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	06/25/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, records review and interviews, the facility failed to protect the resident's right to be free from neglect by failing to ensure 1 (Resident #2) of 3 residents reviewed received incontinent care to meet their needs. The findings included: Review of the Facility's Abuse, Neglect and Exploitation/Misappropriation of Resident Property policy (last revised 3/1/2024) revealed, Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. The policy noted under prevention to, identify, correct and intervene in situation in which abuse, neglect and/or exploitation/misappropriation of resident property is more likely to occur. The facility policy noted to, identify the staff member(s), the length of time involved, and any outcome of the victim. Be specific. Review of the clinical record revealed Resident #2 was admitted on [DATE]. Diagnoses included Dementia, Parkinson's Disease and overactive bladder. Review of the Brief Interview for Mental Status dated 4/2/25 revealed Resident #2 scored 14, indicative of intact cognition. Review of the Discharge Minimum Data Set (MDS) assessment with a target date of 5/7/25 revealed Resident #2 was frequently incontinent of bladder. The MDS noted the resident required partial/moderate assistance for sit to stand and supervision or touching assistance for toileting hygiene. Review of the care plan Resident #2's Care Plan noted Problem: (Resident #2) may experience urinary incontinence R/T (related to) overactive bladder and dementia. (Resident #2) is incontinent of bowel. The approaches included 2 urinals at bedside for large nighttime urine output. Review of the facility's grievance investigations revealed on 4/2/25 the facility initiated a neglect investigation when Resident #2 complained about calling all night for help and no one came. Review of facility investigation revealed: (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/2025 Certified Nursing Assistant (CNA) Staff L said she entered Resident #2's room around 6:45 a. m. and his urinal was full. He stated that he was calling for help all night, and no one came. Once getting him out of bed I saw that his pull up and his bed was [sic] wet. I asked the CNA (Certified Nursing Assistant) if he's been in there, and he told me that him and the other CNA changed him (Resident #2) at 1:00 a.m. On 4/2/25 CNA Staff K stated she entered the resident's room to provide personal care at 6:55 a.m. Resident #2 said he was not going to get out of bed until the nurse came, because he spent all night calling, and no one came to help him. His urinal was full. She emptied it and found that his pull up was wet. The Medical Record Clerk said that on 4/2/25 at around 7:30 a.m., Resident #2 said that he was upset and wanted to file a complaint because he tried calling the staff all night because he was wet. Registered Nurses (RN) Staff N, RN Staff O and RN Staff P when interviewed said Resident #2 stated, Nobody cared for me last night, and I needed help. The investigation noted Resident #2 frequently becomes agitated during morning shift change and quickly calms down when he receives care. The facility's investigation conclusion noted the allegation of neglect was verified. Resident #2 stated that he did not receive care during the 11:00 p.m., to 7:00 a.m. shift on 4/1/25. Staff stated that he was awake most of the night, in and out of bed, asking for food, and being toileted 1 to 3 times throughout the night. Resident #2 is a 2-person assist due to confabulation and 2 staff attended to his needs throughout the shift. When the 7:00 a.m., to 3:00 p.m. shift arrived, his urinal was full, and his bed and brief were wet. Although staff statements and interviews differ in account of the occurrence, there was a lack of sufficient evidence to disprove Resident #2's allegation. The investigation noted CNA Staff H who was assigned to Resident #1 during the 11:00 p.m. to 7:00 a.m. was placed on administrative leave and returned pending disciplinary actions. On 6/25/2025 at 10:03 a.m. the Nursing Home Administrator (NHA) said the investigation found that Resident #2 did receive care. The NHA said between 4 CNAs, 2 nurses and the CNA in question statements, staff had been in Resident #2's room multiple times throughout the night. The NHA confirmed that Resident #2 was found that morning with a full urinal and wet bed. The NHA also said that the report they submitted should have noted the neglect as unverified. When asked for intake and output records, they said there is no documentation because they don't document every time they empty urinals. On 6/25/2025 at 10:51 a.m., in an interview Resident #2 said, night shift is very bad I use the call light, and they don't come. Resident #2 said it is always the night shift between 11 p.m. and 7 a.m. Resident #2 said he made a mess recently when he had an episode of incontinence. Resident #2 said the sheet, pillows and blanket were soaked. Resident #2 said the nurse came in, shut off the light and left. Resident #2 said she didn't do nothing. Resident #2 was unable to identify the nurse. