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	08/21/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. (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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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and staff and resident interviews, the facility failed to treat 1(Resident #1) of 3 residents reviewed with dignity by denying the resident access and assistance to the bathroom. The findings included:Review of the facility provided incident investigations revealed on 7/25/25 the facility initiated an investigation for Resident #1 related to staff denying him access to the bathroom in the therapy department. The facility's investigation noted that on 7/25/25 at approximately 11:30 a.m., Resident #1 needed to use the bathroom and stopped in the therapy department to use their restroom. Resident #1 stated that staff denied him access and assistance to the therapy department bathroom, resulting in an incontinence episode, causing the resident to miss a doctor's appointment. Resident #1 stated that he was embarrassed and angry. The facility's investigation included statements of staff involved. Review of the facility provided staff statements revealed:Physical Therapist (PT) Staff D stated that on 7/25/25 at approximately 11:00 a.m., she entered the therapy room to start a group session. Several residents, including Resident #1 were present. Resident #1 wanted to use the bathroom. Physical Therapy Staff C told Resident #1 that he could not use the restroom without assistance, and she had another resident in the room at the time. PT Staff C offered to take Resident #1 to his unit to use the bathroom. He refused her assistance. PT Staff D said Resident #1 began cussing and flailing his arms and she was extremely uncomfortable with his behavior. Physical Therapist Staff E stated that on 7/25/25 at approximately 11:00 a.m., Resident #1 entered the therapy gym and headed for the bathroom stating he was going to use the toilet. PT Staff C told him that he could not use the toilet in the gym because he needed assistance and she was busy treating a patient. PT Staff C told Resident #1 that the Director of Rehab (DOR) had told him that he could not use the toilet independently or use the gym's toilet is he was not in treatment. Resident #1 reposted urgency to use the toilet. PT Staff C said she could take him to his room. PT Staff C asked PT Staff E if she could assist the resident to the toilet. She stated that she could not. PT Staff C and PT Staff D again stated that Resident #1 needed assistance to transfer. Resident #1 began cussing and left the room. Licensed Practical Nurse (LPN) Staff F provided a statement that on 7/25/25 at approximately 11:15 a.m., she heard Resident #1 coming down the hall, cussing. She asked the resident what was wrong. He stated that therapy told him he could not use the restroom, that he had to use the restroom in his room. Resident #1 told her that PT Staff D put a wheelchair in front of the bathroom door to block the entrance. LPN Staff F said that the driver was here to take him to his appointment. He told her to send the driver away because he had to get cleaned up. The investigation noted that Resident #1 was a 1 assist transfer (stand and pivot) as well as using the sit to stand lift when requested. Resident #1's therapy notes stated that the resident was able to use the restroom with minimal to no assistance. Resident #1 was going to therapy 3 times a week at the time of the event but was not on therapy caseload for that day. On 8/4/25 the facility documented in the conclusion of their investigation, This event will be verified due to the 3 therapy staff members not personally assisting (Resident #1) to the restroom. The therapists are professionally trained to assist with standing and pivoting individuals. (Resident #1) was offered assistance to get back to his room but never assistance with the toilet nor was he allowed to toilet himself due to placing a wheelchair in front of the bathroom door. The three individuals never requested assistance from the nursing department nor notified them of his need. (Resident #1) is alert and oriented and is capable of toileting himself but is recommended by therapy to have staff present to prevent falls per therapy notes.On 8/20/25, review of the clinical record for Resident #1 revealed an admission date of 3/4/21. Diagnoses included Parkinson's disease, Alzheimer's disease.Review of the Quarterly Minimum Data Set (MDS) assessment with a target date of 7/28/25 revealed Resident #1 scored 15 on the Brief Interview for Mental Status, indicating intact cognition. The care plan initiated on noted the resident assistance of 1 for transfers (stand and pivot). Resident #1 also used a sit to stand lift when requested. On 8/20/25 at 10:30 a.m. , in an interview the Regional Administrator, Risk Manager, and Assistant Director of Nursing said they were aware of the incident of Resident #1 not being allowed to use the restroom in the Physical Therapy Department which resulted in Resident #1 soiling himself. They said all three therapists involved in the incident were contracted from an outside company to provide Physical Therapy services to all state facilities. On 8/20/2025 at 12:45 p.m., in an interview Resident #1 said the incident on 7/25/2025 made him very angry. He said that he was dressed and, on his way up front to catch his ride for a doctor's appointment. He said he suddenly realized he needed to poop and the Physical Therapy room was right there. They wouldn't let him use the restroom. He said PT Staff D threw a wheelchair in front of the bathroom door to block him