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: Colorado Veterans Community Living Center at Homelake

Location: 3749 Sherman Ave, Monte Vista, Colorado 81135

Onsite / Virtual: Onsite

Dates of Survey: 7/18/22-7/21/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 60

Census on First Day of Survey: 40

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from July 18, 2022, through July 21, 2022, at the Colorado Veterans Community Living Center at Homelake. The facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.43 (b) Drugs and medicines for certain veterans. VA will also furnish drugs and medicines to a State home for a veteran receiving nursing home, domiciliary, or adult day health care in a State home pursuant to 38 U.S.C. 1712(d), as implemented by §17.96 of this chapter, subject to the limitation in §51.41(c)(2). Level of Harm – No Actual Harm, with potential for minimal harm. Residents Affected - Few	The facility was unable to demonstrate that the VA only furnished drugs and medicines to a State Home for Veterans who were eligible to receive such medications. Based on interviews and record review, it was identified that the facility failed to furnish drugs and medicines to one (1) of nine (9) residents for whom the facility received the prevailing rate of VA Per Diem from September 6, 2013, to present. Based on interviews and record reviews, the resident was admitted to the SVH in 2001 and an agreement with the VA of jurisdiction was made to continue providing the medication as part of this admission. Per review of records, including the resident's completed VA Form 10-10SH, the facility began receiving the prevailing rate of VA Per Diem in 2013 for this Veteran, at which time the facility became responsible for all medication costs for this Veteran.

	An interview with Administrative Staff A, Administrative Staff B, and Consultant Staff A revealed that the SVH did not reimburse the VA of jurisdiction for the medication received for this one (1) resident. The prescription was written by the VA provider, filled by the VA Pharmacy, and the medication was sent to the SVH.
§ 51.120 (a) (3) Reporting of Sentinel Events The facility management must report sentinel events to the director of VA medical center of jurisdiction within 24 hours of identification. The VA medical center of jurisdiction must report sentinel events by calling VA Network Director (10N 1-22) and Office of Geriatrics and Extended Care in VA Central Office within 24 hours of notification. 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 identify a Sentinel Event and report the Sentinel Event to the VA Medical Center of Jurisdiction within 24 hours of identification. The findings include: Review of Resident #17's medical record revealed an admission date of 2022 and a discharge date of 2022. Resident #17 was admitted to the facility for rehabilitation services with a goal to return home with their wife. Their primary medical diagnosis was Type 2 Diabetes. The admission Minimum Data Set (MDS) assessment identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #17 required extensive assistance with Activities of Daily Living (ADLs). According to the Nurse Progress Notes, on [DATE], at approximately 1:30 p.m., Resident #17 notified staff that they had swallowed a plastic toothpick. The staff notified the physician and transferred Resident #17 to the hospital for evaluation and treatment. After being transferred to the hospital, Resident #17 underwent an esophagogastroduodenoscopy (EGD) to retrieve the foreign body. During conclusion of the procedure, the resident suffered a cardiac arrest and required two (2) minutes of Cardiopulmonary Resuscitation (CPR) and was admitted to the Intensive Care Unit where they expired on [DATE]. Continued review of Resident #17's medical record revealed no documentation of the conversations with the Resident or their family member regarding the risks of injury from the toothpicks. Additionally, Resident #17's baseline Care Plan did not address the issue. During an interview with Administrative Staff A on 7/21/22, at 3:08 p.m., they explained that Resident #17 was alert, oriented, and their own responsible party. They stated that Resident #17 had a habit of chewing on the toothpicks which their wife brought in for them. Administrative Staff A also added that the facility had attempted to intervene in the behavior on admission because they saw this behavior as a risk. Resident #17's wife was adamant that the facility allowed Resident #17 to continuing chewing the toothpicks. Administrative Staff A explained that they had determined the incident was not a Sentinel Event and therefore it was not reported as such.

