STATE	FOR MEDICARE & MEDICAID  MENT OF DEFICIENCIES  PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 106059	٩	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		OMB NO. 0938-0391	
	DE PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	ANS NURSING HOME	1	TREET ADDRESS, CITY, STATE, ZIP COL 1281 GRAYTON TERRACE, PORT CHAR		54	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREF TAG		I SHOULD BE TO THE	(X5) COMPLETION DATE	
F0000	2025008722 and 202500491 Douglas Jacobson State Vet- home in Port Charlotte, Florid	erans Nursing Home, a nursing da. erans Nursing Home is not in deral Regulations (CFR) 42,	F0000				
F0600 SS = D	but its not limited to freedom involuntary and an not required to treat symptoms.  §483.12(a) The facility must- §483.12(a)(1) Not use verbal	Neglect, and . be free from resident property, and subpart. This includes from corporal punishment, y physical or chemical the resident's medical the resident's medical . , or ishment, or involuntary . MET as evidenced by: rds review and interviews, e resident's right to to ensure 1 (Resident	F060C				
	Review of the Facility's "	, Neglect and					
safeguards days followi	provide sufficient protection to t ing the date of survey whether of e date these documents are ma	the patients. (See reverse for further or not a plan of correction is provided	instruction in Form	astitution may be excused from correcting p ctions.) Except for nursing homes, the findir sursing homes, the above findings and plan re cited, an approved plan of correction is re	igs stated above are of s of correction are dis	disclosable 90 closable 14 days	

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Facility ID: 35960995

		(X1) PROVIDER/SUPPLIER	/CLIA	- 1	OWN THE TOTAL PROPERTY OF THE		
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106059			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPL A. BUILDING B. WING			
NAME OF I	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP COD	E	
DOUGLAS	JACOBSON STATE VETER	ANS NURSING HOME		2128	B1 GRAYTON TERRACE , PORT CHAR	LOTTE, Florida, 3395	54
(X4) ID PREFIX TAG	SUMMARY STATEME! (EACH DEFICIENCY MUS' REGULATORY OR LSC IDE			ID REFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
SS = D	policy (last revised ) failure to provide goods and avoid physical harm, mental ilmess." The policy noted und "identify, correct and interven ,neglect and/or resident property is more like facility policy noted to, 'dentificatility noted admitted to Diagna and over the clinical record admitted on Diagna and over Review of the	anguish, or mental ere "prevention" to, e in situation in which "misappropriation of ly to occur". The fy the staff by involved, and any outcome revealed Resident #2 was sees included active dated scored "14", indicative of imum Data Set (MDS) e of revealed of The ired partial dispersion or night hygiene.	FC	D600	APPROPRIATE DEFICI	ency)	
	Review of the facility's grieva revealed on the facility investigation when Resident all night for help and no one	initiated a neglect #2 complained about calling					
	Review of facility investigation	n revealed:					
	said she entered Resident #2	ated that he was calling					

RVICES OMB NO. 0938-0391

	EMENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 106059	IA		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVE	EY COMPLETED
	OF PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	RANS NURSING HOME			REET ADDRESS, CITY, STATE, ZIP COD 81 GRAYTON TERRACE, PORT CHAR		54
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)		D FIX NG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0600 SSS = D	room to provide personal cas said he was not going to get came, because he spent all came to help him. His and found that his pull up was the provided of the provided his pull that he said that he sai	ed Nursing Assistant) if it do met that him and the sident #2) at 1:00 a.m.*.  If she entered the resident's read to 55 5 am. Resident #2 out of bed until the nurse night calling, and no one was full. She emptied it is wet.  But that on at around that he was upset and cause he tried calling the swet.  If N, RN Staff O and RN Staff ident #2 stated, "Nobody needed help."  If N, RN Staff O and RN Staff ident #2 stated, "Nobody needed help."  If N, RN Staff O and RN Staff ident #2 stated, "Nobody needed help."  If N, RN Staff O and RN Staff ident #2 stated during the stated wing the stated wing the 11:00 p.m. of fire stated that he was red out of bed, asking for 3 times throughout the son assist due to moded to his needs re 7:00 a.m., to 3:00 p.m. all, and his bed and statements and the occurrence, there noce to disprove Resident Vol p.m. to 7:00 a.m. was re and returned pending	F06	00			
	On at 10:03 a.m. I Administrator (NHA) said the	he Nursing Home investigation found that					

	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 106059	IA .	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURV	EY COMPLETE
	OF PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	ANS NURSING HOME	1	TREET ADDRESS, CITY, STATE, ZIP C 1281 GRAYTON TERRACE, PORT CH		954
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE D TO THE	(X5) COMPLETIO DATE
=0600 SS ≈ D	Continued from page 3 Resident #2 did receive acre CNAs, 2 nurses and the CNV staff had been in Resident #2 throughout the right. The NH #2 was found that morning w bed. The NHA also said that should have noted the negle for intake and output records documentation because they they empty	k in question statements, 2s room multiple times A confirmed that Resident ith a full and wet the report they submitted a su unvertified. When asked t, they said there is no don't document every time	F0600			
	said, "night shift is very bad I and they don't come". Reside the night shift between 11 p. #2 said he "made a mess" re	ent #2 said "it is always n. and 7 a.m.". Resident cently when he had an ident #2 said the sheet, ked. Resident #2 said the				
	Resident #2 was unable to id	lentify the nurse.		***************************************		
	said CNAs are responsible for residents. When asked how are checked, Staff Ks aid we anytime the resident needs it Resident #2 uses the bathrou hit the call light if he needs for he will ask for help if he feels Resident #2 is in the chair in lift his hat in the air when he bathroom, Staff K said Resid when he is when he is when he is when he is when he is when he is	often residents check after every meal and check after every meal and When asked about how Staff K said if the will go. Staff K also said wet. Staff K said if the common room, he will needs to go to the ent #2 uses a nd in bad. Staff K showed it in the system where be documented for				
	said nurses and CNAs are re residents. Staff L	said that documentation e computer, CNA Staff L umented in the progress #2 "is someone we d Resident #2 was "with te needs to be changed wn". When asked if there				