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/2025 at 11:10 a.m., in an interview CNA Staff K said CNAs are responsible for checking incontinent residents. When asked how often incontinent residents are checked, Staff K said we check after every meal and anytime the resident needs it. When asked about how Resident #2 uses the bathroom, Staff K said if he will hit the call light if he needs to go. Staff K also said he will ask for help if he feels wet. Staff K said if Resident #2 is in the chair in the common room, he will lift his hat in the air when he needs to go to the bathroom. Staff K said Resident #2 uses a urinal and incontinence pad when he is in bed. Staff K showed documentation of urine output in the system where small, medium and large can be documented for urine output. CNA Staff K said, I put in the amount and color. On 6/25/2025 at 12:05 p.m., in an interview CNA Staff L said nurses and CNAs are responsible for checking incontinent residents. Staff L said that documentation of incontinence is done on the computer. CNA Staff L said refusals of care are documented in the progress notes. Staff L said Resident #2 is someone we frequently check. Staff L said Resident #2 was with it and he will let you know if he needs to be changed or needs to go to the bathroom. When asked if there have been issues with residents having full urinals or being soaked in the morning when coming on shift at 7:00 a.m., Staff L said, I'd be lying if I said no. Staff L said they will come in and urinals are overflowing and beds are soaking wet. Staff L said the call lights are all on and flickering fast. Staff L explained that the light above the door flickers faster the longer they have been on. When asked if staff are around when they are flickering, Staff L said yes. During an interview on 6/25/2025 at 12:12 p.m. LPN Staff M said nurses and CNAs check incontinent residents. Staff M said incontinent residents are checked every 2 hours and as needed. Staff M said CNAs document the output in the resident's chart. Staff M said, we document refusals in the progress notes. During a telephone interview on 6/25/2025 1:02 p.m., Licensed Practical Nurse (LPN) Staff J said on 4/1/25, she provided care for Resident #2 at the beginning and end of the shift. Staff J said CNAs were going in and out of the room that night. Staff J said Resident #2 was very behavioral that night. When asked what that meant, Staff J said Resident #2 was verbally resistant and refused things. When asked if refusals were documented, Staff J said, refusals are usually documented. Review of the clinical record for Resident #2, including progress notes, urine output record, intake and output record, resident's level of control with bladder function from 3/25/25 through 4/4/25 failed to reveal documentation of Resident #2's bladder function, and incontinent care provided on 4/1/25 for the night shift. The clinical record did not contain documentation Resident #2 refused care during the night shift of 4/1/25. On 6/25/2025 at 12:37 p.m., in an interview the Director of Nursing (DON) said there was no policy for documentation. On 6/25/2025 at 2:42 p.m., in an interview the Nursing Home Administrator (NHA) said the CNAs and nurses are responsible for checking incontinent residents. When asked what the process is when they receive a report that a resident didn't receive incontinence care, the NHA said it should be reported to a supervisor. The NHA said if it is a neglect issue, it goes to risk management, the Director of Nursing (DON) and then herself. The NHA said based on staff statements, Resident #2 was constantly receiving care and attention throughout the night. When asked about the lack of documentation of care provided, the NHA stepped out of the interview to get the DON. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/2025 at 2:47 p.m., a joint interview was conducted with the NHA and the DON to discuss Resident #2's neglect and the lack of documentation of incontinent care provided on 4/1/25 during the night shift . The NHA and DON said Resident #2 was care planned for confabulation. The DON reviewed the bowel and bladder documentation for Resident #2 and verified the lack of documentation Resident #2 received incontinent care during the day, evening and/or night shifts on 3/25/25 (evening and night), 3/26/25 (evening) 3/27/25 (evening and night), 3/28/25 (evening and night), 3/29/25 (day, evening and night), 3/30/25 (day, evening and night), 3/31/25 (day, evening and night), 4/1/25 (evening and night), 4/2/25 (evening and night), 4/3/25 (day and night), and 4/4/25 (evening).

