STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	686128	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ardie R Copas State Veterans Nursing Home	13000 SW Tradition Parkway Port Saint Lucie, FL 34987

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure written consent for psychotropic medications for 1 of 5 sampled residents, Resident #69, which was the facility's method of informing the resident and or representative of the risks and benefits of proposed treatments. The findings included: Review of the record revealed Resident #69 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] lacked a Brief Interview for Mental Status (BIMS) score for the resident as he was rarely understood and was rarely able to understand. Review of the current physician orders documented the use of Depakote, being used for the resident's mood disorder, along with an order for Ativan that was being used for an anxiety disorder. Further review of the record lacked any consent for the use of these two medications, or any other means of informing the resident's representative of the risks and benefits of the medications. During a side-by-side record review and interview on 06/19/25 at 12:09 PM, the Assistant Director of Nursing (ADON) confirmed the lack of the consents, and informing the representative.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3) Review of the record revealed Resident #69 was admitted to the facility on [DATE] and later admitted to hospice services on 04/08/25. Review of the current physician orders confirmed Resident #69 was admitted to the hospice services on 04/08/25. Another order dated 04/08/25 documented the use of Ativan, a psychotropic medication, every 4 hours as needed for anxiety. Further review of this order revealed it was an open ended order and lacked any stop date or duration of use. During a phone interview on 06/19/25 at 9:07 AM, when asked the process for ensuring a re-evaluation for the use of Ativan, and to ensure Ativan and other psychotropic medication were not used as needed without a duration of use, the Consultant pharmacist stated, If the resident is on hospice, they usually get evaluated by the physician or a practitioner weekly. The Consultant pharmacist suggested the rationale and or evaluation for the Ativan would be in the hospice physician's progress note. On 06/19/25 the Assistant Director of Nursing (ADON) was made aware of the as needed open ended Ativan order for Resident #69. During an interview on 06/19/25 at 10:01 AM, the ADON stated she spoke with the hospice nurse for Resident #69, who stated the physician and or nurse practitioner had not been out to see the resident since admission as he was still in his first benefit period. The ADON stated the hospice nurse thought the Ativan was initiated prior to the hospice admission. During a side-by-side review of the record at this time, the ADON confirmed the Ativan was initiated by hospice services on 04/08/25 as an open ended as needed psychotropic medication. Based on record review and interviews the facility failed to ensure a PRN (as needed) psychotropic medication did not extend beyond 14 days without a documented rationale and duration of use for 3 of 5 sampled residents, as evidenced by the failure to ensure a discontinue date for PRN Lorazepam (an antiaxiety psychotropic medication) prescribed to Resident #30, Resident #38, and Resident #69. The findings included: 1) Review of the record revealed Resident #30 was admitted to the facility on [DATE]. The quarterly comprehensive assessment dated [DATE], documented that the resident had a Brief Interview for Mental Status (BIMS) Score of 9 on a 0 to 15 scale, indicating moderate cognitive impairment. The resident had a documented medical diagnosis history of dementia (loss of memory) with behavior disturbance, major depressive disorder, and psychosis. Review of the record revealed an order dated 08/05/24 for Resident #30 to administer Lorazepam 1 milligrams (mg) every two hours as needed for anxiety dated 08/05/24 with no date to discontinue or documented rationale by the doctor to extend the medication. Review of the May and June Medication Administration Record (MAR) for Resident #30, revealed administration of Lorazepam 1 mg at various times by staff. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Review of the record revealed Resident #38 was admitted to the facility on [DATE]. The quarterly comprehensive assessment dated [DATE], documented that the resident's BIMS score was not completed because the resident was rarely understood. The resident had a documented medical diagnosis history of dementia (loss of memory) and psychosis (mental disorder that affects contact with reality). Review of the record revealed an order for Resident #38 dated 02/05/25, to administer Lorazepam 1 mg by mouth scheduled twice a day. There was a second order dated 02/19/25 for Lorazepam 0.5 milligrams (mg) every 4 hours as needed for agitation with no date to discontinue or documented rationale by the doctor to extend the medication. Review of the March and May Medication Administration Record (MAR) for Resident #38, revealed administration of the as needed (PRN) Lorazepam 0.5 mg by staff.