	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER: 106059	.IA		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLE	
	OF PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	RANS NURSING HOME			REET ADDRESS, CITY, STATE, ZIP COI B1 GRAYTON TERRACE, PORT CHAR		54
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFIC	SHOULD BE TO THE	(X5) COMPLETION DATE
F0600 SS = D	Continued from page 4 being soaked in the morning 7:00 a.m., Staff L said, "I'd b Staff L said, "I'd b Staff L said they will come in overflowing and beds are so call lights are all on and flick explained that the light abov the longer they have been of around when they are flicker During an interview on Staff M said nurses and CN/residents. Staff M said checked every 2 hours and 4 document the output in the residue. The said, "we document refusals said," we document refusals between the said, "we document refusals between the said," we document refusals when the said we document refusals the said we said the said when the said we said the said we said the said we said and the said we said and the said we said the said we sa	e lying if I said no", and " are aking wer". Staff L said the ering fast. Staff L at 12-12 p.m. LPN As check.  at 12-12 p.m. LPN As check residents are residents are solvents are solvents and no said CNAs esidents of the said CNAs exit of the said con not 10-10 p.m. PN) Staff J said con not 22 at the beginning and CNAs were going in and aff J said Resident #2 th' When asked what that #2 was verbally resistant ked if refusals were	FO	600			
	shift of	output record, intake level of control with through falled to ident #2's function, d on for the night tot contain refused care during the night in an interview the					
	On at 2:42 p.m., in Home Administrator (NHA) s responsible for checking asked what the process is what a resident didn't receive NHA said it should be report said if it is a neglect issue, it management, the Director or	care, the ed to a supervisor. The NHA goes to risk					

		SERVICES				DMB NO. 0938-03	
	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 106059	A	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SUR	(X3) DATE SURVEY COMPLETED	
	OF PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	ANS NURSING HOME	1	STREET ADDRESS, CITY, STATE, ZIP CO 11281 GRAYTON TERRACE, PORT CHA		3954	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREF TAC		ON SHOULD BE D TO THE	(X5) COMPLETIO DATE	
F0600 SSS = D	#Z's neglect and the lack of care provided on shift. The NHA and DON sai planned for 'confabulation.'' and documentation fat he lack of documentation fat (evening) (evening a and night), (day, evening and night), (day and night), right), (day and night). Free from Misappropriation/ CFR(s): 483.12  \$483.12  The resident has the right to neglect, misappropriation of a defined in this but is not limited to freedom involuntary and an	seciving care and attention sked about the lack of led, the NHA stepped out of led, th	F0602	0	JENCY)		
	This REQUIREMENT is NOT Based on record review and failed to protect the residents misappropriation of resident's have effective processes in p misappropriation of controlle (Residents #1 and #4) of 3 re	interview, the facility I' right to be free from Is property by failing to Iace to prevent the Id substances for 2					
	The findings included:						
	Review of the facility's policy and /Misappropri with a revision date of and Misappropriation of Resi	ation of Resident Property revealed ,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTIONS A BUILDING 106059 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE DOUGLAS JACOBSON STATE VETERANS NURSING HOME 21281 GRAYTON TERRACE . PORT CHARLOTTE, Florida, 33954 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DATE APPROPRIATE DEFICIENCY) E0602 Continued from page 6 F0602 deliberate misplacement, wrongful, temporary or SS = E 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 ma/325 ma (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., at 6:00 a.m., revealed 44 tablets of 10 mg/325 mg had been administered during that time frame. 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

Facility ID: 35960995

CENTERS	FOR MEDICARE & MEDICALD	SERVICES				- On	IB NO. 0938-039
	EMENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER: 106059	LIA	(X2) M A. BUII B. WIN		(X3) DATE SURVI	EY COMPLETED
NAME (	OF PROVIDER OR SUPPLIER		Т	STREET A	DDRESS, CITY, STATE, ZIP COI	DE	
DOUGL	AS JACOBSON STATE VETER	ANS NURSING HOME		21281 GRA	YTON TERRACE , PORT CHAR	LOTTE, Florida, 339	54
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	PRE TA	FIX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFIC	SHOULD BE TO THE	(X5) COMPLETION DATE
F0602 SS = E	Continued from page 7 days:		F060	02			
	The first dose of administered on at 1	- 10 mg/ 325 mg was 2:00 p.m.					
	The last dose of administered 11 days later o	- 10 mg/325 mg was n at 12:00 a.m.					
	Review of the "Administration" - 10 mg/32! to at 12:00 a.m., reve - 10 mg/32! during that time frame.	mg from at 12:00 p.m.,					
	The doses of documented as "missed" on p.m.), and (6:00 p.m.)	(12:00 p.m., and 6:00		***************************************			
	The "Controlled Substance F #1 and #2 of multiple dates had been scri- making it illegible or difficult if for the doses of administered.	obled or written over o make out the date					
	count was correct. However, Resident #1 received 8 or 11 10 mg/32	they discovered 'so was requested and 'ormed the facility it was 120 tablets of img (30 day supply) were e physician's order for '2325 mg was to administer 1 medication was not due for '#15 should have lets daily. The Pharmacy noce record of use and lesident #1 received more - 10 mg/325 mg. The compared the count d substance record of use age of medications), the some days it looked like doses of the ing when he should have only					
	received 4 per day. The decli sheets looked like there were	dates changed, scribbled					
ORM OM	IS-2567 / Provinge Version	e Obsolete Ev	agent ID:	T1RI 11	Facility ID: 35960995	If continuation (	to R and I tood:

CENTERS F	FOR MEDICARE & MEDICAID	SERVICES				OM	IB NO. 0938-0391
	MENT OF DEFICIENCIES LAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 106059	A		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVE	EY COMPLETED
NAME OF	F PROVIDER OR SUPPLIER	·	Т	STR	F		
1	S JACOBSON STATE VETER	ANS NURSING HOME			EET ADDRESS, CITY, STATE, ZIP COD B1 GRAYTON TERRACE , PORT CHARI		5.4
DOUGLA	O MOODOON OINIE TETEN	AND NOTION OF TOME		- 1-1	or other for the fact of the other		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED' APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0602 SS = E	said during their investigations similar issue with the , ma The Administrator said there residents, and they did not go medication.  Review of the clinical record a physician's order for tablet every 6 hours for non-tablet every 6 hours for ev	iot catching that it was es per day. The Administrator they discovered a didication for Resident #4, were no ill effects to the o without their scheduled for Resident #4 revealed (IR) 5 mg , 1 could be seen that the scheduled for Resident #4 revealed (IR) 5 mg were dent #4. Multiple dates making it difficult to see on the controlled on the scheduled for the scheduled fo	F06	602	APPROPRIATE DEFICI	ENCY)	
	was filled on , which i that it was not due to be refill from last fill). In the morning i						

......

