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 – Fresno

Location: 2811 West California Ave., Fresno, CA 93706

Onsite / Virtual: Onsite

Dates of Survey: 8/22/24 – 8/23/24

NH / DOM / ADHC: DOM

Survey Class: Annual

Total Available Beds: 180

Census on First Day of Survey: 124

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from August 22, 2024, through August 23, 2024, at the Veterans Home of California – Fresno. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.70 (n) Self-Administration of Drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defined by § 51.110(d)(2)(ii) of this part, has determined that this practice is safe. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, record review, and facility policy review, facility staff failed to ensure medications self-administered by residents were securely stored. This deficient practice affected two (2) of two (2) residents reviewed for self-administration of medications from a total of eight (8) residents sampled (Resident #1 and Resident #3). The findings include: A review of the facility's policy and procedure titled, "Medication, Self-Administration-RCFE [Residential Care Facility for the Elderly] (All Homes)," dated 3/26/24, indicated: "Definitions: Self-Administration: The administration of medication to a Resident by oneself or by a person who is not a staff member, in the absence of a qualified staff member. Self-administered medications are kept secured in the Resident's room…Storage of Medications: …4. Self-administered medications will be stored in a secured storage space in the Resident's room at all times."

	1. A review of Resident #1's medical record revealed an initial admission date of [DATE]. Their medical diagnoses included Heart Disease and Essential Hypertension. On 8/22/24, at approximately 12:45 p.m., an interview was conducted with Resident #1 in their room regarding the care and services they were receiving in the facility. During the interview, four (4) medication bottles were sitting on top of several stacked books beside the resident's bedside table. Resident #1 was asked whether they administered their own medications, to which they replied, "Yes." When asked about the four (4) unsecured bottles of medication, Resident #1 explained that they generally kept their medication bottles secured in the top drawer of their bedside table (which had the capability to lock), but went on to explain that the four medication bottles beside the table were "too tall to fit." When asked whether they had notified facility staff that the bottles would not fit in the drawer, they stated, "I don't think so." Continued review of Resident #1's medical record revealed an "RCFE Medication Self-Administration Form" dated [DATE]. Question seven (7) of the form indicated that Resident #1 was "fully capable" to demonstrate secure storage of their medications. Continued review of Resident #1's medical record revealed a second "RCFE Medication Self-Administration Form" dated [DATE]. Question seven (7) of the form again indicated that Resident #1 was "fully capable" to demonstrate secure storage of their medications. On 8/22/24, at 1:10 p.m., an interview was conducted with Licensed Nurse A regarding the facility's practices for ensuring medications were stored securely. They explained that residents who self-administered medications were required to store their medications in the locking top drawer of the bedside table. When asked whether they were aware that Resident #1 had four (4) bottles of medications stored in their room unsecured, Licensed Nurse A stated, "No, but I'll see if I can find somewhere to put them." 2. A review of Resident #3’s undated “Admission Face Sheet Record” indicated Resident #3 was admitted to the facility on [DATE], with diagnoses including, but not limited to, Hypertension and Diabetes. During a concurrent observation and interview, on 8/23/24, at 10:00 a.m., conducted in Resident #3’s room, Resident #3 showed their unlocked medicine cabinet with 13 bottles of medications inside of it. Resident #3 stated that they never

	locked their medicine cabinet. Resident #3 further stated that their bedroom door was always closed but not locked. A review of Resident #3's "Appraisal/Needs and Services Plan," dated [DATE], indicated "Problem/Needs: Medication Self-Administration. Goal/Objective: Resident will manage self-administration as directed by MD [Medical Doctor] …Maintain medications in locked cabinets at all times, and allow weekly medication checks for safety." A review of Resident #3's "Monthly Evaluation for Medication and Treatment Self Administration-AM & PM LVN only," dated [DATE], found it was checked "yes" for the question regarding if the resident's medications were stored properly in their room and locked. A review of Resident #3's "Weekly Monitor of Medication Self Administration," dated [DATE], found it was marked "yes" that self-administered medications were stored properly. A review of Resident #3's "Self-Administered Medication Record," dated [DATE], indicated: 1. Allopurinol 100 mg (milligrams-unit of measure) take one (1) tab (tablet) orally daily for gout. 2. Amlodipine 10 mg tab take one (1) tab orally everyday in the morning for HTN (hypertension). Hold if SBP (systolic blood pressure) <100 or DBP (diastolic blood pressure) <60. 3. Cyanocobalamin (B12) 1000 mcg (Micrograms-unit of measure) take one (1) tab orally daily for Vitamin B12 deficiency. 4. Levothyroxine 100 mcg take one (1) tab Q AM (every morning) for hypothyroidism. Do not take with food. 5. Lisinopril 40 mg tab take one (1) tab orally daily for HTN. 6. Metformin 1000 mg tab take one (1) tab orally two times a day with food for DMII (Diabetes Mellitus Type 2). 7. Propanolol HCL (hydrochloride) 60 mg tab take one (1) tab orally BID (twice daily) for tremors. 8. Rosuvastatin 10 mg tab take one (1) tab orally QHS (at bedtime) for hyperlipidemia. 9. Vitamin D 1000 IU (international units) tab take two (2) tabs orally daily for Vit D deficiency. 10. Jardiance 25 mg tab PO (orally) every day for diabetes. 11. Mybetriq 25 mg tab take one (1) tablet by mouth daily for incontinence. 12. Flomax 0.4 mg capsule take one (1) capsule by mouth at bedtime. DX (diagnosis): BPH (benign prostatic hyperplasia). 13. Daily Vite tab take one (1) tab orally daily for supplement.