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide services to ensure abilities in Activities of Daily Living (ADL) did not diminish for 1 of 3 sampled residents, Resident #27, reviewed for ambulation. The findings included: During an initial interview on 06/16/25 at 2:56 PM, Resident #27 reported that he was concerned about being discharged from Physical Therapy (PT) because he was walking with a hemi walker and since his discharge from PT he has not walked at all and only uses a wheelchair for mobility in the facility. There was a hemi walker located in Resident #27's room during the initial interview. Review of the record revealed that Resident #27 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #27 had a Brief Interview for Mental Status (BIMS) score of 15 on a 0-15 scale, indicating the resident was cognitively intact. Further review of the MDS dated [DATE], section GG for Functional Abilities, revealed that in subsection I5, Walking 10 feet was coded as Not Applicable/Not Attempted. Review of the Physical Therapy Discharge summary dated [DATE], revealed that Resident #27's status was that he ambulated on level surfaces for 50 feet using a hemi walker with supervision/standby/touching assistance to increase independence in facility. The discharge destination was listed as long-term care setting and the discharge reason was listed as maximum potential achieved, referred to the Restorative Nursing Program (RNP)/Functional Maintenance Program (FMP). Review of a care plan meeting dated 05/06/25 revealed that Resident #27's resident representative who attended the meeting with Resident #27, requested that Resident #27 get picked up for Physical Therapy again. During an interview on 06/18/25 at 10:48 AM, the Director of Rehabilitation (DOR) confirmed that Resident #27 was discharged from PT on 04/10/25 and was referred to the RNP. During an interview on 06/18/25 at 4:44 PM, the Assistant Director of Nursing (ADON) was asked about the RNP and the ADON replied we do not have the RNP in place yet. The ADON stated that nursing staff can assist a resident who has been discharged from PT and wanted to continue to work on walking. During an interview on 06/19/25 at 7:49 AM, when asked if Resident #27 can walk with assistance during ADL care, Staff C, Certified Nursing Assistant (CNA) reported that Resident #27 needs stand by assistance for most transfers and that he used to walk with Physical Therapy (PT), but she does not walk with him and she does not think he gets PT anymore. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/19/25 at 10:25 AM, the Director of Rehabilitation (DOR) was asked what the Walk to Dine program was and the DOR reported that residents that are on therapy and can walk are assisted by nursing staff to walk to and from their rooms to the dining room for meals. When asked if residents that are discharged from PT stay on the Walk to Dine program she replied, Yes. The DOR was then asked if Resident #27 was participating in the Walk to Dine program to which she replied, No, because the distance he walked was limited and he would not make it all the way to the dining room. When asked if Resident #27 could walk within his room if he had assistance, she replied, I guess he could. The DOR added that if a resident has a decline in function, they can evaluate the resident for more Physical Therapy. When the DOR was asked how would you know if there was a decline in Resident #27's ambulation if nobody has walked him since his discharge from PT on 04/27/25 to which the DOR replied, that is true, we would not know if he had a decline in ambulation.

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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** 3) Review of the record revealed Resident #72 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE] documented the resident had a BIMS score of 9, on a 0 to 15 scale, indicating mild cognitive impairment. This MDS also indicated the resident had an infection of the foot. Review of the current physician orders documented as of 06/06/25 wound care to the right foot, to include the application of betadine (an antiseptic used for skin infections), was to be completed daily and as needed for soiling, saturation, or dislodgement. The routine order for the wound care was scheduled during the evening (7 PM to 7 AM) shift. The current care plan initiated on 04/08/25 and revised on 05/23/25 documented the treatment time for the wound care had been changed to the evening shift as per the family's request to promote comfort. During an interview on 06/16/25 at 3:39 PM, when asked how he was doing, Resident #72 responded he had concerns about his feet. When asked what was going on, Resident #72 removed his sock from his right foot and his three middle toes were black and necrotic. There was a strong odor coming from the foot. When asked about a dressing, Resident #72 explained that he had taken a shower that morning so there was no dressing, but that staff must do the dressing at night because when he wakes up in the morning, it's all bandaged up. When asked what time he had his shower that morning, Resident #72 stated about 11 AM. An observation on 06/19/25 at 10:46 AM revealed Resident #72 in his room sitting in his wheelchair. Resident #72 was wearing white socks. A large area of saturation, extending from the end of his toes for 2 to 3 inches toward his ankle was noted. During an interview on 06/19/25 at 11:07 AM, Staff H, Registered Nurse (RN), confirmed she was the direct care nurse for Resident #72 on Monday and again today. When asked if she had changed the resident's dressing to his right foot at all that week, the RN stated she had not and further stated it was due on the night shift. When asked if anyone had told her the dressing had come off during the resident's shower on Monday 06/16/25 at about 11 AM, the RN stated she was unaware. When asked if she was aware of the condition of the resident's right foot dressing at this time the RN stated she had not noticed any issues. Upon observation of the resident's right foot, the RN agreed the dressing needed to be changed. 