Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Veterans Home of California – Chula Vista

Location: 700 East Naples Court, Chula Vista, CA 91911

Onsite / Virtual: Onsite

Dates of Survey: 12/5/22 – 12/8/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 180

Census on First Day of Survey: 144

VA Regulation Deficiency	Findings
	Initial Comments: An Annual VA survey was conducted from December 5, 2022, through December 8, 2022 at the Veterans Home of California – Chula Vista. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.70 (c) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	Based on record review, interviews, and facility policy, the facility management failed to convey funds and provide a final accounting of trust fund monies to the resident's representative or next of kin (NOK) within 90 calendar days for six (6) out of 29 residents (Residents #19, #22, #23, #25, #26, #27), following the death of the resident. Additionally, the facility management failed to convey funds and provide a final accounting of trust fund monies to the resident and/or representative within 90 calendar days for one (1) out of 29 residents (Resident #24), who was discharged to another facility. The findings include: Review of the facility's policy titled, "Conveyance of Funds on Resident's Death (All Homes)," revealed: "Following the death of a Resident with personal funds deposited with the Veterans Homes of California (VHC), the CalVet will convey within 30 days the Resident's funds and a final accounting of those funds,

	to the individual or probate jurisdiction administering the Resident's estate." On 12/7/22, at 9:37 a.m., a review of the current Patient Fund Balances spreadsheet revealed seven (7) residents had open trust fund balances as of [DATE]. The following were observed: Resident #19, admitted on [DATE], and expired at the facility on [DATE], had a trust fund account balance of $1,023.95. Resident #22, admitted on [DATE], and expired at the facility on [DATE], had a trust fund account balance of $277.93. Resident #23, admitted to the facility on [DATE], and expired at the facility on [DATE], had a trust fund account balance of $25.00. Resident #24, admitted to the facility on [DATE], and discharged to another facility on [DATE], had a trust fund account balance of $125.37. Resident #25, admitted to the facility on [DATE], and expired at the facility on [DATE], had a trust fund account balance of $898.61. Resident #26, admitted to the facility on [DATE], and expired at the facility on [DATE], had a trust fund account balance of $115.54. Resident #27, admitted to the facility on [DATE], and expired at the facility on [DATE], had a trust fund account balance of $8,412.38. On 12/7/22, at 10:45 a.m., during an interview with Administrative Staff A, they confirmed the above residents' accounts were still open and that they would have to contact someone from the legal office to verify the status of the residents' accounts. On 12/8/22, at 9:03 a.m., during an interview with Administrative Staff A, they revealed Resident #25, Resident #26, and Resident #27 trust fund accounts were still open because the legal office had not been able to contact the residents' NOK. Administrative Staff A stated that the facility's legal office sends a distribution letter to the resident's NOK, and the funds become unclaimed until they have been notified by the resident's NOK. Administrative Staff A stated, per facility policy, the facility can hold resident trust fund money, not to exceed $15,000.00, for up to one (1) year if the facility has not made contact with the NOK or estate heir to claim the funds. Administrative Staff A was asked to provide a copy of the distribution letters that were sent to the responsible party for Residents #25, #26, and #27. The facility management did not provide any additional information to verify the facility attempted to contact the NOK for the above residents. On 12/8/22, at 9:16 a.m., during an interview with Administrative Staff A, they revealed Resident #19's, #22's, and #23's trust

	fund accounts were closed as of [DATE]. Administrative Staff A stated it may have been an oversight, but the residents' trust fund accounts should have been closed and a check should have been mailed to the responsible party within the 90 days. On 12/8/22, at 9:21 a.m., during an interview with Administrative Staff A, they revealed Resident #24 was transferred to another facility. Administrative Staff A stated the resident's trust fund account was closed on [DATE], and the funds were mailed to the resident. Administrative Staff A stated the trust fund balance should have been sent with the resident when they were discharged from the facility.
§ 51.80 (b) (3) Permitting resident to return to facility. A nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold period is readmitted to the facility immediately upon the first availability of a bed in a semi-private room, if the resident requires the services provided by the facility. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on interviews and record review, the facility failed to immediately allow readmission of a resident requiring services provided by the facility for one (1) of one (1) resident (Resident #4) reviewed for compliance with discharge rights from a total sample of 22 residents. The findings include: Review of Resident #4's medical record revealed an admission date of [DATE]. Resident #4's primary medical diagnosis was Hereditary Ataxia. Resident #4 required extensive to total assistance with activities of daily living. Review of Resident #4's Physician Orders revealed an order, dated [DATE], 1:00 p.m., which directed staff to transfer the resident to the hospital for psychiatric evaluation due to uncontrolled yelling, severe agitation, and trying to hit staff. The order read, "Not safe for self or others," and, "Transfer via 911." Review of hospital discharge notes, dated [DATE], revealed Resident #4 was transferred to the hospital due to "increased agitation." A narrative by the provider read, "On my examination, patient is partially cooperative, answers some questions, uses a loud voice but without verbally or physically aggressive behavior. Although the nursing facility is requesting psychiatric evaluation, I do not feel that transient yelling or aggression is an appropriate indication for a psychiatric consult… Patient is medically cleared for return to the nursing facility." The note also added, "The nurse I spoke to at the SNF [skilled nursing facility] says that they are unable to accept the patient until it is reviewed with a supervisor who will not be present until 8 a.m." During an interview with Administrative Nurse A, on 12/6/22, at 2:15 p.m., they confirmed that Resident #4's readmission was held by the night shift staff until a supervisor could review Resident #4's hospital discharge records.