CENTERS	FOR MEDICARE & MEDICAID	SERVICES				ON	IB NO. 0938-0391
	EMENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 106059	.IA		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVE	Y COMPLETED
1	OF PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	RANS NURSING HOME			REET ADDRESS, CITY, STATE, ZIP COI 81 GRAYTON TERRACE, PORT CHAR		54
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	PR	ID EFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0602 SS = E	technically 8 days early for fi documentation and found me than 4 tablets taken. On signed out. I reported this to supervisor (do not remembe tell the Director of Nursing (if went to the DON's office and with reviewing the tracking as the concern, more tablets be prescribed.  On at 12:42 p.m., in of Nursing (ION) said on that the Pharmacy Consultabelleved to be an error in a Resident #1. The DON said how many tablets. She said so count was accurate. The DO Consultant showed her the pard pointed out the dates. It medication was signed out of day. The order was for 1 table counting the days, there sho 25 tablets in the first was signed out of and the Risk Manager Found and the Risk Manager Found and the Risk Manager Found 1 do so the significant of the refined significant of the Risk Manager Found 1 do so the Risk Manager Found 2 do so the Risk Manager Found 1 do so the Risk Manager Found	ntill at the soonest, exceeding orders that would anding order and there was so for any PRN orders and found none. The order was liling, I reviewed to the utilities, I reviewed to the utilities, I reviewed to the utilities, I reviewed to the soon soon and the property of the property o	FOI	602			

FORM APPROVED

ENTERS	FOR MEDICARE & MEDICAID	SERVICES				OM	IB NO. 0938-039
	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 106059	IA		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVE	EY COMPLETED
NAME O	F PROVIDER OR SUPPLIER		Т	STR	EET ADDRESS, CITY, STATE, ZIP COD	E	
DOUGLA	AS JACOBSON STATE VETER	RANS NURSING HOME			81 GRAYTON TERRACE , PORT CHAR		54
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
======================================	was all right but found conce #1. She said these instances Practical Nurse (LPN) Staff. Administration met with LPN discrepancies on the control administration documents. L multiple of the signatures we not recall who she signed of events. LPN Staff A also star multiple dates on several of When asked why she would have made a mistake." The IStaff A was adament that sh and also denied over medica when the presented LPN Stamtliple discrepancies, she to began to cry. LPN Staff A retreatment program in lieu of of nursing.  On at 4 p.m., in an is said LPN Staff A was no lon facility, the incident was report.	all related to Licensed A. She said she and the Staff A regarding multiple led substances PN Staff A claimed that re not here and she could fon her cart for multiple act that she had changed the medication documents, do that she stade, if, must less Manager said that LPN less Manager said find with the vedience of secame overwhelmed and upeased to undergrea for multiple said that with the vedience of the said that was that he board that was put in place and les logs were legible and ell to ensure documentation	F06	602			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER: 130471029			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVI 06/25/2025	NTE SURVEY COMPLETED	
PROVIDER OR SUPPLIER S JACOBSON STATE VETER	ANS NURSING HOME	1			54	
(EACH DEFICIENCY MUST	F BE PRECEDED BY FULL	ID PREFI) TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED	N SHOULD BE TO THE	(X5) COMPLETION DATE	
INITIAL COMMENTS		N0000				
2025008722 and 202500491 Douglas Jacobson State Vete	4 was conducted on at erans Nursing Home, a nursing					
Deficiencies were identified a	at the time of survey.					
Right to be Free from ,	, etc	N0204				
CFR(s): 400.022(1)(o), FS						
and make public a statement responsibilities of the resident and shall treat such residents provisions of that statement.	of the rights and its of such facilities in accordance with the The statement shall					
punishment, extended involun- corporal puni- involuntary and ph except those writing by a physician for a speriod of time or as are nece- in case of an emergency, by a qualified licensed nurse- writing the circumstances req- and, in the case of in the case of in- tercept of the companies of the con- supervision or merely for staff punishment, or for reasons of protection or safety.  This LICENSURE REQUIRE!	. corporal  hary and  shment, extended  yssical and chemical  authorized in  beefiled and limited  ssittled by an emergency,  may be applied only  who shall set forth in  juiring the use of  see of a chemical  consulted immediately  be used in lieu of staff  f convenience, for  ther than resident	c				
	EPROVIDER OR SUPPLIER  S JACOBSON STATE VETER  S JACOBSON STATE VETER  S JACOBSON STATE VETER  S JACOBSON STATE VETER  (EACH DEFICIENCY MUS)  REGULATORY OR LSC IDE  INITIAL COMMENTS  An unannounced complaint s 20250059722 and 202500491  Douglas Jacobson State Veter home in Port Charlotte, Floric  Deficiencies were identified a Right to be Free from  CFR(e): 400.022(1)(o), FS  400.022, F. S. (1)(o)  All licensees of nursing home and make public a statement responsibilities of the resident provisions of that statement. assure each resident the folic punishment, extended involuntary  (o) The right to be free from many companies of the statement assure each resident the folic punishment, extended involuntary  EXCEPTION OF THE STATE OF THE S	IDEN II ICATION NUMBER: 130471029  PROVIDER OR SUPPLIER  S JACOBSON STATE VETERANS NURSING HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  An unannounced complaint survey for complaints number 2025009722 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. 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 involuntant, extended involuntary or those push those pus	LAN OF CORRECTIONS  IDENTIFICATION NUMBER: 130471029  SPROVIDER OR SUPPLIER S JACOBSON STATE VETERANS NURSING HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  An unannounced complaint survey for complaints number 2025006722 and 2025004914 was conducted on at Douglas Jacoboson State Veterans Nursing Home, a nursing home in Port Charlotte, Florida.  Deficiencies were identified at the time of survey. Right to be Free from , etc N0204  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 har enidents 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 , corporal punishment, extended involuntary , and , corporal punishment, extended involuntary and , and in the case of use of a chemical , and in the case of use of a chemical , a physician for a specified and limited period of time or as are necessited by an emergency in case of an emergency in a period of time of for reasons on the rhan resident protection or safety.  This LICENSURE REQUIREMENT is NOT MET as evidenced by	DENTIFICATION NUMBER:  130471029  A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COI 21281 GRAYTON TERRACE, PORT CHAF SJACOBSON STATE VETERANS NURSING HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  An unannounced complaint survey for complaints number 2025008722 and 2025004914 was conducted on at Douglas Jacoboson State Veterans Nursing Home, a nursing home in Port Charlotte, Florida.  Deficiencies were identified at the time of survey. Right to be Free from , etc  CFR(s): 400.022(1)(c), FS  400.022, F. S. (1)(e)  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 , corporal punishment, extended involuntary and physical and involuntary and physical punishment, extended involuntary and physical and involuntary and physical physical physical physical physical physical 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	LAN OF CORRECTIONS  IDENTIFICATION NUMBER: 130471029  A BUILDING BUING  PROVIDER OR SUPPLIER  S JACOBSON STATE VETERANS NURSING HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCECED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  An unannounced complaint survey for complaints number 2025006722 and 2025004914 was conducted on at Douglas Jacobion State Veterans Nursing Home, a nursing home in Port Charlotte, Florida.  Deficiencies were identified at the time of survey. Right to be Free from , etc N0204  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. 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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 130471029	A. BUILDING B. WING  (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ( 06/25/2025				
	F PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	RANS NURSING HOME	1		EET ADDRESS, CITY, STATE, ZIP COI 1 GRAYTON TERRACE , PORT CHAR		954
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFIC	SHOULD BE TO THE	(X5) COMPLETIO 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' properly by fishing to ensure 1 (Resident #2) of 3 residents reviewed received. Care to meet their needs and failing to insure 1 forestending to prove the meet standard to prove the message properties of controlled substances for 2 (Residents #1 and #4) of 3 residents reviewed.		N020	14			
	The findings included:						
	The findings included:						
		anguish, or mental fer "prevention" to, te in situation in which /misappropriation of bly to occur". The ffy the staff		***************************************			
	Review of the clinical record admitted on Diagn 's and over	oses included ,					
	Review of the revealed Resident #2 intact cognition.	scored "14", indicative of					
	Review of the Discharge Min assessment with a target da' Resident #2 was frequently MDS noted the resident requested for "sit to stand" a touching assistance for toilet	te of revealed of .The sired partial/ and supervision or					
	Review of the care plan Resi "Problem: (Resident #2) may R/T (related to) . (Resident #2) is	experience ,		***************************************			