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. Based on record review and interview, the facility failed to protect the residents' right to be free from misappropriation of resident's property by failing to have effective processes in place to prevent the misappropriation of controlled substances for 2 (Residents #1 and #4) of 3 residents reviewed. The findings included: Review of the facility's policy titled Abuse, Neglect and Exploitation/Misappropriation of Resident Property with a revision date of 3/1/24 revealed Exploitation and Misappropriation of Resident Property means a deliberate misplacement, wrongful, temporary or permanent use of a resident's belongings without the resident consent. Examples included: stealing from a client/resident. Review of the clinical record for Resident #1 revealed a physician's order for Oxycodone-APAP 10 mg/325 mg (Controlled substance), 1 tablet ever 6 hours for non-acute pain. The medication was scheduled to be administered each day at 6:00 a.m., 12:00 p.m., 6:00 p.m., and 12:00 a.m. Review of the Controlled Substance Record of Use logs for Resident #1 revealed on 5/15/25 the pharmacy delivered 2 packs of 60 tablets each of Oxycodone-APAP 10 mg/325 mg to the facility. Each pack of Oxycodone-APAP 10 mg/325 mg contained a 15 day supply of the medication. Review of the Controlled Substance Record of Use log for pack #1 revealed the 60 tablets of Oxycodone-APAP 10 mg/325 mg were documented as administered within 12 days: The first dose of Oxycodone-APAP 10 mg/325 mg was administered on 5/16/25 at 6:00 a.m. The last dose of Oxycodone-APAP 10 mg/325 mg was administered on 5/28/25 at 6:00 a.m. Review of the Administration History for the Oxycodone-APAP 10 mg/325 mg from 5/16/25 at 6:00 a.m., to 5/28/25 at 6:00 a.m., revealed 44 tablets of Oxycodone-APAP 10 mg/325 mg had been administered during that time frame. The doses of Oxycodone-APAP 10 mg/325 mg were documented as missed on 5/17/25 (12:00 p.m., and 6:00 p.m.), 5/18/25 (6:00 a.m., and 12:00 p.m.) and 5/23/25 (6:00 a.m.). Review of the Controlled Substance Record of Use for pack #2 for Resident #1 revealed the 60 tablets of Oxycodone-APAP 10 mg/325 mg were administered within 11 days: The first dose of Oxycodone-APAP 10 mg/ 325 mg was administered on 5/28/25 at 12:00 p.m. The last dose of Oxycodone-APAP 10 mg/325 mg was administered 11 days later on 6/7/25 at 12:00 a.m. Review of the Administration History for the Oxycodone-APAP 10 mg/325 mg from 5/28/25 at 12:00 p.m., to 6/7/25 at 12:00 a.m., revealed 36 tablets of Oxycodone-APAP 10 mg/325 mg had been administered during that time frame. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The doses of Oxycodone-APAP 10 mg/325 mg were documented as missed on 6/1/25 (12:00 p.m., and 6:00 p.m.), and 6/6/25 (6:00 p.m.). The Controlled Substance Record of Use logs for Packs #1 and #2 of Oxycodone-APAP 10 mg/325 mg revealed multiple dates had been scribbled or written over making it illegible or difficult to make out the date for the doses of Oxycodone-APAP 10 mg/325 mg administered. On 6/25/25 at 10:25 a.m., in an interview the Administrator said on 6/6/25 they discovered discrepancies in Resident #1's Oxycodone-APAP 10mg/325 mg when a refill of the medication was requested and the Pharmacy Consultant informed the facility it was too soon for a refill. On 5/15/25 120 tablets of Oxycodone-APAP 10 mg/325 mg (30 day supply) were delivered for Resident #1. The physician's order for the Oxycodone-APAP 10 mg/325 mg was to administer 1 tablet 4 times a day and the medication was not due for a refill until 6/12/25. Resident #1 should have received a maximum of 4 tablets daily. The Pharmacy audited the controlled substance record of use and found that on multiple days Resident #1 received more than 4 tablets of the Oxycodone-APAP 10 mg/ 325 mg. The Administrator said when you compared the count documented on the controlled substance record of use against the blister pack (package of medications), the count was correct. However, some days it looked like Resident #1 received 8 or 11 doses of the Oxycodone-APAP 10 mg/325 mg when he should have only received 4 per day. The declining narcotic inventory sheets looked like there were dates changed, scribbled out, started on a previous day. The end count was correct but the nurses were not catching that it was documented more than 4 times per day. The Administrator said during their investigation they discovered a similar issue with the pain medication for Resident #4. The Administrator said there were no ill effects to the residents, and they did not go without their scheduled pain medication. Review of the clinical record for Resident #4 revealed a physician's order for Oxycodone HCL (IR) 5 mg , 1 tablet every 6 hours for non-acute pain. Review of the controlled substance record of use revealed 60 tablets of Oxycodone (IR) 5 mg were delivered on 5/27/25 for Resident #4. Multiple dates were scribbled or written over making it difficult to make out or illegible. The dates on the controlled substance record of use were not in order. The