STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106059	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas Jacobson State Veterans Nursing Home	21281 Grayton Terrace Port Charlotte, FL 33954

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on interview and record review The facility failed to ensure staff notified the physician of a change in condition for one resident (Resident #114) of seven resident surveyed for falls when after a head injury the resident's systolic blood pressure dropped and the resident's mental status changed. Findings included: Resident #114 was an [AGE] year-old male who was admitted to the facility on palliative care with a history of Type 2 Diabetes, Dementia, Anxiety Disorder, Hypertension, Atrial Fibrillation, Makor Depressive Disorder, seizures, Anemia, with a Cardiac Pacemaker. According to the timeline provided by the facility, on 8/20/24 at 2:40 p.m. Resident #114 was redirected from an exit in the facility and while walking away from the exit had a witnessed fall with a head injury. Review of the Fall Occurrence (Form 110514) dated 8/20/24 revealed after the fall the Resident #114 complained of a headache. The resident was observed holding his head and a quarter size reddened spot was noted to the left posterior (rear) of the resident's head. Documentation of the neurological checks form showed at 2:45 p.m. on 8/16/24, Resident #114's blood pressure was 161/96. At 3:30 p.m. the resident's blood pressure was documented as 152/80. On 8/20/24 at 5:30 p.m. a significant drop in blood pressure is noted on the Neuro Checklist at 100/50. Pupil reaction and hand grasp are not documented on the form on 8/20/24 at 5:30 p.m. Licensed Practical Nurse, Staff H documented Asleep under pupil reaction time on the form. Staff H documented Resting in bed. On 8/20/24 at 6:09 p.m. Staff H documented shortly before 6:00 p.m. the resident was found with no vital signs. On 9/6/24 at 1:40 p.m., in an interview, the Medical Director said he was told by the nursing staff the resident was walking around after the incident and after dinner he had gone to lay down. The Medical Director said if the resident's mental status changed to where he was not arousable, he would have wanted the resident sent out to the emergency room . (continued on next page)

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

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F 0580 Level of Harm - Actual harm Residents Affected - Few	On 9/6/24 at 2:30 p.m. in a telephone interview, Staff H said Resident #114 was arousable when she obtained his vital signs on 8/20/24 at 5:30 p.m. When asked why she did not check his pupils of hand grasp she said the resident was sleeping and she did not want to wake him. When asked about the drop in Resident #114's blood pressure after his injury Staff H said she did not think a blood pressure of 100/50 was low pressure. Staff H said she never noticed the drop in blood pressure. Staff H verified she did not notify the physician of the residents change in blood pressure.

