet, 5 milligrams (mg) administer 5 mg orally, twice a day for atrial fibrillation. The administration time was scheduled for 10:00 AM and 8:00 PM. Resident #18 had an order for Sertraline 50 mg, administer 50 mg daily by mouth. The medication was scheduled for 10:00 AM, daily.</p> <p>On 2/26/25 at 1:09 PM, RN B was observed preparing the 10:00 AM medications for resident #18 at her medication cart. She stated she was new at the facility and had a hard time with medication administration because she did not know the residents very well. RN B explained sometimes the residents were located all over the building. She explained sometimes if the resident was away from the area on an activity they would receive their medications late. RN B was observed to prepare and administer resident #18's Eliquis 5 mg tablet scheduled for 10:00 AM and Sertraline 50 mg tablet scheduled at 10:00 AM, at approximately 1:10 PM, over two hours late.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2025
NAME OF PROVIDER OR SUPPLIER  Alwyn C Cashe State Veterans Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/27/25 at 12:26 PM, the interim Director of Nursing (DON) acknowledged the medication error rate and problem with late medications administered by nurses. She stated the facility used a liberal medication pass policy, and explained there was a lot of late documentation. She stated nurses should document in real time and that sometimes they did not ask for help. The interim DON stated they notified the provider of the late medications. She said the expectation was that all residents received their medication and treatments prior to leaving the unit so they were not late or missed.</p> <p>Review of the facility policy for Medication Administration dated 12/31/21 revealed medications must be administered in accordance with the orders including any required time frame.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2025
NAME OF PROVIDER OR SUPPLIER  Alwyn C Cashe State Veterans Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>13252</p> <p>Based on observation, interview and policy review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections when linen was folded without demonstrating proper folding techniques and hygiene protocols.</p> <p>Findings:</p> <p>On 02/27/25 at 1:34 PM the facility's laundry area was observed. The clean area and the dirty section were separated by a door. In the clean area a laundry aide was observed at the folding table and also in the room was the administrator, housekeeping manger and the laundry supervisor. The laundry aid began folding a bed sheet. The bed sheet was folded in half, then the aid placed the bed sheet against his/her body and folded it again. The laundry aide said he/she had infection control training but could not remember the date. When informed that he/she was holding the linen against his/her body, the aide appeared to get irritated and tossed the bed sheet on previously folded items. The housekeeping manager stated the bed sheet would be re-washed. Informed the housekeeping manager the bed sheet in question was now touching other clean items. Several minutes later the administrator could not explain why the managers/supervisors in attendance at that time, herself included, did not correct the laundry aide to prevent the potential cross contamination.</p> <p>Review of the facility policy for laundry/laundry workers noted, Folding clothes in a nursing home requires attention to detail, hygiene . The section titled Training and Protocol noted, Ensure all staff are trained in proper folding techniques and hygiene protocols.</p> <p>On 02/27/25 at 3:18 PM the Infection Preventionist said the laundry supervisor trains the laundry staff on infection control. He spoke about random spot checks to ensure staff are following infection control policies and protocols but that the spot checks were not documented. The Infection Preventionist talked about empowering the other managers to correct the staff when there are breaks in infection control observed. He added it was about reminding staff to get out of bad habits.</p>