STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106059	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS JACOBSON STATE VETERANS NURSING HOME	21281 GRAYTON TERRACE , PORT CHARLOTTE, Florida, 33954

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An unannounced complaint survey for complaints number 2025008722 and 2025004914 was conducted on at Douglas Jacobson State Veterans Nursing Home, a nursing home in Port Charlotte, Florida. Douglas Jacobson State Veterans Nursing Home is not in compliance with Code of Federal Regulations (CFR) 42, Part 483, Requirements for Long-Term Care Facilities.	F0000		
F0600 SS = D	Free from and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from , Neglect, and , The resident has the right to be free from , neglect, misappropriation of resident property, and , as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary and any physical or chemical not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, , or , , , corporal punishment, or involuntary ; This REQUIREMENT is NOT MET as evidenced by: 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 care to meet their needs. The findings included: Review of the Facility's " , Neglect and	F0600		

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106059	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED

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F0600 SS = D	Continued from page 1 , /Misappropriation of Resident Property" policy (last revised) 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 , neglect and/or /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 . Diagnoses included , 's and overactive . Review of the dated revealed Resident #2 scored "14", indicative of intact cognition. Review of the Discharge Minimum Data Set (MDS) assessment with a target date of revealed Resident #2 was frequently of . The MDS noted the resident required partial/ 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 , R/T (related to) overactive and . (Resident #2) is of ". The approaches included 2 at bedside for large nighttime output. Review of the facility's grievance investigations revealed on 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: On Certified Nursing Assistant (CNA) Staff L said she entered Resident #2's room around 6:45 a.m. and "his was full. He stated that he was calling for help all night, and no one came. Once getting him	F0600		

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F0600 SS = D	Continued from page 2 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 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 was full. She emptied it and found that his pull up was wet. The Medical Record Clerk said that on 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 . 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 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 at 10:03 a.m. the Nursing Home Administrator (NHA) said the investigation found that	F0600		

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F0600 SS = D	Continued from page 3 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 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 . On 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 . 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. On at 11:10 a.m., in an interview CNA Staff K said CNAs are responsible for checking residents. When asked how often 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 and , when he is in bed. Staff K showed documentation of output in the system where small, medium and large can be documented for output. CNA Staff K said, "I put in the amount and color". On at 12:05 p.m., in an interview CNA Staff L said nurses and CNAs are responsible for checking residents. Staff L said that documentation of 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 or	F0600		

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F0600 SS = D	Continued from page 4 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 " 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 at 12:12 p.m. LPN Staff M said nurses and CNAs check residents. Staff M said 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 1:02 p.m., Licensed Practical Nurse (LPN) Staff J said on , 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, output record, intake and output record, resident's level of control with function from through failed to reveal documentation of Resident #2's function, and care provided on for the night shift. The clinical record did not contain documentation Resident #2 refused care during the night shift of . On at 12:37 p.m., in an interview the Director of Nursing (DON) said there was no policy for documentation. On at 2:42 p.m., in an interview the Nursing Home Administrator (NHA) said the CNAs and nurses are responsible for checking residents. When asked what the process is when they receive a report that a resident didn't receive 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	F0600		

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F0600 SS = D	Continued from page 5 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. On at 2:47 p.m., a interview was conducted with the NHA and the DON to discuss Resident #2's neglect and the lack of documentation of care provided on during the night shift . The NHA and DON said Resident #2 was care planned for "confabulation." The DON reviewed the and documentation for Resident #2 and verified the lack of documentation Resident #2 received care during the day, evening and/or night shifts on (evening and night), (evening) (evening and night), (evening and night), (day, evening and night), (day, evening and night), (evening and night), (evening and night), (day and night), and (evening).	F0600		
F0602 SS = E	Free from Misappropriation/ , CFR(s): 483.12 §483.12 The resident has the right to be free from , neglect, misappropriation of resident property, and as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary and any physical or chemical not required to treat the resident's medical symptoms. This REQUIREMENT is NOT MET as evidenced by: 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 , Neglect and /Misappropriation of Resident Property with a revision date of revealed and Misappropriation of Resident Property means a	F0602		

