

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  106059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/29/2024
NAME OF PROVIDER OR SUPPLIER  Douglas Jacobson State Veterans Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</b></p> <p>Based on observation, record review, resident and staff interviews the facility failed to protect the residents' rights to be free from neglect by failing to follow the hot liquid safety procedures to ensure hot beverages were served at a safe temperature to prevent thermal burn for 1 (Resident #65) of 3 sampled residents.</p> <p>The findings included:</p> <p>The facility policy #1001 Abuse, Neglect and Exploitation/Misappropriation of resident Property, revised 3/01/2024 documented, Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Additionally, neglect may also be defined as failure to make reasonable effort to protect a resident from abuse, neglect or exploitation by others and or carelessness which causes or could reasonably cause a serious physical or psychological injury or a substantial risk of death to a resident.</p> <p>The facility policy #3124 Hot Liquid Safety, effective 7/15/2024 documented Food and drinks will be served at a temperature that is appetizing to residents, but also minimizes the risk for scalding and burns . Hot liquids will be monitored at the point of service prior to distribution from the kitchen or pantry and temperature will be recorded daily on the Daily Temperature Log. Residents will be assessed for their ability to handle containers and consume hot liquids . Residents determined to be unsafe will receive appropriate supervision or use of assistive devices to consume hot liquids. Interventions will be individualized and noted in the residents Care Plan.</p> <p>Safe serving precautions when serving hot liquids:</p> <ol style="list-style-type: none"> <li>a. Make sure residents are alert and in proper position to consume hot liquids.</li> <li>b. Use cups, mugs or other containers that are appropriate for hot beverages.</li> <li>c. Do not overfill containers.</li> <li>d. Filled containers will be placed directly on the table and not given directly to residents.</li> <li>e. Hot liquids will be placed away from the edges of the table.</li> </ol> <p>(continued on next page)</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
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>f. Refills on hot beverages will not be done while resident is holding the container.</p> <p>g. Residents will be provided with supervision as needed.</p> <p>Review of the facility's event reports revealed on 6/23/24 Resident #100 was sitting at the nurse's station and requested a cup of coffee. Nursing prepared the hot beverage and while drinking it Resident #100 spilled the coffee on himself.</p> <p>Resident #100 sustained redness to his abdomen and upper thigh area that required daily monitoring every shift for seven days.</p> <p>On 10/28/24 at 2:55 p.m., in an interview the Administrator said after the incident with Resident #100, they in-serviced the staff and showed them how to measure the temperature of hot liquids. The Nurse Managers or the Administrator check the temperature logs to make sure the temperatures were recorded.</p> <p>The facility provided sign-in sheets dated 6/24/24 and 6/25/24 showing 88 employees received an in-service with instructions to obtain the temperature of hot liquids prior to serving. The temperature was to be 165 degrees F before serving. Use a thermometer and report if the thermometer is not working.</p> <p>The facility provided Coffee and Hot Water Temperature Checks forms which noted, Please do not serve if over 165 degrees-Temps must be taken on every new pot of coffee and every cup of hot chocolate, tea or hot water beverage. Staff were to record the date, time and the temperature of the coffee pot, hot chocolate/tea and sign the form.</p> <p>The Administrator said the facility did not complete audits or competencies on 6/24/24 or 6/25/24 to ensure the staff understood the in-service directions.</p> <p>2. Review of the clinical record revealed Resident #65 was a [AGE] year-old male with an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, osteoarthritis, disorientation, and hearing loss.</p> <p>Review of the Quarterly Minimum Data Set (MDS) with a target date of 10/11/24 documented Resident #65 required set up/clean up at meals. The MDS noted the resident's cognitive skills for daily decision making were severely impaired with a Brief Interview for Mental Status score of 07.