	On 7/21/22, at approximately 3:20 p.m., an interview was conducted with Licensed Nurse A. They stated that they and other staff had been concerned that the resident would fall asleep with the toothpicks in their mouth, and on the day Resident #17 was transferred to the hospital, they had swallowed a toothpick. Licensed Nurse A stated that they and other staff had educated the resident and their representative on more than one (1) occasion about the risks, but that Resident #17 insisted on continuing to chew on the toothpicks.
§ 51.120 (j) Nutrition. Based on a resident's comprehensive assessment, the facility management must ensure that a resident— (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when a nutritional deficiency is identified. Level of Harm – Actual Harm that is not immediate jeopardy. Residents Affected- Few	Based on observations, interviews, and record review, the facility failed to maintain acceptable parameters of nutritional status by failing to: 1) Provide a therapeutic diet, and 2) Assess the resident's nutritional needs, evaluate unexpected weight loss, and implement interventions to address unexpected weight loss, for one (1) of two (2) residents reviewed for nutrition from a total sample of 16 residents. The findings include: 1) Review of Resident #1's medical record revealed an admission date of 2022. Their primary medical diagnosis was Alzheimer's Disease. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. Resident #1 required extensive assistance with most activities of daily living (ADLs) and required supervision with eating. The assessment identified the presence of excessive weight loss without a prescribed weight loss regimen. Review of Resident #1's Physician Order revealed an order dated [DATE], for a regular diet with pureed texture. On 7/19/22, at 11:58 a.m., Resident #1 was observed sitting at a table in the main dining room. They were alone at the table. A plate was on the table in front of them. On the plate were three (3) pureed items. They also had a dessert plate with a piece of cake (regular texture) on the table. None of the food had been eaten. Their silverware was neatly wrapped in a napkin. When asked whether they were going to eat their lunch, Resident #1 stated, "I don't know what to do. Sit here and stare, I guess." On 7/19/22, at 12:05 p.m., Dietary Staff A unwrapped Resident #1's silverware and handed them a spoon. Resident #1 immediately began eating the cake. Their chewing was prolonged, and they took several sips of water between bites of the cake. On 7/19/22, at 12:06 p.m., an interview was conducted with Dietary Staff A. They were asked what the facility was serving for dessert for residents on pureed diets. Dietary Staff A stated, "It's a banana split cake." When asked whether the cake

	Resident #1 was eating was the appropriate consistency for their ordered pureed diet, they stated, "Yes. It seems like that is all [Resident #1] is eating. [They aren't] eating [their] food. I know [they] like [their] sweets." Resident #1 continued to eat the cake and eventually consumed 100% of the cake. Review of Resident #1's Comprehensive Care Plan revealed a focus area for unplanned or unexpected weight loss related to the use of diuretics and dysphagia. Interventions included alerting the dietitian if consumption was poor for more than 48 hours, providing a regular diet with mechanical soft texture and pureed meats, labs as ordered, monitoring and evaluation of any weight loss (and follow facility protocol for weight loss), and monitoring/recording food intake at each meal. The Care Plan had not been updated to reflect Resident #1's pureed texture diet. On 7/20/22, at 7:58 a.m., Resident #1 was observed in the main dining room. They were eating pancakes which had been cut into bite-size pieces. There were pieces of egg on top of the pancakes. The pancakes were covered in syrup but were not "saturated." Resident #1 continued taking bites of the pancake and chewed for approximately 90 seconds between bites. On 7/20/22, at 8:01 a.m., Licensed Nurse A was alerted to the fact that Resident #1 was eating pancakes that had not been pureed. Licensed Nurse A stated, "[They] ha[ve] an order for pancakes as long as they are soaked in syrup." A second review of Resident #1's diet order revealed the order had been changed on 7/20/22, at 8:28 a.m., to read, "May have pancakes with extra syrup for breakfast or any other meal at resident's request." A Speech Therapy (ST) Plan of Care dated [DATE] revealed Resident #1 was demonstrating prolonged chewing with mechanical, soft, solid food and was "pocketing" food in their mouth at meals. The assessment identified delayed swallowing and moderate pocketing of food. Resident #1 completed several sessions of Speech Therapy and was discharged from therapy on [DATE] with a pureed texture diet. During an interview with Dietary Staff B on 7/20/22, at 1:33 p.m., they were asked whether the banana split cake and pancakes were appropriate for Resident #1's pureed diet. They stated, "I was told that the cake was taken away from [them] when it was mentioned. I don't think [they were] supposed to have it." Dietary Staff B then added that they weren't sure whether the pancakes were appropriate. During an interview with Dietary Staff C on 7/20/22, at approximately 1:45 p.m., they explained that whole banana split