Florida Sta	te Department of Health								
	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 130471029	IA	RVEY COMPLETED					
	OF PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	RANS NURSING HOME	1	STREET ADDRESS, CITY, STATE, ZIP CODE 21281 GRAYTON TERRACE, PORT CHARLOTTE, Florida, 33954					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE D TO THE	(X5) COMPLETION DATE			
N0204 SS ≖ E	Continued from page 2 The approaches included 2 at bedside for large nighttime output.		N0204	4					
	Review of the facility's grieva revealed on the facility investigation when Resident all night for help and no one	y initiated a neglect #2 complained about calling							
	Review of facility investigation	n revealed:		Na					
	said she entered Resident #	tated that he was calling came. Once getting him up and his bed was [sic] led Nursing Assistant) if lid me that him and the							
	room to provide personal car said he was not going to get came, because he spent all	out of bed until the nurse night calling, and no one was full. She emptied it							
	The Medical Record Clerk sa 7:30 a.m., Resident #2 said wanted to file a complaint be staff all night because he wa	that he was upset and cause he tried calling the							
	Registered Nurses (RN) Star P when interviewed said Res cared for me last night, and i								
	The investigation noted Resi agitated during morning shift down when he receives care	change and quickly calms							
	The facility's investigation or allegation of neglect was ver that he did not receive care of 7:00 a.m. shift on . Sta awake most of the night, in a food, and being toileted 1 to night. Resident #2 is a 2-pen	ified. Resident #2 stated during the 11:00 p.m., to siff stated that he was and out of bed, asking for 3 times throughout the							

	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 130471029	Ą	/	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/25/2025	
	DF PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	RANS NURSING HOME	1		EET ADDRESS, CITY, STATE, ZIP COI 1 GRAYTON TERRACE, PORT CHAF		954
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N0204 SS ≂ E			N020	04			
	disciplinary actions.  On at 10:03 a.m. Administrator (NHA) said the Resident #2 did receive care CNAs, 2 nurses and the CN, staff had been in Resident #4 throughout the night. The NH #2 was found that morning when the night is the night in the night i	eave and returned pending  m. the Nursing Home the investigation found that are. The NHA said between 4 NA in question statements, if 25 room multiple times NHA confirmed that Resident yoth a full and wet at the report they submitted gloct as unverified. When asked		***************************************			
	said, "night shift is very bad l and they don't come". Reside the night shift between 11 p.: #2 said he "made a mess" re	ent #2 said "it is always m. and 7 a.m.". Resident ocently when he had an sident #2 said the sheet, aked. Resident #2 said the		***************************************			
	Resident #2 was unable to id	dentify the nurse.					
	On at 11:10 a.m., said CNAs are responsible for residents. When asked how are checked, Staff K said we anytime the resident needs it Resident #2 uses the bathro hit the call light if he needs to he will ask for help if he feels Resident #2 is in the chair in lift his hat in the air when he bathroom. Staff K said Resident #2 is 10 the chair in lift his hat in the air when he	often residents check after every meal and check after every meal and t. When asked about how om, Staff K said if he will o go. Staff K also said s wet. Staff K said if the common room, he will needs to go to the		***************************************			

rioliua Stat	e Department of Health							
	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 130471029	1 ' '			(X3) DATE SURVE 06/25/2025	TE SURVEY COMPLETED 025	
	F PROVIDER OR SUPPLIER	ANS NURSING HOME	1		REET ADDRESS, CITY, STATE, ZIP COE B1 GRAYTON TERRACE , PORT CHAR		54	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	PRE		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE	
N0204 SS = E	documentation of outpot small, medium and large can output, CNA Staff K said, "I p color".  On at 12:05 p.m., said nurses and CNAs are re residents. Staff L	ut in the amount and  in an interview CNA Staff L sponsible for checking said that documentation e computer. CNA Staff L umented in the progress 12 ris somone we 14 Resident #2 was "with the needs to be changed m". When asked if there the hand in the progress 19 long if I said of the staff of the staff are string sat. Staff L staff N scheck fresidents are s needed. Staff M said CNAs staff Staff L staff M said CNAs staff Staff L staff M said Staff A staff M said Staff Staff chant Staff M staff Staff Staff M staff Staff Staff Staff chant Staff M staff St	N02	04				