4) Review of the record revealed Resident #69 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE] documented the resident had a terminal diagnosis and was receiving hospice services. Review of the current physician orders revealed a hospice consult was requested by the resident's spouse and ordered by the physician on 04/03/25. Further review of the physician orders lacked any current order for hospice services. Review of the hospice paperwork revealed Resident #69 was admitted to the hospice provider on 04/08/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a side-by-side review of the record and interview on 06/19/25 at 10:01 AM, the Assistant Director of Nursing (ADON) agreed with the finding as she was unable to locate a current order for hospice services for Resident #69. Based on observation, record review, and interviews, the facility failed to ensure care and services for 4 of 31 sampled residents as evidenced by the failure to address the urinalysis and culture result in a timely manner for Resident #25, failure to ensure the geri-sleeves for Resident #38 were in place, failure to ensure a dressing change to wounds after a shower for Resident #72, and failure to ensure there was a Hospice order for Resident #69. The findings included: 1) Record review revealed that Resident #25 was admitted to the facility on [DATE]. The initial comprehensive assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12, on a 0-15 scale, indicating no cognitive impairment. Record review revealed a urinalysis with a culture and sensitivity (U/A C&S) was ordered on 06/03/25 to determine if Resident #25 had a Urinary Tract Infection (UTI). The U/A C&S lab results dated 06/05/25 revealed that the resident was positive for a UTI and needed antibiotic treatment. Review of a progress note dated 06/06/25 at 6:16 AM, documented by Staff E, Licensed Practical Nurse (LPN) revealed that she faxed the U/A C&S lab results to the physician. Review of a second progress note dated 06/09/25 at 11:50 PM documented by Staff E, LPN, revealed that the physician went into the facility to visit Resident #25 and at that time she was given an order for the resident to start taking Bactrim DS (antibiotic) 1 tablet twice a day for seven days for treatment of the UTI. This order was given 4 days after the results were faxed to the physician. Review of the Medication Administration Record (MAR) for the month of June, revealed that Resident #25 was administered the first dose of antibiotic for treatment of the UTI on 06/10/25. During an interview on 06/18/25 at 12:22 PM, when asked what was the process for making sure that labs are communicated to the physician, the Director of Nursing (DON) stated, When we receive labs the results are called into the doctor. We have three doctors that see residents in the facility but only one of them receives faxes and will answer immediately. When asked what happened to the communication to the physician regarding the U/A C&S results for Resident #25, the DON looked into the computer and stated, The lab result should have been called into the doctor. When asked if the U/A C&S results were faxed, the DON stated, According to the note in the record, it looks like the nurse faxed the results to the physician, but she should have called him to follow up and make sure he got the fax. The DON confirmed Resident #25 didn't receive antibiotic treatment until 06/10/25, which caused a delay in treatment. 2) Record review revealed that Resident #38 was admitted to the facility on [DATE]. The quarterly comprehensive assessment dated [DATE], documented that the BIMS was not completed, because the resident was rarely understood and was rarely able to understand. The resident had a medical diagnosis history of dementia (loss of memory), and psychosis (mental disorder that affects contact with reality). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a care plan revised on 04/29/25, revealed that Resident #38 was at high risk for skin tears and impaired skin integrity related to advanced age, fragile skin, and cognitive decline. He had a documented history of skin tears on his right posterior leg as of 12/25/24, a skin tear to his right arm as of 12/28/24, a skin tear to his left pinky on 01/07/25, and a skin tear to his right lower extremity on 05/22/25, which was healed on 06/09/25. Review of a physician order dated 03/21/24 for Resident #38, instructed staff to apply geri sleeves to his bilateral lower extremities every shift and to remove them for hygiene and skin care. A second order dated 11/01/24, instructed staff to apply geri sleeves to his bilateral arms every shift and to remove them for hygiene, skin observation. Review of the Medication Administration Record for June on 06/18/25 at 1:35 PM, revealed that Staff D, LPN had signed acknowledging that the geri sleeves were applied to Resident #38 on that same date of 06/18/25. During an interview on 06/18/25 at 1:40 PM, Resident #38 was noted sitting in the TV room on the America Unit, in a high back reclining wheelchair. The resident did not have on geri sleeves to his bilateral lower extremity or bilateral arms as ordered. Staff D, Licensed Practical Nurse, was noted sitting at the nurse's station. When asked