</p> <p>On 10/17/24 at 7:32 a.m., the facility documented in an event report Resident #65, was drinking hot chocolate that spilled into his lap and caused redness to the left inner thigh. At this time, we are monitoring the area and DPOA (Durable Power of Attorney) and MD (physician) were notified. Wound care will also follow up.</p> <p>On 10/17/24 at 11:51 a.m., the wound care Advanced Practice Registered Nurse (APRN) documented Resident #65 sustained an in house acquired partial thickness thermal burn to the left medial lower leg measuring 10 centimeters (cm) in length by 5.0 cm in width and 0 cm in depth.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The APRN documented, S/P (status post) hot chocolate spill this morning, presents with intact skin, dark pink and not well-defined area of injury, there is some mild raised texture change to center suggestive of possible forming blister. He does not complain of pain. Area is partial thickness first degree burn, possibly will evolve to second degree.</p> <p>Review of the nursing progress note dated 10/18/24 at 10:02 a.m., revealed the blister to left inner thigh had popped. The wound care APRN issued an order to cleanse the left inner thigh with normal saline, apply a thin layer of topical Silvadene 1% (antibiotic) and cover with silicone foam dressing daily.</p> <p>On 10/24/24 at 1:24 p.m., the wound care APRN documented in a progress note the thermal burn to the resident's left medial lower leg measured 4.0 cm in length by 1.8 cm in width and 0.1 cm in depth. The wound had 30% of slough (dead tissue).</p> <p>On 10/28/24 at 9:20 a.m., in an interview Resident #65 was asked if he remembered the incident with the spilled hot chocolate and he replied, Oh yes, you mean when I got burned on the leg here (pointing to left upper thigh). The hot chocolate was on the table here (pointed to the bedside table in his room). I went to grab it and it tipped over onto my lap and wet my pants. It hurt as it burned quite a bit. They are putting cream on it.</p> <p>Resident #65 said he was right handed and uses a regular handled cup when he is drinking coffee or hot chocolate. The Resident said, I did not ask for anyone to reheat the hot chocolate for me, I like it cool, you know kind of cool so I can drink it and it was very hot Resident #65 repeated three times that he did not request the hot chocolate to be reheated and he did not have a cup in his lap. Resident #65 said it was sitting here on this table, it tipped over and spilled on me.</p> <p>On 10/28/24 at 12:10 p.m., observation of Resident #65's wound with LPN Staff E revealed an opened wound approximately the size of a quarter in diameter with yellow wound bed.</p> <p>On 10/28/24 at 3:10 p.m., in a telephone interview the Wound Care APRN said on 10/17/24 she was asked to assess Resident #65 for a hot liquid spill. The area was not well defined but the center looked like it might blister. It was red but not open, it was a 1st degree burn (skin red, not opened) initially and once it opened, it is a partial thickness, 2nd degree burn (affects the both the outer layer of skin and the layer beneath).</p> <p>Review of the facility's investigation revealed Licensed Practical Nurse (LPN) Staff G documented in a handwritten statement dated 10/18/24, This nurse made hot chocolate for resident. I let it sit to cool. Up on returning temperature was checked at 178 degrees. Drink was given to resident, resident said it was too cold. I re-heated the hot chocolate. Temperature was not checked a second time. I added a couple pieces of ice to the hot chocolate and gave it to the resident.</p> <p>Licensed Practical Nurse (LPN) staff G signed the in-service form on 6/25/24 specifying to obtain the temperature of hot liquids prior to serving.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The conclusion to the facility's investigation read, After a complete and thorough investigation, it has been determined that the allegation of neglect is verified. LPN (Staff G) did not re-temp the hot chocolate after reheating and before giving it to Resident #65. Resident #65 placed the cup of hot chocolate on his lap and proceeded to propel himself to his room when the hot chocolate spilled onto his left inner thigh resulting in a partial thickness thermal burn.