Florida Sta	te Department of Health						
	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 130471029	LIA         (X2) MULTIPLE CONSTRUCTION         (X3) DATE SURVE           A. BUILDING         06/25/2025           B. WING				EY COMPLETED
	OF PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	RANS NURSING HOME	1		REET ADDRESS, CITY, STATE, ZIP COI 81 GRAYTON TERRACE, PORT CHAR		954
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N0204 SS ≖ E	Continued from page 5 documentation Resident #2 shift of	refused care during the night	N020	)4			
	On at 12:37 p.m., Director of Nursing (DON) se documentation.	in an interview the aid there was no policy for					
	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 if should be reported to a supervisor. The NHA said if it is a neglect issue, it goes to risk management, the Director of Nursing (CON) and then herself. The NHA sald based on staff statements, Resident 42 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.						
	#2's neglect and the lack of care provided on shift . The NHA and DON sa planned for "confabulation." and documentation in the lack of documentation Rear during the care during the cyening a (evening a (evening)	It the DON to discuss Resident documentation during the night id Resident #2 was care The DON reviewed the for Resident #2 and verified seldent #2 and verified also was care may be a seldent #2 and verified also was care in a seldent #2 received also was a seldent #2 received also was a seldent #2 received and registry, (evening and night), (evening and ight), (evening and jight), (evening and jight), (evening and					
	Review of the facility's policy and , /Misappropr with a revision date of and Misappropriation of Res deliberate misplacement, wr permanent use of a resident resident consent. Examples client/resident.	iation of Resident Property revealed , ident Property means a ongful, temponary or 's belongings without the					
	Review of the clinical record a physician's order for (Controlled substance), 1 tal	<ul> <li>10 mg/325 mg</li> </ul>					

Florida Sta	te Department of Health							
	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 130471029	A		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURV 06/25/2025	URVEY COMPLETED	
	OF PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	RANS NURSING HOME	1	STREET ADDRESS, CITY, STATE, ZIP CODE 21281 GRAYTON TERRACE, PORT CHARLOTTE, Florida, 33954				
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N0204 SS = E			N02	04				
	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 administered on at 6	- 10 mg/325 mg was :00 a.m.						
		- 10 mg/325 mg was 5:00 a.m.						
	Review of the "Administration" - 10 mg/32! to at 6:00 a.m., reve	5 mg from at 6:00 a.m.,						
	The doses of documented as "missed" on p.m.), (6:00 a.m., an (6:00 a.m.).	10 mg/325 mg were (12:00 p.m., and 6:00 d 12:00 p.m.) and						
	Review of the "Controlled Substance Record of Use" for pack #2 for Resident #1 revealed the 60 tablets of							
	The first dose of administered on at 1	- 10 mg/ 325 mg was 2:00 p.m.						
	The last dose of administered 11 days later o	- 10 mg/325 mg was n at 12:00 a.m.						

Iorida State	e Department of Health							
	MENT OF DEFICIENCIES LAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 130471029	IA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE*  A. BUILDING 06/25/2025  B. WING				EY COMPLETED	
	F PROVIDER OR SUPPLIER	ANS NURSING HOME	1	STREET ADDRESS, CITY, STATE, ZIP CODE 21281 GRAYTON TERRACE , PORT CHARLOTTE, Florida, 33954				
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N0204 SS = E			N020	04				
	discrepancies in Resident #1 mg when a refill of the medic the Pharmacy Consultant into soson for a refill. On mg/32! delivered for Resident #1. The the a refill when a refill while a refill while a refill until received a maximum of 4 tat audited the controlled substate found that on multiple days fround that on multiple days fround that on multiple while administrator said when you documented on the controlled against the pack (pad count was correct. However, Resident #1 received 8 or 1 mg/32! received 4 per day. The decil sheets looked like there were out, started on a previous documented nor a previous documented more than 4 time.	they discovered 1so 2, 10mg/325 station was requested and office a						
	said during their investigation similar issue with the , m The Administrator said there residents, and they did not g , medication.	n they discovered a edication for Resident #4. were no ill effects to the						

Florida Stat	e Department of Health							
	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 130471029	CLIA         (X2) MULTIPLE CONSTRUCTION         (X3) DATE SURVEY COID           A. BUILDING         06/25/2025           B. WING         (X3) DATE SURVEY COID					
	F PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	ANS NURSING HOME	1		DDRESS, CITY, STATE, ZIP CO YTON TERRACE , PORT CHA		954	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCEI APPROPRIATE DEFIN	N SHOULD BE O TO THE	(X5) COMPLETION DATE	
NO204 SS = E	were scribbled or written over make out or flieighte. The dissubstance record of use wer controlled substance record on the substance record on the substance record may was administered on to administration of the substance record may be a substance record may be a substance on the substance of	stance record of use (IR) 5 mg , 1  stance record of use (IR) 5 mg were dent #4. Multiple dates rmaking it difficult to see on the controlled e not in order. The of use showed , then the went 5 mg on  (IR) 5 mg was administered sablets of indicating 50 tablets of indicating 50 tablets of pack had been signed p.m., and at 12:50  History for the s of (IR) 5 mg stered from at 6:00 p.m. igation revealed:  Int Pharmacist dated seelved a request for 255mg, 1 tab p 4 times	N0204	4 4	APPROPRIATE DEFI	JENCY)		
	that it was not due to be reflif from last fill). In the morning supervisor Staff E called to it and I told him it wasn't due u I checked for any PRN (as nequate to more use of the st none. RN Staff E checked als	is a 30 day supply. Saw led until (28 days Registered Nurse (RN) nquire about the refill intil at the sconest, seeded) orders that would anding order and there was so for any PRN orders and found none. The order was ling, I reviewed the little days that had more						