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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 - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50970 Based on observation, record review, review of facility policies and procedures, and staff interviews, the facility failed to provide the appropriate supervision and assistance to prevent avoidable fall related accidents for 1 (Resident #16) of 7 residents identified as being at risk for falls and sustained falls with injury while at the facility. The findings included: The facility policy 5240, Fall and Fall Risk Management effective 5/15/24 effective 5/15/2017, documented The facility will ensure that the residents environment remains as free from accident hazards as possible and each resident receive adequate supervision and assistive devices to prevent accidents .A fall is defined as an unintentional coming to rest on the ground, floor or other lower level that is not the result of external force . Based on resident assessment, the facility will identify interventions related to the resident's specific risk and behaviors and develop a plan of care to try to prevent the resident from falling and to minimize complications if a fall does occur . Facility staff will identify appropriate resident specific interventions to reduce the risk of falls .The clinical team will monitor and document each residents response to interventions intended to reduce falls or the risk of falls .If a resident continues to fall, the clinical team in consultation with the physician will re-evaluate the situation and determine whether it is appropriate to continue and or change current information. Review of the clinical record showed Resident #16 was admitted to the facility on [DATE]. Resident #16's diagnoses included Parkinson's disease with Dyskinesia (uncontrolled involuntary muscle movement), unspecified dementia, other abnormalities of gait and mobility, tremor, unspecified, Insomnia. The Admission Minimum Data Set (MDS) assessment (standardized tool that measures health status in nursing home residents) with an assessment reference date of 4/22/24 documented Resident #16 required the assistance of 1 person for supervision of transfers, ambulation and toileting. The MDS noted the Resident #16's cognitive status was moderately impaired. The care plan initiated on 4/15/22 identified Resident #16 as a fall risk, had falls, was at risk for falls due to poor safety awareness, forgetting to ask for assistance and had a history of falls with a hip fracture. Fall prevention interventions included to keep personal items within reach, keep call light within reach at all times, anti-roll backs on wheelchair. On 4/15/22 a fall risk assessment documented Resident #16 had a fall risk score of 17, indicating he was at risk for falls. A fall risk score of 10 or higher represents a high risk for falls. Additional fall risk assessments scored 18, and were completed on 3/14/24, and 6/10/24 which continued to indicate a high risk for falls. The facility fall record review revealed Resident #16 had 18 falls since 11/17/23. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Unwitnessed falls occurred on 11/27/23 at 5:49 a.m., 1/1/24 at 6:45 p.m., 1/27/24 at 10:30 a.m., 1/29/24 at 1:20 p.m., 2/2/24 at 9:19 p.m., 2/26/24 at 4:49 p.m., 3/12/24 at 12:28 a.m., 3/15/24 at 4:50 a.m., 7/16/24 at 8:45 a.m., 7/25/24 at 10:01 a.m., 8/4/24 at 7:30 a.m., 8/14/24 at 3:30 a.m., 8/23/24 at 8:23 a.m., 8/29/24 at 5:25 a.m. Witnessed falls occurred on 2/16/24 at 5:20 a.m., 5/9/24 at 11:15 p.m., 7/16/24 at 7:44 p.m., and 7/21/24 at 8:46 a.m. On 9/05/24 at 9:07 a.m., Resident #16 was observed alone in his room, standing at the sink and brushing his teeth. There was no Certified Nursing Assistant (CNA) assisting him to brush his teeth per the care plan intervention added 8/29/24. On 9/5/24 at 9:08 a.m., CNA Staff I said she was assigned to Resident #16. She said, he [Resident #16] was in the dining room, but I don't know where he went. He falls easy, we are supposed to monitor him, but he likes to move around. On 9/5/24 at 9:15 a.m., Resident #16 said he fell a couple of weeks ago but was not able to explain how it happened. On 9/05/24 at 9:35 a.m. during an interview, Staff I, CNA said the staff checked on him every 2 hours. Resident #16 goes around in his wheelchair to the library, and the porch. We have to go find him. On 9/5/24 at 10:47 a.m., Resident #16 was observed in his wheelchair near the front door, leading to the lobby. He was rolling towards 300 unit without supervision. On 9/5/24 at 11:00 a.m., Resident #16 was observed in his wheelchair on the outside patio, no staff were observed in sight of him. On 9/6/24 at 1:08 p.m., during an interview the Director of Nursing (DON) said she did not see any documentation of new interventions added to the care plan following each fall, except for 1/1/24 when nonskid footwear was added, and 8/29/24 when a protective bumper was added to the sink and for the caregiver to assist Resident #16 with brushing his teeth because he has a history of falling near the sink. The DON said the facility fall report noted Resident #16 sustained 7 skin tears following a fall on 2/26/24. The care plan was updated on 2/27/24 and specified new interventions to use handrails and hand grips. The DON said, he would not be able to remember to do that intervention. The DON said Resident #16 complained of left rib pain on 8/22/24 and was sent to the emergency room for evaluation but not until 8/23/24. Resident #16 returned from the hospital with a new diagnosis of left 7th rib fracture. The fall program encourages purposeful rounding which means frequent rounding. The DON said, short of putting someone 1:1 with him all the time I'm not sure what else we can do. The DON stated Resident #16 is not cognitive enough for new interventions. The only possible intervention would be one-on-one supervision, but we did not want to take away his independence.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30599 Based on interview and record review The facility failed to ensure nursing staff were competent in completing Neurological (Neuro) checks for one resident who had had a fall with a head injury (Resident #114) of seven resident surveyed for falls by not obtaining a complete neuro check and allowing the resident to sleep after noting a significant drop in blood pressure. The findings included: Resident #114 was an [AGE] year-old male who was admitted to the facility on palliative care with a history of Type 2 Diabetes, Dementia, Anxiety Disorder, Hypertension, Atrial Fibrillation, Makor Depressive Disorder, seizures, Anemia, with a Cardiac Pacemaker. According to the timeline provided by the facility, on 8/20/24 at 2:40 p.m. Resident #114 was redirected from an exit in the facility and while walking away from the exit had a witnessed fall with a head injury. Review of the Fall Occurrence (Form 110514) show after the fall the resident complained of a headache. The resident was observed holding his head and a quarter size reddened spot was noted to the left posterior of the resident's head. Documentation of the Neuro checks form showed at 2:45 p.m. Resident #114's blood pressure was 161/96. At 3:30 p.m. the resident's blood pressure was documented as 152/80. On 8/20/24 at 5:30 p.m. a significant drop in blood pressure is noted on the Neuro Checklist documented as 100/50. Pupil reaction and hand grasp are not documented on the form on 8/20/24 at 5:30 p.m. Licensed Practical Nurse, Staff H documented Asleep under pupil reaction time on the form. Staff H documented Resting in bed. On 8/20/24 at 6:09 p.m., Staff H documented shortly before 6:00 p.m. the resident was found with no vital signs. On 9/6/24 at 1:00 p.m., the Administrator said the facility did not a have policy for completing neuro checks. On 9/6/24 at 2:30 p.m., in a telephone interview, Staff H said Resident #114 was arousable when she obtained his vital signs on 8/20/24 at 5:30 p.m. When asked why she did not check his pupils or hand grasp, she stated the resident was sleeping and she did not want to wake him. When asked about the decrease in Resident #114's blood pressure after his injury, Staff H said she did not think a blood pressure of 100/50 was low blood pressure. Staff H said she never noticed the drop in blood pressure. On 9/06/24 at 3:27 p.m., the Director of Nursing verified the Neuro checks were not completed on 8/20/24 at 5:30 p.m. She said neuro checks should be completed for any resident with a head injury. The Director of Nursing verified a resident should be awakened so the neuro checks can be completed.