controlled substance record of use showed Oxycodone 5 mg was administered on 5/30/25, then 5/31/25, then went back to administration of the Oxycodone 5 mg on 5/30/25. The first dose of Oxycodone (IR) 5 mg was administered on 5/27/25 at 6:00 p.m. On 6/6/25 at 12:50 p.m.,10 tablets of Oxycodone (IR) remained in the blister pack, indicating 50 tablets of Oxycodone IR 5 mg from the blister pack had been signed out between 5/27/25 at 6:00 p.m., and 6/6/25 at 12:50 p.m. Review of the Administration History for the Oxycodone (IR) 5 mg revealed 38 tablets of Oxycodone (IR) 5 mg were documented as administered from 5/27/25 at 6:00 p.m., through 6/6/25 at 12:50 p.m. Review of the facility's investigation revealed: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A statement by the Consultant Pharmacist dated 6/10/25 which indicated: Pharmacy received a request for Resident #1 for Percocet 10/325mg, 1 tab po 4 times daily 120 tabs dispensed. Previous order for 120 tabs was filled on 5/15/25, which is a 30 day supply. Saw that it was not due to be refilled until 6/12 (28 days from last fill). In the morning Registered Nurse (RN) supervisor Staff E called to inquire about the refill and I told him it wasn't due until 6/12 at the soonest. I checked for any PRN (as needed) orders that would equate to more use of the standing order and there was none. RN Staff E checked also for any PRN orders pharmacy may have missed and found none. The order was technically 8 days early for filling. I reviewed the documentation and found multiple days that had more than 4 tablets taken. On 6/4 for example, 11 doses were signed out. I reported this to Staff E and the 3-11 RN supervisor (do not remember name). They asked that I tell the Director of Nursing (DON). Around 3:50 pm I went to the DON's office and showed her what I found with reviewing the tracking sheets and she understood the concern, more tablets being signed out than prescribed. On 6/25/25 at 12:42 p.m., in an interview the Director of Nursing (DON) said on 6/6/25 RN Staff E reported that the Pharmacy Consultant identified what they believed to be an error in a narcotic count for Resident #1. The DON said she and RN Staff E counted how many tablets of Percocet had been given. 120 tablets were delivered, 115 were administered with 5 remaining tablets. She said Staff E and her felt the count was accurate. The DON said the Pharmacy Consultant showed her the pages from the narcotic book and pointed out the dates. It sowed on certain days the medication was signed out 6, 7, 10 or 11 times in one day. The order was for 1 tablet 4 times a day. In counting the days, there should have been approximately 25 tablets left and there were only 5. The DON said they conducted an audit of all controlled substances and the Risk Manager found further issues. On 6/25/25 at 1:21 p.m., in an interview Registered Nurse (RN) Staff E said he reordered the Oxycodone-APAP for Resident #1. The pharmacy said the medication was not due for a refill yet. When the Pharmacy Consultant reviewed the controlled substance record of use, he found that Resident #1 had been receiving more than the 4 doses of pain medication ordered daily. RN Staff E said he reported it to the DON and didn't know what happened after that. On 6/25/25 at 1:25 p.m., in an interview the Risk Manager (RM) said the facility investigated, reviewed the controlled substance logs for all the residents receiving Oxycodone and found the following concerns: With Resident #4's pain medication they found the count was all right but found concerns similar to Resident #1. She said these instances all related to Licensed Practical Nurse (LPN) Staff A. She said she and the Administrator met with LPN Staff A regarding multiple discrepancies on the controlled substances administration documents. LPN Staff A claimed that multiple of the signatures were not hers and she could not recall who she signed off on her cart for multiple events. LPN Staff A also stated that she had changed multiple dates on several of the medication documents. When asked why she would do that she stated, I must have made a mistake. The Risk Manager said that LPN Staff A was adamant that she did not take any pills and also denied over medicating any resident. She said when the presented LPN Staff A with the evidence of multiple discrepancies, she became overwhelmed and began to cry. LPN Staff A requested to undergo a drug treatment program in lieu of notifying the state board of nursing. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/25 at 4 p.m., in an interview the Administrator said LPN Staff A was no longer employed at the facility, the incident was reported to law enforcement, the Drug Enforcement agency and the Board of Nursing. A performance Improvement Plan was put in place and audits were ongoing to ensure logs were legible and pharmacy was auditing as well to ensure documentation was legible. All nurses have been educated on drug diversion.