	The facility was asked to produce a copy of its policy governing the practices for readmission of residents. The facility produced a copy of a policy titled, "Nursing Admission," which was dated 6/21/21. The policy did not direct staff on the process for ensuring residents were immediately readmitted to the facility if the facility's services were required by the resident.
§ 51.140 (e) Therapeutic diets. Therapeutic diets must be prescribed by the primary care physician. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to ensure thickened liquids provided to residents were ordered by the physician for one (1) of one (1) resident (Resident #4) reviewed from a total sample of 22 residents. The findings include: Review of Resident #4's medical record revealed an admission date of [DATE]. Resident #4's primary medical diagnosis was Hereditary Ataxia. Resident #4 required extensive to total assistance with activities of daily living. During a tour of the facility, on 12/5/22, at 12:54 p.m., Resident #4 approached the surveyor in a hallway and was holding a meal ticket. Resident #4 immediately began yelling, with several expletives intermingled in their statements. Resident #4 voiced concerns of staff competence related to assessment of their blood pressures, and providing the appropriate liquid consistency for their fluids of choice. Resident #4 went on to explain that they had been provided thickened liquids on their meal tray, and that they were supposed to be receiving regular, thin liquids per a doctor's order. Resident #4 explained that they did have swallowing difficulties, but that the concern had been discussed with the attending physician and the liquid order was changed. Following the dialogue with Resident #4, they continued to have verbal outbursts and were repeatedly voicing concerns to several staff members about the incorrect consistency of liquids on the meal tray. On 12/5/22, at 12:58 p.m., an observation of Resident #4's meal tray was conducted. Present on the tray was one (1) 120 milliliter (ml) cup of milk and one (1) 120ml cup of juice. Both the milk and juice had been thickened to approximately nectar consistency. Resident #4's meal tray ticket indicated they should be receiving mildly thickened liquids. Review of Resident #4's Physician Orders revealed an order, dated [DATE], for regular diet and thin liquids. A corresponding dietary communication was not found in the medical record. On 12/7/22, at 2:02 p.m., an interview was conducted with Licensed Nurse A regarding the facility's practices for ensuring updated Physician Orders were communicated to the nutrition department. Licensed Nurse A explained that when a new

	dietary order was received, the order was transcribed to a "dietary communication form" and was then faxed to the Nutritional Services Department. Licensed Nurse A reviewed Resident #4's Physician Order and confirmed that, as of [DATE], Resident #4 did have a Physician Order for a regular diet and thin liquids. Licensed Nurse A also confirmed that there was no corresponding dietary communication form reflecting the order. On 12/8/22, at 12:00 p.m., an interview was conducted with Dietary Staff A. They explained that on Sunday night, 12/4/22, the Dietary department received communication that Resident #4 required thickened liquids. They added that a Dietary employee communicated that request to Dietary Staff B the following morning, [DATE], and Dietary Staff B confirmed the order should be for thin liquids. When asked whether Resident #4 had suffered a change in condition requiring a change in liquid consistency, Dietary Staff A was unsure and restated that Dietary Staff B had reviewed the record and confirmed that Resident #4 should have been receiving thin liquids. The facility was asked to produce a copy of its policy governing the processes for ensuring residents received appropriate diets to include liquids of appropriate consistency. Dietary Staff A explained that the facility did not have a policy that directly addressed that topic.
§51.200(a) Life safety from fire The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. (a) The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	**<u>Electrical Systems</u>** 1. Based on records review and interview the facility failed to test the non-hospital grade electrical receptacles in patient care areas. The deficient practice affected 10 of 14 smoke compartments, staff, and all residents. The facility had a capacity for 180 beds with a census of 144 on the day of the survey. The findings include: Records review on 12/6/22, at 10:46 a.m., revealed non-hospital grade electrical receptacles located in resident care areas throughout the facility did not have annual continuity, polarity, physical integrity, or retention testing documentation as required by sections 6.3.3.2 through 6.3.4.2.1.2 of NFPA 99 Health Care Facilities Code. An interview, on 12/6/22, at approximately 10:46 a.m., with Maintenance Staff A and Maintenance Staff B revealed the facility conducted some version of electrical receptacle inspections that tested only 10% of the outlets in the building on June 1, 2022. Additional interview with Maintenance Staff A and Maintenance Staff B revealed the facility was not aware of the