					1			
	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130471029	LIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMF A. BUILDING 06/25/2025 B. WING					
	F PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	ANS NURSING HOME	3	STREET ADDRESS, CITY, STATE, ZIP CODE 21281 GRAYTON TERRACE , PORT CHARLOTTE, Florida, 33954				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	MMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTIO CROSS-REFERENCE APPROPRIATE DEFIC	N SHOULD BE TO THE	(X5) COMPLETION DATE		
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 35:0 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.		N0204					
	On at 12:42 p.m., in of Nursing (DON) said on that the Pharmacy Consultan believed to be an error in a Resident #1. The DON said town many labels of the pharmacy and the pharmacy Consultant shows the pharmacy consult	count for she and RN Staff E counted had been given. 120 yers administered with 5 staff E and her felt the N said the Pharmaey ages from the book sowed on certain days the 7, 10 or 11 times in one et 4 times a day. In uld have been approximately only 5. The DON said						
	Nurse (RN) Staff E said he no for Resident #1. The pharmat not due for a refill yet. When reviewed the controlled substituted found that Resident #1 had to	cy said the medication was the Pharmacy Consultant tance record of use, he been receiving more than the rdered daily. RN Staff E						
	Manager (RM) said the facilit the controlled substance log-							
	With Resident #4's med was all right but found conce #1. She said these instances Practical Nurse (LPN) Staff Administrator met with LPN discrepancies on the control administration documents. Li multiple of the signatures we not recall who she signed off	all related to Licensed A. She said she and the Staff A regarding multiple led substances PN Staff A claimed that re not hers and she could						

	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 130471029	CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETE 06/25/2025	
	NAME OF PROVIDER OR SUPPLIER DOUGLAS JACOBSON STATE VETERANS NURSING HOME			TREET ADDRESS, CITY, STATE, ZIP C 281 GRAYTON TERRACE, PORT CH		3954
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI: TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTI CROSS-REFERANCE APPROPRIATE DEF	ON SHOULD BE ED TO THE	(X5) COMPLETIO DATE
N0204 \$SS = E	said LPN Staff A was no long facility, the incident was repo	the medication documents, do that she state, 'I must visit Manager said that LPN e 'Idi not take any pills' titing any resident. She said iff A with the evidence of became overwhelmed and quested to undergo a drug notifying the state board their view the Administrator ger employed at the treat to law enforcement, cy and the Board of Nursing. A lan was put in place and re logs were legible and ell to ensure documentation	N0204			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS  (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 130471029  (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COM 06/25/2025  B. WING					EY COMPLETED			
PROVIDER OR SUPPLIER S JACOBSON STATE VETER	ANS NURSING HOME	1	STREET ADDRESS, CITY, STATE, ZIP CODE 21281 GRAYTON TERRACE, PORT CHARLOTTE, Florida, 33954					
(EACH DEFICIENCY MUST	F BE PRECEDED BY FULL	ID PREFI) TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED	N SHOULD BE TO THE	(X5) COMPLETION DATE			
INITIAL COMMENTS		N0000						
2025008722 and 202500491 Douglas Jacobson State Vete	4 was conducted on at erans Nursing Home, a nursing							
Deficiencies were identified a	at the time of survey.							
Right to be Free from ,	, etc	N0204						
CFR(s): 400.022(1)(o), FS								
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punishment, extended involun- corporal puni- involuntary and ph except those writing by a physician for a speriod of time or as are nece- in case of an emergency, by a qualified licensed nurse- writing the circumstances req- and, in the case of in the case of in- tercept of the companies of the con- supervision or merely for staff punishment, or for reasons of protection or safety.  This LICENSURE REQUIRE!	. corporal  hary and  shment, extended  yssical and chemical  authorized in  beefiled and limited  ssittled by an emergency,  may be applied only  who shall set forth in  juiring the use of  see of a chemical  consulted immediately  be used in lieu of staff  f convenience, for  ther than resident	c						
	EPROVIDER OR SUPPLIER  S JACOBSON STATE VETER  S JACOBSON STATE VETER  S JACOBSON STATE VETER  S JACOBSON STATE VETER  (EACH DEFICIENCY MUS)  REGULATORY OR LSC IDE  INITIAL COMMENTS  An unannounced complaint s 20250059722 and 202500491  Douglas Jacobson State Veter home in Port Charlotte, Floric  Deficiencies were identified a Right to be Free from  CFR(e): 400.022(1)(o), FS  400.022, F. S. 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The statement shall assure each resident the following:  (o) The right to be free from mental and , corporal punishment, extended involuntary and physical and involuntary and physical punishment, extended involuntary and physical and involuntary and physical physical physical physical physical physical 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	LAN OF CORRECTIONS  IDENTIFICATION NUMBER: 130471029  A BUILDING BUING  PROVIDER OR SUPPLIER  S JACOBSON STATE VETERANS NURSING HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCECED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  An unannounced complaint survey for complaints number 2025006722 and 2025004914 was conducted on at Douglas Jacobion State Veterans Nursing Home, a nursing home in Port Charlotte, Florida.  Deficiencies were identified at the time of survey. Right to be Free from , etc N0204  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 , corporal punishment, extended involuntary , and , corporal punishment, extended involuntary and , corporal punishment, or as are necessitated by an emergency, in as each are as a punishment of the rase			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

				Т		I		
	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 130471029	LIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY CO A. BUILDING 06/25/2025 B. WING					
	F PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	RANS NURSING HOME	1	STREET ADDRESS, CITY, STATE, ZIP CODE 21281 GRAYTON TERRACE , PORT CHARLOTTE, Florida, 33954				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFIC	SHOULD BE TO THE	(X5) COMPLETIO 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.		N020	14				
	The findings included:							
	The findings included:							
		anguish, or mental fer "prevention" to, te in situation in which /misappropriation of bly to occur". The ffy the staff		***************************************				
	Review of the clinical record admitted on Diagn 's and over	oses included ,						
	Review of the revealed Resident #2 intact cognition.	scored "14", indicative of						
	Review of the Discharge Min assessment with a target da' Resident #2 was frequently MDS noted the resident requested for "sit to stand" a touching assistance for toilet	te of revealed of .The sired partial/ and supervision or						
	Review of the care plan Resi "Problem: (Resident #2) may R/T (related to) . (Resident #2) is	experience ,		***************************************				