</p> <p>On 10/28/24 at 2:45 p.m., and 10/29/24 at 11:17 a.m., attempts were made to conduct a telephone interview with LPN Staff G. LPN Staff G did not answer the phone. Each time a message was left with contact phone number to return the call. LPN Staff G did not return the call.</p> <p>On 10/28/24 at 4:25 p.m., in an interview the Risk Manager said no audits were conducted to ensure staff understood and followed the process when serving hot liquids to residents.</p> <p>On 10/28/24 at 5:00 p.m., in an interview the Director of Nursing and the Risk Manager confirmed LPN Staff G did not follow the facility policy for temping the hot liquids resulting in Resident #65 sustaining a second degree burn to the left inner thigh.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</b></p> <p>Based on observation, record review, review of facility's policy and procedure, the facility failed to serve hot beverages at a safe temperature to prevent avoidable thermal burn for 1 (Resident #65) of 3 residents reviewed for accidents.</p> <p>On 10/17/24 staff reheated a cup of hot chocolate and gave it to Resident #65 without ensuring the beverage was at a safe temperature. Resident #65 spilled the hot chocolate on his lap and sustained an avoidable second degree burn (affects the both the outer layer of skin and the layer beneath) to the left anterior thigh.</p> <p>The findings included:</p> <p>The facility policy #3124 Hot Liquid Safety, effective 7/15/24 documented Food and drinks will be served at a temperature that is appetizing to residents, but also minimizes the risk for scalding and burns . Hot liquids will be monitored at the point of service prior to distribution from the kitchen or pantry and temperature will be recorded daily on the Daily Temperature Log. Residents will be assessed for their ability to handle containers and consume hot liquids . Residents determined to be unsafe will receive appropriate supervision or use of assistive devices to consume hot liquids. Interventions will be individualized and noted in the residents Care Plan.</p> <p>Safe serving precautions when serving hot liquids:</p> <ol style="list-style-type: none"> <li>a. Make sure residents are alert and in proper position to consume hot liquids.</li> <li>b. Do not use cups, mugs or other containers that are appropriate for hot beverages.</li> <li>c. Do not overfill containers.</li> <li>d. Filled containers will be placed directly on the table and not given directly to residents.</li> <li>e. Hot liquids will be placed away from the edges of the table.</li> <li>f. Refills on hot beverages will not be done while resident is holding the container.</li> <li>g. Residents will be provided with supervision as needed.</li> </ol> <p>Review of the clinical record revealed Resident #65 was a [AGE] year-old male with an admitted [DATE]. Diagnoses included Alzheimer's disease, dementia, osteoarthritis, disorientation, and hearing loss.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 10/11/24 documented Resident #65 required set up/clean up at meals. The MDS noted the residents cognitive skills for daily decision making were severely impaired with a Brief Interview for Mental Status score of 07.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the nursing progress notes revealed documentation on 10/17/24 at 8:07 a.m., Resident was drinking hot chocolate that spilled into his lap and caused redness to the left inner thigh. At this time, we are monitoring the area and DPOA (Durable Power of Attorney) and MD (Physician) were notified. Wound care will also follow up.</p> <p>Review of the Wound Care Advanced registered Nurse Practitioner (ARNP) note dated 10/17/24 at 11:51 a. m., revealed Resident #65 was status post hot chocolate spill this morning. The skin to the left medial lower leg was intact, dark pink and not well-define area of injury. There was some mild raised texture change to the center suggestive of possible forming blister. Resident #65 did not complain of pain. The APRN documented the area was an in-house acquired partial thickness first degree burn (skin red, not opened), possibly will evolve to a second degree. The area measured 10 centimeters (cm) in length by 5.0 cm in width by 0 cm in depth.</p> <p>The Wound care APRN ordered to apply a thin layer of Silvadene cream 1% (antibiotic used to treat and prevent wound infections in people with burns) apply a thin layer to the left medial thigh every shift and leave open to air.