

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 07/16/2025
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 - 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. (continued on next page)		

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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on review of facility policy and procedures, record review and staff and resident interviews, the facility failed to protect the resident's right to be free from physical abuse by failing to use the proper mechanical lift during a transfer for 1(Resident #899) of 3 residents reviewed for abuse.The findings included:Review of the facility's policy and procedure titled, Abuse, Neglect and Exploitation/Misappropriation of Resident Property with a revised date of 3/01/2024 revealed, The goal is to achieve and maintain an abuse-free environment for the residents . Abuse means any wilful act or failure to act which causes or is likely to cause significant injury to a resident's physical, mental or emotional health . Prevention . Identify, correct and intervene in situations in which abuse . is more likely to occur . This includes an analysis of . The supervision of staff to identify inappropriate behaviors such as . rough handling .Review of the clinical record for Resident #899 revealed an admission date of 2/14/25. Diagnoses included restlessness, dementia with psychotic disturbance, anxiety and flaccid hemiplegia (paralysis) affecting the right side.Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 5/20/25 revealed Resident #899 scored 03 on the Brief Interview for Mental Status, indicating severely impaired cognition. The resident required partial to moderate assistance with activities of daily living, including transfers.Review of the care plan initiated on 2/21/25 and edited on 7/1/25 revealed Resident #899's ability to transfer, dress, eat, toilet and maintain personal hygiene had deteriorated related to CVA (Cerebrovascular accident) with right side flaccid hemiplegia.The approaches as of 2/21/25 included to provide 2 person assistance for transfers.On 6/12/25, the care plan noted Resident #899 had a recent incident of placing himself on the floor.On 7/16/25, review of facility provided incident investigations revealed that on 7/1/25 the facility initiated a staff to resident physical abuse investigation for Resident #899.The detailed description of the allegation/incident noted:Resident #899 was allegedly pulled approximately 4 to 5 feet. Resident placed self on the floor, as per his care plan. CNA (Certified Nursing Assistant) was attempting to move him from in front of the door way [sic] to prevent injury. CNA Staff B provided a statement that on 7/1/25 CNA Staff A grabbed Resident #899 by his shirt and dragged him on the floor so that she could place him closer to the mechanical lift.CNA Staff A provided a statement that on 7/1/25 at approximately 10:00 a.m., Resident #899 was laying on his bedroom floor in front of the doorway. She did not want the door to injure him, so she requested assistance to move him back into the bed. CNA Staff A stated that she took the shoulder and the other CNA (CNA Staff B) took the legs and they moved him in his room under the ceiling lift track. CNA Staff A stated that initially she pulled Resident #899 out of the doorway to his armoire, approximately 2 inches, unassisted by holding the resident's left arm, shoulder. Once positioned, CNA Staff B assisted her getting the resident positioned in the lift sling for the mechanical lift.Review of CNA Staff A's handwritten statement revealed that on 7/1/25 Resident #899 was in the doorway and they had to move him in the room. She took the shoulders and the other CNA took the legs and they moved the resident in his room under the (brand name) mechanical lift tract. She avoided touching the resident's paralyzed arm and they hooked him up to the lift.Review of CNA Staff B's written statement revealed that Resident #899 was on the floor by the dresser. She asked CNA Staff A if she needed help getting the resident up. Resident #899 was not close to the (brand name) mechanical lift track. She (CNA Staff A) dragged him by the collar of his shirt to be closer to the track, got him in the sling and back to bed. The investigation noted that on 7/1/25 at approximately 1:45 p.m., the Nursing Home Administrator and the Risk Manager interviewed CNA Staff B. Staff B stated that she was in a different room caring for a resident. She exited the room and walked past Resident #899's room. She noted CNA Staff A standing over Resident #899. The resident was laying on the floor in front of his armoire. She offered her assistance to CNA Staff A, which she accepted. She closed the door. At this time, CNA Staff A grabbed Resident #899 by his shirt and moved him closer to the track of the lift to get the resident off the floor. CNA Staff B demonstrated to the Risk Manager and the Nursing Home Administrator the location of Resident #899 when she entered the room. CNA Staff B stated to the Risk Manager and the Nursing Home Administrator that this was not right, she was not going to participate in moving a resident this way. Staff B said when she presented this to CNA Staff A, the response was, This is how I do it.On 7/1/25 at approximately 2:00 p.m., the Nursing Home Administrator and the Risk Manager spoke with CNA Staff A regarding the concerns brought to their attention. CNA Staff A stated that she noted Resident #899 in the doorway and wanted to move him away from the doorway. She grabbed his left arm and shoulder, and he assisted by scooching himself. CNA Staff A stated that she only moved Resident #899 2 inches and the other CNA (CNA Staff B) assisted by lifting the legs. CNA Staff A</p>		