Florida Sta	te Department of Health								
	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 130471029	IA	RVEY COMPLETED					
	OF PROVIDER OR SUPPLIER AS JACOBSON STATE VETER	RANS NURSING HOME	1	STREET ADDRESS, CITY, STATE, ZIP CODE 21281 GRAYTON TERRACE, PORT CHARLOTTE, Florida, 33954					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE D TO THE	(X5) COMPLETION DATE			
N0204 SS ≖ E	Continued from page 2 The approaches included 2 at bedside for large nighttime output.		N0204	4					
	Review of the facility's grieva revealed on the facility investigation when Resident all night for help and no one	y initiated a neglect #2 complained about calling							
	Review of facility investigation	n revealed:		Na					
	said she entered Resident #	tated that he was calling came. Once getting him up and his bed was [sic] led Nursing Assistant) if lid me that him and the							
	room to provide personal car said he was not going to get came, because he spent all	out of bed until the nurse night calling, and no one was full. She emptied it							
	The Medical Record Clerk sa 7:30 a.m., Resident #2 said wanted to file a complaint be staff all night because he wa	that he was upset and cause he tried calling the							
	Registered Nurses (RN) Star P when interviewed said Res cared for me last night, and i								
	The investigation noted Resi agitated during morning shift down when he receives care	change and quickly calms							
	The facility's investigation or allegation of neglect was ver that he did not receive care of 7:00 a.m. shift on . Sta awake most of the night, in a food, and being toileted 1 to night. Resident #2 is a 2-pen	ified. Resident #2 stated during the 11:00 p.m., to siff stated that he was and out of bed, asking for 3 times throughout the							

	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 130471029	Ą	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR  A. BUILDING 06/25/2025  B. WING		VEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER DOUGLAS JACOBSON STATE VETERANS NURSING HOME			1	STREET ADDRESS, CITY, STATE, ZIP CODE 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)		IC PRE TA	FIX			(X5) COMPLETION DATE
N0204 SS ≂ E	SS = E confebulation 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		N020	04			
	Administrator (NHA) said the Resident #2 did receive care CNAs, 2 nurses and the CNJ staff had been in Resident # throughout the night. The NH#2 was found that morning w bed. The NHA also said that	the Nursing Home investigation found that investigation found that in the Nirth Said between 4 in question statements, 2s norm multiple times. 2s norm multiple times (the online that Resident ith a full and wet the report they submitted at as unverified. When asked is, they said there is no		***************************************			
	said, "night shift is very bad l and they don't come". Reside the night shift between 11 p.: #2 said he "made a mess" re	ent #2 said "it is always m. and 7 a.m.". Resident ocently when he had an sident #2 said the sheet, aked. Resident #2 said the		***************************************			
	Resident #2 was unable to id	dentify the nurse.					
	On at 11:10 a.m., said CNAs are responsible for residents. When asked how are checked, Staff K said we anytime the resident needs it Resident #2 uses the bathro hit the call light if he needs to he will ask for help if he feels Resident #2 is in the chair in lift his hat in the air when he bathroom. Staff K said Resident #2 is 10 the chair in lift his hat in the air when he	often residents check after every meal and check after every meal and t. When asked about how om, Staff K said if he will o go. Staff K also said s wet. Staff K said if the common room, he will needs to go to the		***************************************			

rioliua Stat	e Department of Health						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/ICLIA IDENTIFICATION NUMBER: 130471029			Ą	( X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 06/25/2025 B. WING			Y COMPLETED
NAME OF PROVIDER OR SUPPLIER DOUGLAS JACOBSON STATE VETERANS NURSING HOME			1	STREET ADDRESS, CITY, STATE, ZIP CODE 21281 GRAYTON TERRACE , PORT CHARLOTTE, Florida, 33954			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		D FIX AG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETIO DATE
N0204 SS = E	documentation of outpot small, medium and large can output, CNA Staff K said, "I p color".  On at 12:05 p.m., said nurses and CNAs are re residents. Staff L	ut in the amount and  in an interview CNA Staff L sponsible for checking said that documentation e computer. CNA Staff L umented in the progress 27 is someone we at Resident #2 was "with the needs to be changed m". When asked if there the hard of the staff at hying fill all of the hind of the	N02	04			

Florida Sta	te Department of Health								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS  (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 130471029			IA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY C A. BUILDING 06/25/2025 B. WING			EY COMPLETED		
NAME OF PROVIDER OR SUPPLIER DOUGLAS JACOBSON STATE VETERANS NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 21281 GRAYTON TERRACE , PORT CHARLOTTE, Florida, 3395					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	FIX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFIC	SHOULD BE TO THE	(X5) COMPLETION DATE		
N0204 SS ≖ E	Continued from page 5 documentation Resident #2 shift of	refused care during the night	N020	04					
	On at 12:37 p.m., Director of Nursing (DON) se documentation.	in an interview the aid there was no policy for							
		care, the ed to a supervisor. The NHA goes to risk Nursing (DON) and then on staff statements, receiving care and attention saked about the lack of ded, the NHA stepped out of							
	#2's neglect and the lack of care provided on shift . The NHA and DON sa planned for "confabulation." and documentation in the lack of documentation Rear during the care during the cyening a (evening a (evening)	It the DON to discuss Resident documentation during the night id Resident #2 was care The DON reviewed the for Resident #2 and verified seldent #2 and verified also was care may be a seldent #2 and verified also was care in a seldent #2 received also was a seldent #2 received also was a seldent #2 received and registry, (evening and night), (evening and ight), (evening and jight), (evening and jight), (evening and							
	Review of the facility's policy and , /Misappropr with a revision date of and Misappropriation of Res deliberate misplacement, wr permanent use of a resident resident consent. Examples client/resident.	iation of Resident Property revealed , ident Property means a ongful, temponary or 's belongings without the							
	Review of the clinical record a physician's order for (Controlled substance), 1 tal	<ul> <li>10 mg/325 mg</li> </ul>							

Florida Sta	te Department of Health							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130471029			A	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 06/25/2025 B. WING			Y COMPLETED	
NAME OF PROVIDER OR SUPPLIER DOUGLAS JACOBSON STATE VETERANS NURSING HOME						EET ADDRESS, CITY, STATE, ZIP CODE 11 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)		PRE	FIX	EX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
N0204 SS = E			N02	04				
	The medication was schedul day at 6:00 a.m., 12:00 p.m.,							
	for Resident #1 revealed on delivered 2 packs of 60 table 10 mg/325 mg to the facility.	ts each of						
	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 administered on at 6	- 10 mg/325 mg was :00 a.m.						
		- 10 mg/325 mg was 5:00 a.m.						
	Review of the "Administration" - 10 mg/32! to at 6:00 a.m., reve	5 mg from at 6:00 a.m.,						
	The doses of documented as "missed" on p.m.), (6:00 a.m., an (6:00 a.m.).	10 mg/325 mg were (12:00 p.m., and 6:00 d 12:00 p.m.) and						
	Review of the "Controlled Supack #2 for Resident #1 reve- - 10 mg/328 days:							
	The first dose of administered on at 1	- 10 mg/ 325 mg was 2:00 p.m.						
	The last dose of administered 11 days later o	- 10 mg/325 mg was n at 12:00 a.m.						