	cake would likely not be appropriate for Resident #1 and stated, "The graham cracker crust would really worry me. But you would probably want to check with the Speech Therapist to confirm." Dietary Staff C went on to explain that Dietary Staff B and the facility's nursing department would "trial different things" to encourage residents to eat, and that this was likely what happened in the case of the banana split cake. On 7/20/22, at 2:50 p.m., a telephone interview was conducted with the facility's Consultant Staff B. They explained that they were very familiar with Resident #1 and confirmed that they had provided Speech Therapy services for the resident in [DATE]. When asked about Resident #1's most recent episode of Speech Therapy, Consultant Staff B explained that they had been notified that Resident #1 was continuing to lose weight and that they were pocketing food on their mechanically altered diet. They explained that Resident #1 was chewing for prolonged periods of time, and they felt that it safest that Resident #1 received a pureed diet. When asked whether whole banana split cake or pancakes would be appropriate for Resident #1, Consultant Staff B explained that the facility had notified them earlier in the day about the pancakes Resident #1 had received at breakfast and added that they would, "really need to be monitored and the pancakes would have to be essentially saturated in syrup to a mashed potato consistency." Regarding the cake, Consultant Staff B stated that they were unaware Resident #1 had received it and stated it would not be appropriate for them. Consultant Staff B went on to explain that they would reassess Resident #1 for safety upon their return to the facility. The facility's policy titled, "Puree Consistency Diet," not dated, was reviewed. The policy identified pureed food items as needing to be "smooth and without lumps or pieces." The policy did not reference the facility's procedures for ensuring residents received the correct therapeutic diet. 2) The facility's policy titled, "Weight Loss/Skin Breakdown Prevention and Early Intervention," undated, was reviewed. The policy indicated a purpose of establishing guidelines for early intervention and possible prevention of weight loss and skin breakdown, procedures for determining unavoidable weight loss, and establishing guidelines for assessing effectiveness of interventions. Section D of the policy indicated that the NAR (Nutrition at Risk) committee was to meet monthly to review residents with weight loss. The policy also directed the Dietitian to review residents with weight loss and offer recommendations regarding the cause of the weight loss and possible interventions.

	A nutritional assessment dated [DATE] was reviewed. The assessment was completed by Dietary Staff B. Resident #1's estimated caloric and protein needs were not assessed or documented. Dietary Staff C cosigned the assessment but did not enter any additional comments. Review of Resident #1's weight history revealed an admission weight [DATE], of 232.6 pounds. A subsequent weight on [DATE], revealed a weight of 219 pounds, a 13.6-pound (5.84%) weight loss. On [DATE], a Physician Order was entered for daily weights. Review of Resident #1's Progress Notes revealed an entry dated [DATE], in which Dietary Staff C acknowledged a "Weight Warning" of -3.0% from last weight. Dietary Staff C wrote, "Slight weight change since admission. Weight did not trigger this week. BMI [Body Mass Index] 32. Staff offers snacks, alternates, as well as food preferences. Agree with current dietary interventions. Will continue to monitor for significant changes in labs, meds [medications], weights, and PO [by mouth] intakes." A Physician Progress Note dated [DATE], identified Resident #1's weight loss of 20 pounds since admission. A nutrition consult was ordered. The physician also indicated that Resident #1 was on Lasix for five (5) days and that some of the loss "could have been water weight." A Speech Therapy Note dated [DATE], revealed Resident #1 was screened by Consultant Staff B to determine the presence of any chewing or swallowing problems that might have been contributing to their weight loss. Consultant Staff B documented that Resident #1 presented with an observed chewing difficulty and the resident removed several bites of food from their mouth while stating that they could not chew the food. Consultant Staff B wrote that Resident #1 would benefit from a complete Speech Therapy consultation to assess swallowing function and determine the least restrictive diet texture to maximize intake by mouth. A Weight Change Note dated [DATE], authored by Dietary Staff C, indicated a weight loss with a new weight of 213.8. Dietary Staff C wrote, "Weight loss since admission. Regular, mechanical soft diet with good intakes overall, usually 50-100%. Resident is also receiving Ensure + 1X [one time] per day. Staff also offers snacks prn [as need]. Agree with current dietary interventions. Will continue to monitor for significant changes in labs, meds [medications], weights, and po [by mouth] intakes." Dietary Staff C did not document any evaluation of the potential causes for weight loss or any new dietary interventions despite a weight loss of 8.08% since admission.