if Resident #38 had an order for geri sleeves, the LPN stated, Let me look at his orders. Staff D looked in the record and stated, He should have geri sleeves on his arms. Staff D was then asked if the resident had an order to apply the geri sleeves to the arms only. She then looked again and stated, Oh, he should have them on the legs as well. Staff D went over to check Resident #38's legs and arms to see if the geri sleeves were in place and saw that they weren't. She went over to the treatment cart to get two new pairs. Staff F, Certified Nursing Assistant (CNA) was asked if she applied the geri sleeves on Resident #38, and she stated, He refused to put them on. At that time, Staff D, stated, Why didn't you tell me he refused so I could document that? Staff F stated, I apologize. When Staff F was asked if the resident had the geri sleeves in his room she stated yes, I will show you. She went to the resident's room, and she looked in the drawer and pulled out one pair of white and green geri sleeves. When asked where the other pair was, Staff F asked, Is he supposed to have two pairs? At that time Staff F was told that the resident had an order for geri sleeves to be placed on both the legs and arms. She stated, Ok I will get another pair out of the closet. Staff F was then provided the two pairs of geri sleeves that the nurse had taken from the treatment cart. Staff F, CNA went to get the resident from the TV room and explained to the resident that she was taking him to his room to put on the geri sleeves. She stated, He might try to fight me, he gets aggressive at times. Resident #38 was receptive to having the geri sleeves applied. He stated I don't mind having them on.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, record review, and interviews, the facility failed to ensure respiratory care and services for 1 of 1 sampled resident, Resident #312, as evidenced by the failure to monitor and document a respiratory assessment after administration of a nebulizer (breathing) treatment, and failure to obtain a physician order for administration of oxygen for Resident #312. The findings included: Review of a policy titled, Nebulizer Administration of Medications revised on 08/01/2023, documented in part . Post Treatment Evaluation and Documentation: Document the treatment in the EMR (electronic medical record). Details may include the following: Vital signs, including oxygen saturation pre and post treatment, tolerance to treatment and pertinent information. Record review revealed Resident #312 was admitted to the facility on [DATE]. The initial comprehensive assessment was still in progress, so there was no documentation of a Brief Interview Mental Status Score. The resident had a documented medical history of influenza (flu) and Parkinsons disease (disorder of the central nervous system). During an observation on 06/18/25 at 10:28 AM, Resident #312 was noted sitting in the wheelchair in his room receiving a nebulizer treatment. A portable oxygen tank was noted on the back of the wheelchair. Staff G, Certified Nursing Assistant (CNA), was sitting in the resident's room in a chair. When asked if she was providing one on one care for Resident #312, she stated, No, I'm just sitting with him. When she was asked how Resident #312 was doing today, she stated, He is very weak. When I assisted him to the bathroom it was very difficult. During an observation on 06/18/25 at 10:53 AM, Resident #312 was sitting in the common area on the [NAME] Unit, in the wheelchair, at a table wearing oxygen at 2 liters via nasal cannula. The oxygen tubing was dated 6/15/25. Staff G, CNA was sitting at the table with the resident. When asked who applied the oxygen on the resident, she stated, The nurse put the oxygen on him this morning when I told her Resident #312's oxygen level was 90%, but I guess therapy put him on the portable oxygen tank when they took him to therapy. Record review lacked any documented order for Resident #312 to receive oxygen therapy. Review of the orders for Resident #312, revealed an order instructing staff to administer ipratropium-albuterol solution (medication to treat wheezing, shortness of breath) nebulizer treatment at 8:00 AM and 8:00 PM and instructed staff to document pre and post treatment respiratory assessment and vital signs. Review of the Medication Administration Record (MAR) for the month of June revealed that Staff E, Licensed Practical Nurse (LPN) documented a late entry note that she administered nebulizer treatment at 10:09 AM and the documented reason stated that the medication was given on time. Staff E failed to document the post treatment respiratory assessment and vital signs for Resident #312 on the MAR.