Florida State	e Department of Health									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS  (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 130471029  NAME OF PROVIDER OR SUPPLIER DOUGLAS JACOBSON STATE VETERANS NURSING HOME			A	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 06/25/2025 B. WING			EY COMPLETE			
			1	STR 212	DE LOTTE, Florida, 339	<b>354</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI		FIX	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
NO204 Continued from page 7 SS = E Review of the "Administration History" for the 10 mo/325 mg from at 12:00 p.m.,		N020	04							
	to at 12:00 a.m., reve-									
	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 F #1 and #2 of multiple dates had been scrii making it illegible or difficult to for the doses of administered.	bbled or written over to make out the date								
	discrepancies in Resident #1 mg when a refill of the medic the Pharmacy Consultant into soson for a refill. On mg/32! delivered for Resident #1. The the a refill when a refill while a refill while a refill until received a maximum of 4 tat audited the controlled substate found that on multiple days fround that on multiple days fround that on multiple while administrator said when you documented on the controlled against the pack (pad count was correct. However, Resident #1 received 8 or 1 mg/32! received 4 per day. The decil sheets looked like there were out, started on a previous documented nor a previous documented more than 4 time.	they discovered 1so 2, 10mg/325 station was requested and office a								
	said during their investigation similar issue with the , m The Administrator said there residents, and they did not g , medication.	n they discovered a edication for Resident #4. were no ill effects to the								

AND PLAN OF CORRECTIONS IDENTIFICATION NUMBER: AND PLAN OF CORRECTIONS IDENTIFICATION NUMBER: B. WING  NAME OF PROVIDER OR SUPPLIER DOUGLAS JACOBSON STATE VETERANS NURSING HOME  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	DRESS, CITY, STATE, ZIP CODE TON TERRACE , PORT CHARLOTTE, Florida, 33954  PROVIDER'S PLAN OF CORRECTION (X5)
DOUGLAS JACOBSON STATE VETERANS NURSING HOME 21281 GRAY  [XA) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX	TONTERRACE , PORT CHARLOTTE, Florida, 33954  PROVIDER'S PLAN OF CORRECTION (X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX)	PROVIDER'S PLAN OF CORRECTION (X5)
	(EACH CORRECTIVE ACTION SHOULD BE COMPLETIO DATE APPROPRIATE DEFICIENCY)
NO204  SS = E  Review of the clinical record for Resident #4 revealed a physician's order for (IR) 5 mg , 1 lablet 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 itilegible. 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 p.m., through at 12:50 p.m.  Review of the facility's investigation revealed:  A statement by the Consultant 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	APPROPRIATE DEFICIENCY)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 130471029			A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COME  A BUILDING 06/25/2025  B. WING						
NAME OF PROVIDER OR SUPPLIER DOUGLAS JACOBSON STATE VETERANS NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 21281 GRAYTON TERRACE, PORT CHARLOTTE, Florida, 331					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTIO CROSS-REFERENCE APPROPRIATE DEFIC	N SHOULD BE TO THE	(X5) COMPLETION DATE	
N0204 SS ≖ E	Continued from page 9 signed out. I reported this to supervisor (do not remembe tell the Director of Nursing (I went to the DON's office and with reviewing the tracking st the concern, more tablets be prescribed.	Staff E and the RN r name). They asked that I DON). Around 3:50 pm I I showed her what I found heets and she understood	N0204						
	On at 12:42 p.m., in of Nursing (DON) said on that the Pharmacy Consultan believed to be an error in a Resident #1. The DON said town many labels of the pharmacy and the pharmacy Consultant shows the pharmacy consult	count for she and RN Staff E counted had been given. 12D were administered with 5 staff E and her felt the N said the Pharmacy ages from the book sowed on certain days the 7, 10 or 11 times in one et 4 times a day. In uld have been approximately only 5. The DON said I controlled substances							
	Nurse (RN) Staff E said he no for Resident #1. The pharmat not due for a refill yet. When reviewed the controlled substituted found that Resident #1 had to	cy said the medication was the Pharmacy Consultant tance record of use, he been receiving more than the rdered daily. RN Staff E							
	Manager (RM) said the facilit the controlled substance log-								
	With Resident #4's med was all right but found conce #1. She said these instances Practical Nurse (LPN) Staff / Administrator met with LPN: discrepancies on the control administration documents. Li multiple of the signatures we not recall who she signed off	all related to Licensed A. She said she and the Staff A regarding multiple led substances PN Staff A claimed that re not hers and she could							

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 13047/1029			IA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY CON A. BUILDING 06/25/2025 B. WING				
NAME OF PROVIDER OR SUPPLIER DOUGLAS JACOBSON STATE VETERANS NURSING HOME			1	STREET ADDRESS, CITY, STATE, ZIP CODE 21281 GRAYTON TERRACE, PORT CHARLOTTE, Florida, 33954				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	SUMMARY STATEMENT OF DEFICIENCIES CCH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			N SHOULD BE O TO THE	(X5) COMPLETION DATE
N0204 SSS = E	said LPN Staff A was no long facility, the incident was repo	he medication documents, do that she stated, "must visk Manager said that LPN "did not take any pills" ting any resident. She said if a vith the evidence of lecame overwhelmed and lesested to undergo a drug including the state board titerview the Administrator per employed at the treat to law enforcement, y and the Board of Nursing. A lan was put in place and logs were legible and all to ensure documentation	N0204					