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F0602 SS = E	Continued from page 6 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 , - 10 mg/325 mg (Controlled substance), 1 tablet ever 6 hours for non-acute , . 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 the pharmacy delivered 2 packs of 60 tablets each of , - 10 mg/325 mg to the facility. Each pack of , - 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 , - 10 mg/325 mg were documented as administered within 12 days: The first dose of , - 10 mg/325 mg was administered on at 6:00 a.m. The last dose of , - 10 mg/325 mg was administered on at 6:00 a.m. Review of the "Administration History" for the , - 10 mg/325 mg from at 6:00 a.m., to at 6:00 a.m., revealed 44 tablets of , - 10 mg/325 mg had been administered during that time frame. The doses of , - 10 mg/325 mg were documented as "missed" on (12:00 p.m., and 6:00 p.m.), (6:00 a.m., and 12:00 p.m.) and (6:00 a.m.). Review of the "Controlled Substance Record of Use" for pack #2 for Resident #1 revealed the 60 tablets of , - 10 mg/325 mg were administered within 11	F0602		

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F0602 SS = E	Continued from page 7 days: The first dose of , - 10 mg/ 325 mg was administered on at 12:00 p.m. The last dose of , - 10 mg/325 mg was administered 11 days later on at 12:00 a.m. Review of the "Administration History" for the , - 10 mg/325 mg from at 12:00 p.m., to at 12:00 a.m., revealed 36 tablets of , - 10 mg/325 mg had been administered during that time frame. The doses of , - 10 mg/325 mg were documented as "missed" on (12:00 p.m., and 6:00 p.m.), and (6:00 p.m.). The "Controlled Substance Record of Use" logs for Packs #1 and #2 of , - 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 , - 10 mg/325 mg administered. On at 10:25 a.m., in an interview the Administrator said on they discovered discrepancies in Resident #1's , - 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 120 tablets of , - 10 mg/325 mg (30 day supply) were delivered for Resident #1. The physician's order for the , - 10 mg/325 mg was to administer 1 tablet 4 times a day and the medication was not due for a refill until . 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 , - 10 mg/ 325 mg. The Administrator said when you compared the count documented on the controlled substance record of use against the pack (package of medications), the count was correct. However, some days it looked like Resident #1 received 8 or 11 doses of the , - 10 mg/325 mg when he should have only received 4 per day. The declining inventory sheets looked like there were dates changed, scribbled	F0602		

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F0602 SS = E	Continued from page 8 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 , medication for Resident #4. The Administrator said there were no ill effects to the residents, and they did not go without their scheduled , medication. Review of the clinical record for Resident #4 revealed a physician's order for , (IR) 5 mg , 1 tablet every 6 hours for non-acute , . Review of the controlled substance record of use revealed 60 tablets of , (IR) 5 mg were delivered on 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 , 5 mg was administered on , then , then went to administration of the , 5 mg on . The first dose of , (IR) 5 mg was administered on at 6:00 p.m. On at 12:50 p.m.,10 tablets of , (IR) remained in the pack, indicating 50 tablets of , IR 5 mg from the pack had been signed out between at 6:00 p.m., and at 12:50 p.m. Review of the Administration History for the , (IR) 5 mg revealed 38 tablets of , (IR) 5 mg were documented as administered from at 6:00 p.m., through at 12:50 p.m. Review of the facility's investigation revealed: A statement by the Consultant Pharmacist dated which indicated: Pharmacy received a request for Resident #1 for 10/325mg, 1 tab po 4 times daily 120 tabs dispensed. Previous order for 120 tabs was filled on , which is a 30 day supply. Saw that it was not due to be refilled until (28 days from last fill). In the morning Registered Nurse (RN)	F0602		