	requirement of testing the non-hospital grade electrical receptacles in patient care areas. The census of 144 was verified by Administrative Staff B on 12/5/22. The finding was acknowledged by Administrative Staff B and verified by Maintenance Staff A and Maintenance Staff B during the exit interview on 12/8/22. **Actual NFPA Standard NFPA 99, Health Care Facilities Code (2012)** **6.3.3.2 Receptacle Testing in Patient Care Rooms** **6.3.3.2.1** The physical integrity of each receptacle shall be confirmed by visual inspection. **6.3.3.2.2** The continuity of the grounding circuit in each electrical receptacle shall be verified. **6.3.3.2.3** Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. **6.3.3.2.4** The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz). **6.3.4.1 Maintenance and Testing of Electrical System.** **6.3.4.1.1** Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. **6.3.4.1.2** Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data. **6.3.4.1.3** Receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. **6.3.4.1.4** The LIM circuit shall be tested at intervals of not more than 1 month by actuating the LIM test switch *(see 6.3.2.6.3.6)*. For a LIM circuit with automated self-test and self-calibration capabilities, this test shall be performed at intervals of not more than 12 months. Actuation of the test switch shall activate both visual and audible alarm indicators. **6.3.4.1.5** After any repair or renovation to an electrical distribution system, the LIM circuit shall be tested in accordance with 6.3.3.3.2. **6.3.4.2 Record Keeping.** **6.3.4.2.1*** General. **6.3.4.2.1.1** A record shall be maintained of the tests required by this chapter and associated repairs or modification. **6.3.4.2.1.2** At a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter.

2. Based on records review, observation, and interview, the facility failed to ensure that an emergency stop switch was installed for the emergency generator. The deficient practice affected 14 of 14 smoke compartments, staff, and all residents. The facility had a capacity for 180 beds with a census of 144 on the day of the survey.

The findings include:

Observation during the building inspection tour on 12/7/22, at 12:14 p.m., revealed the facility's emergency generator was not provided with a remote manual stop station located elsewhere on the premises, as required by sections 5.6.5.6 and 5.6.5.6.1 of NFPA 110, Standard for Emergency and Standby Power Systems.

An interview, on 12/7/22, at 12:14 p.m., with Maintenance Staff B revealed the facility was not aware of the requirement for a remote manual stop station and was uncertain why it had not been installed outside of the enclosure.

The census of 144 was verified by Administrative Staff B on 12/5/22. The finding was acknowledged by Administrative Staff B and verified by Maintenance Staff A and Maintenance Staff B during the exit interview on 12/8/22.

Actual NFPA Standard: NFPA 101, Life Safety Code (2012)
19.5 Building Services.
19.5.1 Utilities.
19.5.1.1 Utilities shall comply with the provisions of Section 9.1.
9.1.3 Emergency Generators and Standby Power Systems.
Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2.
9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems.

3. Based on observation and interview, the facility failed to prohibit the improper use of electrical equipment. The deficient practice affected one (1) of 14 smoke compartments, staff, and no residents. The facility had a capacity for 180 beds with a census of 144 on the day of the survey.

The findings include:

Observation during the building inspection tour, on 12/7/22, at 12:07 p.m., revealed one (1) relocatable power tap was plugged

	into another relocatable power tap in the [LOCATION], as prohibited by sections 400.8 and 590.3 of NFPA 70, National Electric Code and section 10.2.4 of NFPA 99, Health Care Facilities Code. An interview at that time with Maintenance Staff B revealed the facility was not aware of the back-to-back (daisy chained) power strips. The census of 144 was verified by Administrative Staff B on 12/5/22. The finding was acknowledged by Administrative Staff B and verified by Maintenance Staff A and Maintenance Staff B during the exit interview on 12/8/22. **Actual NFPA Standard: NFPA 101, (2021) Life Safety Code** **19.5 Building Services.** **19.5.1 Utilities.** **19.5.1.1** Utilities shall comply with the provisions of Section 9.1. **9.1 Utilities.** **9.1.2 Electrical Systems**. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. **Actual NFPA Standard: NFPA 70 (2011) National Electric Code** **400.8 Uses Not Permitted.** Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure **590.3 Time Constraints.** (A) During the Period of Construction. Temporary electric power and lighting installations shall be permitted during the period of construction, remodeling, maintenance, repair, or demolition of buildings, structures, equipment, or similar activities. (B) 90 Days. Temporary electric power and lighting installations shall be permitted for a period not to exceed 90 days for holiday decorative lighting and similar purposes. (C) Emergencies and Tests. Temporary electric power and lighting installations shall be permitted during emergencies and for tests, experiments, and developmental work. (D) Removal. Temporary wiring shall be removed immediately upon completion of construction or purpose for which the wiring was installed. **Actual NFPA Standard: NFPA 99 Health Care Facilities Code (2012)** **10.2.4 Adapters and Extension Cords.** **10.2.4.1** Three-prong to two-prong adapters shall not be permitted.

	10.2.4.2 Adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. **10.2.4.2.1** All adapters shall be listed for the purpose. **10.2.4.2.2** Attachment plugs and fittings shall be listed for the purpose. **10.2.4.2.3** The cabling shall comply with 10.2.3.