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and pharmacy recommendation review, the facility failed to ensure documented physician participation in the monthly pharmacy reviews for each resident, for 3 of 6 months reviewed (February, March, and April 2025). The pharmacist also failed to identify as needed Ativan use without a documented duration of use for 3 of 3 sampled residents reviewed, Residents #69, #30, and #38, who had Ativan orders. The findings included: 1) Review of the monthly pharmacy reviews provided by the Director of Nursing (DON) revealed a grid with five columns. The first column documented the residents' name; the second column the room number, the third column had a X if there were No Irregularities or otherwise was blank; the fourth column documented the recommendation, if any; and the fifth column was titled Approve/Deny. Review of the recommendations for February 2025 documented the physician's initials in column five, but lacked any evidence to determine if the physician had approved or denied the recommendation. Review of the recommendations for March 2025 lacked a fifth column, thus lacked any evidence the recommendations had been reviewed, approved, or denied by the physician. Review of the recommendations for April 2025 documented the word Approved in the fifth column with no indication as to who approved the item. During a phone interview on 06/19/25 at 9:07 AM, when asked about his pharmacy reviews, the Consultant pharmacist stated he does the reviews for every resident monthly. When asked about the form with the five columns, the Consultant pharmacist stated he developed that form because, It became too much paper work as the facility filled up (with residents). The Consultant pharmacist volunteered, What satisfies (name of the state regulatory authority) is proof that I did the reviews. When asked about the missing column for the March 2025 reviews, the pharmacist had no explanation. When asked if there was any other way to show the physician's participation in the monthly reviews with evidence of the physician's acceptance or rejection to each recommendation, the Consultant pharmacist stated we review the recommendations each month and the physician signs the last sheet. 2) Review of the record revealed Resident #69 was admitted to the facility on [DATE] and later admitted to hospice services on 04/08/25. Review of the current physician orders confirmed Resident #69 was admitted to the hospice services on 04/08/25. Another order dated 04/08/25 documented the use of Ativan, a psychotropic medication, every 4 hours as needed for anxiety. Further review of this order revealed it was an open ended order and lacked any stop date or duration of use. Review of the pharmacy recommendations from December 2024 through May 2025 lacked any recommendation regarding the as needed Ativan order. (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 - Few	Review of the monthly letters by the Consultant pharmacist to the facility titled, Additional Comments, Suggestions or Follow-Up (not dated) documented, in part, Suggestions: . adhere to PRN (as needed) psychotropic stop dates of maximum 30 days when entering in matrixcare (electronic medical record) . During a phone interview on 06/19/25 at 9:07 AM, when asked why this as needed Ativan order from April 2025 to present had not been identified by him as a concern, the Consultant pharmacist had no answer. 3) Record review revealed that Resident #30 was admitted to the facility on [DATE]. The quarterly comprehensive assessment dated [DATE], documented that the resident had a Brief Interview for Mental Status Score of 09 on a 0 to15 scale, indicating moderate cognitive impairment. The resident had a documented medical diagnosis history of dementia (loss of memory) with behavior disturbance, major depressive disorder, and psychosis. Review of the orders for Resident #30 revealed an order dated 08/05/24, instructing staff to administer Lorazepam 1 milligrams (mg) every two hours as needed for anxiety dated 08/05/24 with no date to discontinue or documented rationale by the doctor to extend the medication. Review of the care plan for Resident #30 revealed that he is prescribed medication related to anxiety with a goal that he will not exhibit any complications related to medication use and one of the interventions was that the pharmacist will do medication review for medications prescribed to the resident. Review of the May and June Medication Administration Record (MAR) for Resident #30, revealed administration of Lorazepam 1mg at various times by staff. Review of the progress notes for Resident #30 did not reveal any documentation by the physician for a rationale to extend the order for Lorazepam. Review of the pharmacy medication review documentation for January through May 2025 revealed that the pharmacist did not have any recommendations for Resident #30. 4) Record review revealed that Resident #38 was admitted to the facility on [DATE]. The quarterly comprehensive assessment dated [DATE], documented the Brief Interview for Mental Status was not completed because the resident is rarely understood. The resident had a documented medical diagnosis history of dementia (loss of memory) and psychosis (mental disorder that affects contact with reality). Review of the record revealed an order for Resident #38 dated 2/05/25, to administer Lorazepam1mg by mouth scheduled twice a day. There was a second order dated 02/19/25 for Lorazepam 0.5 milligrams (mg) every 4 hours as needed for agitation with no date to discontinue or documented rationale by the doctor to extend the medication. Review of the March and May Medication Administration Record (MAR) for Resident #38, revealed administration of the PRN Lorazepam 0.5 by staff. Review of the progress notes for Resident #38 did not reveal any documentation by the physician for a rationale to extend the order for Lorazepam. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	686128	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ardie R Copas State Veterans Nursing Home	13000 SW Tradition Parkway Port Saint Lucie, FL 34987

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the pharmacy medication review documentation for March through May 2025 revealed that the pharmacist did not have any physician recommendations for Resident #38.