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F0602 SS = E	Continued from page 9 supervisor Staff E called to inquire about the refill and I told him it wasn't due until 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 for example, 11 doses were signed out. I reported this to Staff E and the 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 at 12:42 p.m., in an interview the Director of Nursing (DON) said on RN Staff E reported that the Pharmacy Consultant identified what they believed to be an error in a count for Resident #1. The DON said she and RN Staff E counted how many tablets of 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 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 at 1:21 p.m., in an interview Registered Nurse (RN) Staff E said he reordered the 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 medication ordered daily. RN Staff E said he reported it to the DON and didn't know what happened after that. On 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 and found the following concerns:	F0602		

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F0602 SS = E	Continued from page 10 With Resident #4's , 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. On 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.	F0602		

Florida State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130471029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/25/2025

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N0000	INITIAL COMMENTS An unannounced complaint survey for complaints number 2025008722 and 2025004914 was conducted on at Douglas Jacobson State Veterans Nursing Home, a nursing home in Port Charlotte, Florida. Deficiencies were identified at the time of survey.	N0000		
N0204 SS = E	Right to be Free from , , etc CFR(s): 400.022(1)(o), FS 400.022, F.S. (1)(o) All licensees of nursing home facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident the following: (o) The right to be free from mental and , , , , neglect, , , corporal punishment, extended involuntary , and , , corporal punishment, extended involuntary , and physical and chemical , except those authorized in writing by a physician for a specified and limited period of time or as are necessitated by an emergency. In case of an emergency, may be applied only by a qualified licensed nurse who shall set forth in writing the circumstances requiring the use of , and, in the case of use of a chemical , a physician shall be consulted immediately thereafter. may not be used in lieu of staff supervision or merely for staff convenience, for punishment, or for reasons other than resident protection or safety. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, records review and interviews,	N0204		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130471029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Florida, 33954

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N0204 SS = E	Continued from page 1 the facility failed to protect the resident's right to be free from neglect and misappropriation of residents' property by failing to ensure 1 (Resident #2) of 3 residents reviewed received care to meet their needs and 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: The findings included: Review of the Facility's " , Neglect and , /Misappropriation of Resident Property" policy (last revised) 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 , neglect and/or , /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 . Diagnoses included , 's and overactive . Review of the dated revealed Resident #2 scored "14", indicative of intact cognition. Review of the Discharge Minimum Data Set (MDS) assessment with a target date of revealed Resident #2 was frequently of . The MDS noted the resident required partial/ 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 , R/T (related to) overactive and . (Resident #2) is of ".	N0204		

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N0204 SS = E	Continued from page 2 The approaches included 2 at bedside for large nighttime output. Review of the facility's grievance investigations revealed on 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: On Certified Nursing Assistant (CNA) Staff L said she entered Resident #2's room around 6:45 a.m. and "his 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 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 was full. She emptied it and found that his pull up was wet. The Medical Record Clerk said that on 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 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	N0204		

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N0204 SS = E	Continued from page 3 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 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 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 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 . On 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 . 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. On at 11:10 a.m., in an interview CNA Staff K said CNAs are responsible for checking residents. When asked how often 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 and	N0204		

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N0204 SS = E	Continued from page 4 , when he is in bed. Staff K showed documentation of output in the system where small, medium and large can be documented for output. CNA Staff K said, "I put in the amount and color". On at 12:05 p.m., in an interview CNA Staff L said nurses and CNAs are responsible for checking residents. Staff L said that documentation of 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 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 " 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 at 12:12 p.m. LPN Staff M said nurses and CNAs check residents. Staff M said 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 1:02 p.m., Licensed Practical Nurse (LPN) Staff J said on , 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, output record, intake and output record, resident's level of control with function from through failed to reveal documentation of Resident #2's function, and care provided on for the night shift. The clinical record did not contain	N0204		

