

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  02/11/2025
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**</b> 30599</p> <p>Based on interview and record review the facility failed to protect the resident's right to be free from physical abuse for 1 (Resident #1) of 3 residents reviewed for abuse.</p> <p>The findings included:</p> <p>Review of the facility's policy on Abuse, Neglect and Exploitation/Misappropriation of Resident Property last revised 3/1/24 revealed abuse is defined as, any willful act or failure to act which causes or is likely to cause significant injury to a resident's physical, mental or emotional health. Abuse can also include threats, intimidation, unreasonable confinement or punishment.</p> <p>Review of the clinical record revealed Resident #1 was an [AGE] year-old male, admitted to the facility on [DATE]. Diagnoses included Parkinson's disease without dyskinesia (involuntary, erratic movements), Dementia, Bipolar Disease (significant shifts in mood energy and behavior), Major Depressive Disorder, and Obsessive Compulsive Disorder.</p> <p>Review of the Significant Change Minimum Data Set (MDS) assessment with a target date of 12/10/24 revealed Resident #1's cognition was intact with a Brief Interview for Mental Status score of 15</p> <p>Review of the facility's incident investigations revealed:</p> <p>On 12/21/24 at approximately 4:45 p.m., Resident #1's family members spoke with the Risk Manager regarding concerns they had about the resident's care at the facility.</p> <p>Resident #1 reported to family members that on 12/21/24 at approximately 3:00 a.m., two staff members, one male and one female forcibly removed him from his bed, prying his fingers off the handrail causing bruising to both arms and hands. They reported that the two staff members placed the resident in the dayroom from 3:00 a.m., until 5:00 a.m. They were concerned because Resident #1 had bruises to both his hands and wrists. They wanted to make sure Licensed Practical Nurse (LPN) Staff A was not providing care to Resident #1.</p> <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>Review of the witness statements revealed on 12/21/24 LPN Staff A wrote around 3:00 a.m., to 4:00 a.m., Resident #1 was smearing stool on pillowcases, sheets and blankets. CNA Staff B and him offered to clean him. Resident #1 started swinging his reaching tool at them, gripping and holding their hands tightly while rolling him over to give personal care. Resident #1 started to calm down and started crawling out of bed several times. They decided to get the resident up to prevent him from falling out of bed and placed him in the common area.</p> <p>The investigation noted that on 12/23/24 at approximately 10:00 a.m., the Risk Manager observed scattered purple bruising to Resident #1's hands and wrists. When asked what happened to his hands and wrists, the resident stated they were grabbed by staff. The resident said no when the Risk Manager asked if he felt the staff intentionally tried to hurt him, but they were rough. The Risk Manager asked Resident #1 if he was combative with staff when they were trying to clean him, he said yes. Resident #1 displayed signs and symptoms of mental anguish due to the event, and psychological support is being provided.</p> <p>On 12/23/24 at approximately 11:00 a.m., the Risk Manager spoke to LPN Staff A about Resident #1's care on 12/20/24. LPN Staff A said Certified Nursing Assistant (CNA) Staff B was having a difficult time with the resident's behavior and asked him to help. When CNA Staff B went in the room around 3:30 a.m., Resident #1 had an incontinent episode and was smearing feces on the bed and the mattress. When they attempted to clean the resident, he was very combative, grabbing their arms, and also pushing them away. LPN Staff A said they tried to hold Resident #1's by his hands and wrists so he wouldn't fall out of bed, he was flailing his arms everywhere and at one point grabbed his aluminum reacher and was swinging it at them. After they cleaned him up, Resident #1 kept trying to get out of bed so they placed him in the wheelchair and placed him in the dayroom for observation and monitoring.</p> <p>On 12/24/24 at approximately 10:30 a.m., the Risk Manage spoke with CNA Staff B about Resident #1's care on 12/20/24. CNA Staff B said when she went in the resident's room at approximately 3:30 a.m., the resident had a bowel movement and was playing with the feces. She asked LPN Staff A to help her clean the resident. CNA Staff B said throughout the care, the resident was very combative, swinging his arms at them and grabbing their arms. He used his reacher like a baseball bat to swing at them while they were trying to clean him. She said LPN Staff A and her had to hold Resident #1 by his hands when they were providing care so he wouldn't hit them or fall out of bed. They both decided to place Resident #1 in a wheelchair and took him to the dayroom where they could keep an eye on him.</p> <p>The Risk Manager documented in the incident investigation Resident #1 had significant cognitive impairment due to Parkinson's and dementia, which includes memory loss, paranoia and confabulation.</p> <p>She documented, After a complete and thorough investigation, it has been determined that the allegation of abuse is not verified. During the alleged incident, Resident #1 was smearing feces on his bed and pillowcase when staff entered the room, which was a new behavior for him. Resident #1 was very combative and resistant to care while they were trying to clean him. The resident grabbed both staff members' arms repeatedly as well as pushing them away. Resident #1 used his reaching device as a weapon trying to hit both staff. In order to keep the resident safe, both staff did hold his hands and wrists during care to avoid being hit and to prevent him from falling out of bed due to his combative behaviors.</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>On 2/10/24 at 12:20 p.m., in an interview the Risk Manager verified Resident #1's family members told her the bruising to the resident's hands were from prying his fingers from the handrail when LPN Staff A and CNA Staff B forcibly removed him from the bed. She said she did not document in her investigation as it was hard to understand the resident's answer to her question. She verified she did not ask LPN Staff A or CNA Staff B about prying the resident's fingers from the handrail and forcibly removing him out of bed. She said staff should not have removed the resident from the bed against his will. When asked about the resident's mental anguish documented in her investigation, the Risk Manager said the resident was frustrated when talking about the incident and had a contorted face.</p> <p>On 2/10/25 at 1:00 p.m., Resident #1 was observed in the hallway in his wheelchair with a staff member. In an interview, Resident #1 was asked if staff had forcibly removed his hands from the bedrails during the night of 12/20/24 causing bruising to his hands. Resident #1 replied, yes.</p>		