</p> <p>On 10/18/24 at 10:02 a.m., a nursing progress note documented the blister to the left inner thigh had popped. A new order was obtained to cleanse the left inner thigh wound with normal saline, apply a thin layer of topical Silvadene 1% cream and cover with silicone foam dressing daily.</p> <p>On 10/24/24 at 1:24 p.m., the wound care APRN documented in a progress note the in house acquired thermal burn to the left medial lower leg measured 4.0 cm in length, by 1.8 cm in width, by 0.1 cm in depth. The wound had 30% slough (layer of dead tissue).</p> <p>The wound care APRN noted the area was evolving as expected, now with opening and more defined/decreased size. No associated cellulitis (skin infection). Resident #65 did not complain of pain.</p> <p>On 10/28/24 at 9:20 a.m., in an interview Resident #65 was asked if he remember the incident of the spilled hot chocolate and he replied, Oh yes, you mean when I got burned on the leg here (pointing to left upper thigh). The hot chocolate was on the table here (he pointed to the bedside table in his room). I went to grab it and it tipped over onto my lap and wet my pants. It hurt as it burned quite a bit. They are putting cream on it.</p> <p>Resident #65 said he was right handed and used a regular handled cup when to drink coffee or hot chocolate. Resident #65 said, I did not ask for anyone to reheat the hot chocolate for me, I like it cool, you know kind of cool so I can drink it and it was very hot. Resident #65 repeated three times that he did not request the hot chocolate to be reheated and he did not have a cup in his lap. Resident #65 said the cup was sitting on the bedside table, it tipped over and spilled on me.</p> <p>On 10/28/24 at 12:10 p.m., with Resident #65's permission, the thermal burn to the left inner thigh was observed with Licensed Practical Nurse (LPN) Staff E. The wound was approximately the size of a quarter in diameter with a yellow wound bed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/28/24 at 3:10 p.m., in a telephone interview the Wound Care APRN said on 10/17/24 she was asked to assess Resident #65 for a hot liquid spill. She said the area was not well defined but the center looked like it might blister. It was red but not open, it was a first degree burn. It did develop into a blister and opened. Once it opened, it was a partial thickness second degree burn. She said she's seen the resident twice and the wound was slowly healing.</p> <p>Review of the facility's incident investigation showed on 10/17/24 LPN Staff G made hot chocolate for Resident #65. Staff G temped the hot chocolate and it was 178 degrees. LPN Staff G let the hot chocolate rest for a few minutes so that it was below 165 degrees. She gave the hot chocolate to Resident #65 who said it was too cold. Staff G reheated the hot chocolate in the microwave (length of time unknown), placed a few ice chips into the cup and gave it to the resident. Resident #65 accidentally spilled the hot chocolate on his left thigh while sitting in the wheelchair. The resident sustained a reddened area to his left inner thigh measuring length 2.0 cm by 2.0 cm.</p> <p>On 10/18/24 LPN Staff G documented in a handwritten statement, This nurse made hot chocolate for resident. I let it sit to cool. Up on returning temperature was checked at 178 degrees. Drink was given to resident, resident said it was too cold. I re-heated the hot chocolate. Temperature was not checked a second time. I added a couple pieces of ice to the hot chocolate and gave it to the resident.</p> <p>On 10/28/24 at 2:55 p.m., in an interview the Administrator said on 6/24/24 and 6/25/24 staff were in-serviced with instructions to obtain the temperature of hot liquids prior to serving. She provided in-service signing sheets showing 88 employees received the education with instructions to obtain the temperature of hot liquids prior to serving. The temperature was to be 165 degrees before serving. Staff was to use a thermometer and report if the thermometer was not working.</p> <p>LPN Staff G signed she attended the in-service on 6/25/24.</p> <p>On 10/28/24 at 2:45 p.m., and 10/29/24 at 11:17 a.m., telephone call were placed to interview LPN Staff G. Staff G did not answer the phone. Messages with contact phone number were left but Staff G did not return the calls.</p> <p>On 10/28/24 at 5:00 p.m., in an interview the Director of Nursing and the Risk Manager confirmed LPN Staff G did not follow the facility policy and did not ensure the hot chocolate was at a safe temperature before serving it to Resident #65 to prevent avoidable thermal burn or scalding.</p>		