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N0204 SS = E	Continued from page 5 documentation Resident #2 refused care during the night shift of . On at 12:37 p.m., in an interview the Director of Nursing (DON) said there was no policy for documentation. On at 2:42 p.m., in an interview the Nursing Home Administrator (NHA) said the CNAs and nurses are responsible for checking residents. When asked what the process is when they receive a report that a resident didn't receive 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. On at 2:47 p.m., a , interview was conducted with the NHA and the DON to discuss Resident #2's neglect and the lack of documentation of care provided on during the night shift . The NHA and DON said Resident #2 was care planned for "confabulation." The DON reviewed the and documentation for Resident #2 and verified the lack of documentation Resident #2 received care during the day, evening and/or night shifts on (evening and night), (evening) (evening and night), (evening and night), (day, evening and night), (day, evening and night), (evening and night), (evening and night), (day and night), and (evening). Review of the facility's policy titled , Neglect and , /Misappropriation of Resident Property with a revision date of revealed , 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 , - 10 mg/325 mg (Controlled substance), 1 tablet ever 6 hours for	N0204		

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N0204 SS = E	Continued from page 6 non-acute , . 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 the pharmacy delivered 2 packs of 60 tablets each of , - 10 mg/325 mg to the facility. Each pack of , - 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 , - 10 mg/325 mg were documented as administered within 12 days: The first dose of , - 10 mg/325 mg was administered on at 6:00 a.m. The last dose of , - 10 mg/325 mg was administered on at 6:00 a.m. Review of the "Administration History" for the , - 10 mg/325 mg from at 6:00 a.m., to at 6:00 a.m., revealed 44 tablets of , - 10 mg/325 mg had been administered during that time frame. The doses of , - 10 mg/325 mg were documented as "missed" on (12:00 p.m., and 6:00 p.m.), (6:00 a.m., and 12:00 p.m.) and (6:00 a.m.). Review of the "Controlled Substance Record of Use" for pack #2 for Resident #1 revealed the 60 tablets of , - 10 mg/325 mg were administered within 11 days: The first dose of , - 10 mg/ 325 mg was administered on at 12:00 p.m. The last dose of , - 10 mg/325 mg was administered 11 days later on at 12:00 a.m.	N0204		

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N0204 SS = E	Continued from page 7 Review of the "Administration History" for the , - 10 mg/325 mg from at 12:00 p.m., to at 12:00 a.m., revealed 36 tablets of , - 10 mg/325 mg had been administered during that time frame. The doses of , - 10 mg/325 mg were documented as "missed" on (12:00 p.m., and 6:00 p.m.), and (6:00 p.m.). The "Controlled Substance Record of Use" logs for Packs #1 and #2 of , - 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 , - 10 mg/325 mg administered. On at 10:25 a.m., in an interview the Administrator said on they discovered discrepancies in Resident #1's , - 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 120 tablets of - 10 mg/325 mg (30 day supply) were delivered for Resident #1. The physician's order for the , - 10 mg/325 mg was to administer 1 tablet 4 times a day and the medication was not due for a refill until . 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 , - 10 mg/ 325 mg. The Administrator said when you compared the count documented on the controlled substance record of use against the pack (package of medications), the count was correct. However, some days it looked like Resident #1 received 8 or 11 doses of the , - 10 mg/325 mg when he should have only received 4 per day. The declining 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 , medication for Resident #4. The Administrator said there were no ill effects to the residents, and they did not go without their scheduled , medication.	N0204		

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N0204 SS = E	Continued from page 8 Review of the clinical record for Resident #4 revealed a physician's order for , (IR) 5 mg , 1 tablet every 6 hours for non-acute , . Review of the controlled substance record of use revealed 60 tablets of , (IR) 5 mg were delivered on 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 , 5 mg was administered on , then , then went to administration of the , 5 mg on . The first dose of , (IR) 5 mg was administered on at 6:00 p.m. On at 12:50 p.m.,10 tablets of , (IR) remained in the pack, indicating 50 tablets of , IR 5 mg from the pack had been signed out between at 6:00 p.m., and at 12:50 p.m. Review of the Administration History for the , (IR) 5 mg revealed 38 tablets of , (IR) 5 mg were documented as administered from at 6:00 p.m., through at 12:50 p.m. Review of the facility's investigation revealed: A statement by the Consultant Pharmacist dated which indicated: Pharmacy received a request for Resident #1 for 10/325mg, 1 tab po 4 times daily 120 tabs dispensed. Previous order for 120 tabs was filled on , which is a 30 day supply. Saw that it was not due to be refilled until (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 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 for example, 11 doses were	N0204		