	14. Vitamin C 500 mg tab take one (1) tab orally once daily for supplement. During an interview, on 8/23/24, at 10:45 a.m., Administrative Nurse A stated that all residents were assessed to self-administer their medications, and should have their medications secured at all times.
§ 51.300 (b) Work. The resident must participate, based on his or her ability, in some measure, however slight, in work assignments that support the maintenance and operation of the State home. The State Home management must create a written policy to implement the work requirement. The resident is encouraged to participate in vocational and employment services, which are essential to meeting the psychosocial needs of the resident. The resident must perform work for the facility after the State home has accomplished the following: (1) The facility has documented the resident's need or desire to work in the comprehensive care plan; (2) The comprehensive care plan described in § 51.310 specifies the nature of the work performed and whether the work is unpaid or paid; (3) Compensation for work for which the facility would pay a prevailing wage if done by non-residents is paid at or above prevailing wages for similar work in the area where the facility is located; and (4) The facility consulted with and the resident agrees to the work arrangement described in the comprehensive care plan. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	Based on interviews, record review, and review of facility policy, facility staff failed to 1) Document the resident's need or desire to work, and 2) Ensure that the Care Plan specified the nature of the work performed, and whether the work was paid or unpaid, and 3) Consult with the resident regarding the work arrangement. This deficient practice affected six (6) of six (6) residents reviewed for work from a total of eight (8) residents sampled. The findings include: The facility's policy governing the domiciliary work program was reviewed. The policy was titled, "Domiciliary Work Program," and was undated. The policy described the work program's purpose as: "to promote activities that will help maintain resident independence, dignity, and well-being." The policy directed staff to document (in the resident's comprehensive Care Plan) the resident's need or desire to work and to consult with the resident to ensure they agreed to the work arrangement as it would be described in the comprehensive Care Plan. A review of Resident #1's medical record revealed an initial admission date of [DATE]. Their medical diagnoses included Heart Disease and Essential Hypertension. During an interview with Resident #1, on 8/22/24, at approximately 12:45 p.m., Resident #1 stated they were unfamiliar with the facility's domiciliary work program. Continued review of Resident #1's medical record revealed an "Appraisal/Needs and Services Plan" dated [DATE]. Review of the service plan revealed no focus areas or documentation referencing the resident's need or desire to work. A review of Resident #2's medical record revealed an initial admission date of [DATE]. Resident #2's medical history included Essential Hypertension and Type 2 Diabetes Mellitus. During an interview with Resident #2, on 8/22/24, at approximately 1:35 p.m., Resident #2 explained that they were unfamiliar with the facility's domiciliary work program.

	Continued review of Resident #2's medical record revealed an "Appraisal/Needs and Services Plan" dated [DATE]. Review of the service plan revealed no focus areas or documentation referencing the resident's need or desire to work. A review of the Resident #3's "RCFE [Residential Care Facility for the Elderly] Resident Admission Assessment," dated [DATE], indicated Resident #3 had no orientation problem and ambulated independently. A review of Resident #3's "Appraisal/Needs and Services Plan," dated [DATE], indicated Resident #3 was alert and oriented to person, place, time, and situation. Resident #3 was ambulatory with a cane or FWW (Front Wheel Walker), was independent with their ADLs (Activities of Daily Living), and was continent of B/B (bladder and bowel). A review of Resident #4's "Appraisal/Needs and Services Plan," dated [DATE], indicated Resident #4 was alert and oriented to person, place, time, and situation. Resident #4 ambulated inside their room and used a power wheelchair for long distances. Resident #4 was independent with their ADLs and was continent of B/B. During an interview, on 8/23/24, at 10:50 a.m., with Administrative Nurse A, they stated that Resident #3 and Resident #4 did not have any work documented in their comprehensive Care Plan. A review of Resident #5's medical record revealed an initial admission date of [DATE]. Resident #5's medical history included Skin Cancer and Hyperlipidemia. A review of Resident #5's "Appraisal/Needs and Services Plan" revealed no focus areas or documentation referencing the resident's need or desire to work. A review of Resident #6's medical record revealed a readmission date of [DATE]. Resident #6's medical history included Type 2 Diabetes Mellitus and Atherosclerotic Heart Disease. A review of Resident #6's "Appraisal/Needs and Services Plan" revealed no focus areas or documentation referencing the resident's need or desire to work.