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N0204 SS = E	Continued from page 9 signed out. I reported this to Staff E and the 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 at 12:42 p.m., in an interview the Director of Nursing (DON) said on RN Staff E reported that the Pharmacy Consultant identified what they believed to be an error in a count for Resident #1. The DON said she and RN Staff E counted how many tablets of 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 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 at 1:21 p.m., in an interview Registered Nurse (RN) Staff E said he reordered the 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 medication ordered daily. RN Staff E said he reported it to the DON and didn't know what happened after that. On 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 and found the following concerns: With Resident #4's 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	N0204		

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N0204 SS = E	Continued from page 10 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. On 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. Class III	N0204		

Florida State Department of Health

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130471029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, Florida, 33954

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0204 SS = E	Continued from page 1 the facility failed to protect the resident's right to be free from neglect and misappropriation of residents' property by failing to ensure 1 (Resident #2) of 3 residents reviewed received care to meet their needs and 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: The findings included: Review of the Facility's " , Neglect and , /Misappropriation of Resident Property" policy (last revised) 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 , neglect and/or , /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 . Diagnoses included , 's and overactive . Review of the dated revealed Resident #2 scored "14", indicative of intact cognition. Review of the Discharge Minimum Data Set (MDS) assessment with a target date of revealed Resident #2 was frequently of . The MDS noted the resident required partial/ 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 , R/T (related to) overactive and . (Resident #2) is of ".	N0204		

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N0204 SS = E	Continued from page 2 The approaches included 2 at bedside for large nighttime output. Review of the facility's grievance investigations revealed on 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: On Certified Nursing Assistant (CNA) Staff L said she entered Resident #2's room around 6:45 a.m. and "his 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 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 was full. She emptied it and found that his pull up was wet. The Medical Record Clerk said that on 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 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	N0204		

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N0204 SS = E	Continued from page 3 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 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 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 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 . On 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 . 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. On at 11:10 a.m., in an interview CNA Staff K said CNAs are responsible for checking residents. When asked how often 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 and	N0204		

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N0204 SS = E	Continued from page 4 , when he is in bed. Staff K showed documentation of output in the system where small, medium and large can be documented for output. CNA Staff K said, "I put in the amount and color". On at 12:05 p.m., in an interview CNA Staff L said nurses and CNAs are responsible for checking residents. Staff L said that documentation of 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 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 " 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 at 12:12 p.m. LPN Staff M said nurses and CNAs check residents. Staff M said 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 1:02 p.m., Licensed Practical Nurse (LPN) Staff J said on , 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, output record, intake and output record, resident's level of control with function from through failed to reveal documentation of Resident #2's function, and care provided on for the night shift. The clinical record did not contain	N0204		

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N0204 SS = E	Continued from page 5 documentation Resident #2 refused care during the night shift of . On at 12:37 p.m., in an interview the Director of Nursing (DON) said there was no policy for documentation. On at 2:42 p.m., in an interview the Nursing Home Administrator (NHA) said the CNAs and nurses are responsible for checking residents. When asked what the process is when they receive a report that a resident didn't receive 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. On at 2:47 p.m., a , interview was conducted with the NHA and the DON to discuss Resident #2's neglect and the lack of documentation of care provided on during the night shift . The NHA and DON said Resident #2 was care planned for "confabulation." The DON reviewed the and documentation for Resident #2 and verified the lack of documentation Resident #2 received care during the day, evening and/or night shifts on (evening and night), (evening) (evening and night), (evening and night), (day, evening and night), (day, evening and night), (evening and night), (evening and night), (day and night), and (evening). Review of the facility's policy titled , Neglect and , /Misappropriation of Resident Property with a revision date of revealed , 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 , - 10 mg/325 mg (Controlled substance), 1 tablet ever 6 hours for	N0204		

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N0204 SS = E	Continued from page 6 non-acute , . 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 the pharmacy delivered 2 packs of 60 tablets each of , - 10 mg/325 mg to the facility. Each pack of , - 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 , - 10 mg/325 mg were documented as administered within 12 days: The first dose of , - 10 mg/325 mg was administered on at 6:00 a.m. The last dose of , - 10 mg/325 mg was administered on at 6:00 a.m. Review of the "Administration History" for the , - 10 mg/325 mg from at 6:00 a.m., to at 6:00 a.m., revealed 44 tablets of , - 10 mg/325 mg had been administered during that time frame. The doses of , - 10 mg/325 mg were documented as "missed" on (12:00 p.m., and 6:00 p.m.), (6:00 a.m., and 12:00 p.m.) and (6:00 a.m.). Review of the "Controlled Substance Record of Use" for pack #2 for Resident #1 revealed the 60 tablets of , - 10 mg/325 mg were administered within 11 days: The first dose of , - 10 mg/ 325 mg was administered on at 12:00 p.m. The last dose of , - 10 mg/325 mg was administered 11 days later on at 12:00 a.m.	N0204		

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N0204 SS = E	Continued from page 7 Review of the "Administration History" for the , - 10 mg/325 mg from at 12:00 p.m., to at 12:00 a.m., revealed 36 tablets of , - 10 mg/325 mg had been administered during that time frame. The doses of , - 10 mg/325 mg were documented as "missed" on (12:00 p.m., and 6:00 p.m.), and (6:00 p.m.). The "Controlled Substance Record of Use" logs for Packs #1 and #2 of , - 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 , - 10 mg/325 mg administered. On at 10:25 a.m., in an interview the Administrator said on they discovered discrepancies in Resident #1's , - 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 120 tablets of - 10 mg/325 mg (30 day supply) were delivered for Resident #1. The physician's order for the , - 10 mg/325 mg was to administer 1 tablet 4 times a day and the medication was not due for a refill until . 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 , - 10 mg/ 325 mg. The Administrator said when you compared the count documented on the controlled substance record of use against the pack (package of medications), the count was correct. However, some days it looked like Resident #1 received 8 or 11 doses of the , - 10 mg/325 mg when he should have only received 4 per day. The declining 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 , medication for Resident #4. The Administrator said there were no ill effects to the residents, and they did not go without their scheduled , medication.	N0204		

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N0204 SS = E	Continued from page 8 Review of the clinical record for Resident #4 revealed a physician's order for , (IR) 5 mg , 1 tablet every 6 hours for non-acute , . Review of the controlled substance record of use revealed 60 tablets of , (IR) 5 mg were delivered on 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 , 5 mg was administered on , then , then went to administration of the , 5 mg on . The first dose of , (IR) 5 mg was administered on at 6:00 p.m. On at 12:50 p.m.,10 tablets of , (IR) remained in the pack, indicating 50 tablets of , IR 5 mg from the pack had been signed out between at 6:00 p.m., and at 12:50 p.m. Review of the Administration History for the , (IR) 5 mg revealed 38 tablets of , (IR) 5 mg were documented as administered from at 6:00 p.m., through at 12:50 p.m. Review of the facility's investigation revealed: A statement by the Consultant Pharmacist dated which indicated: Pharmacy received a request for Resident #1 for 10/325mg, 1 tab po 4 times daily 120 tabs dispensed. Previous order for 120 tabs was filled on , which is a 30 day supply. Saw that it was not due to be refilled until (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 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 for example, 11 doses were	N0204		

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N0204 SS = E	Continued from page 9 signed out. I reported this to Staff E and the 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 at 12:42 p.m., in an interview the Director of Nursing (DON) said on RN Staff E reported that the Pharmacy Consultant identified what they believed to be an error in a count for Resident #1. The DON said she and RN Staff E counted how many tablets of 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 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 at 1:21 p.m., in an interview Registered Nurse (RN) Staff E said he reordered the 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 medication ordered daily. RN Staff E said he reported it to the DON and didn't know what happened after that. On 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 and found the following concerns: With Resident #4's 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	N0204		

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N0204 SS = E	Continued from page 10 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. On 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. Class III	N0204		