	Continued review of Resident #1's weight history revealed a weight of 212.8 pounds on [DATE]. A Physician Progress Note dated [DATE], revealed the physician was asked to evaluate Resident #1 due to a "weight increase and edema." The physician discontinued Resident #1's Ensure supplement and started a diuretic. Continued review of Resident #1's weight history revealed a weight of 209.2 pounds on [DATE]. Dietary Staff C acknowledged a system-generated weight warning on [DATE]. Dietary Staff C documented that the resident had triggered for a weight change and was on daily weights. They added that the weight had been stable for "a few months now." Dietary Staff C also added that they agreed with current dietary interventions. There were no documented evaluations of the potential causes for continuing weight loss and there were no new dietary interventions implemented. Dietary Staff B acknowledged a system-generated weight warning on [DATE], which indicated a new weight of 205.8 pounds. Dietary Staff B wrote that the resident consumed 50-100% of meals. There were no documented evaluations of the potential causes for continuing weight loss and there were no new dietary interventions implemented. A nutritional assessment, dated [DATE], was reviewed. The assessment was completed by Dietary Staff B. The reason for the assessment was marked as "Change in condition." Resident #1's estimated caloric and protein needs were not calculated. The assessment identified that Resident #1 had poorly fitting dentures but did not identify any other potential causes for the continued weight loss. The assessment was cosigned by Dietary Staff C on [DATE]. There were no additional comments or recommendations. Continued review of Resident #1's weight history revealed a weight of 197 pounds on [DATE]. Dietary Staff B acknowledged a system-generated weight warning on [DATE]. Dietary Staff B wrote, "Resident broke [their] lower dentures. Having difficulty." On [DATE], Dietary Staff B entered a Progress Note indicating that a significant change assessment had been conducted and wrote that Resident #1's diet order had been changed to a mechanical soft texture with pureed meats due to Resident #1 pocketing food in their mouth. On [DATE], Dietary Staff C acknowledged a system-generated weight warning for a new weight of 193.5 pounds. Dietary Staff C documented that the resident had triggered for a weight change, that their intakes were fair to good, and that they

	agreed with current dietary interventions. There were no new dietary interventions implemented. Subsequent weights were 193 pounds on [DATE] and 191 pounds on [DATE]. A Physician Progress Note dated [DATE], indicated the resident's weight had "stabilized" and made mention of a nutrition consult which the physician was unable to locate notes for. On 7/20/22, at 1:33 p.m., an interview was conducted with Dietary Staff B. They were asked to explain the processes for identifying, evaluating, and intervening in excessive weight loss. Regarding nutritional assessments, they explained that they completed the assessment, and the Dietitian reviewed it. Dietary Staff B confirmed that the facility did not calculate the calorie or protein needs for residents on any assessments. Regarding the identification of weight loss, they explained that each resident was weighed weekly and that, at the end of each week, Dietary Staff B "goes in and makes a progress note." Regarding evaluation and intervention by the Dietitian, Dietary Staff B explained that the Dietitian was "not allowed in the building during the COVID-19 pandemic," and that they had only recently returned to in-person visits. Dietary Staff B explained that the Dietitian typically reviewed anyone who "triggered" for weight loss and "make[d] a note." Dietary Staff B was unsure what the components of the assessment included. When asked if residents experiencing weight loss were reviewed with the interdisciplinary team, Dietary Staff B explained that the facility had not been conducting "Nutrition At Risk" meetings "since the early part of 2020," because the Dietitian had not been allowed in the building due to the pandemic. On 7/20/22, at approximately 1:45 p.m., an interview was conducted with Dietary Staff C. They were asked about their role in identifying and evaluating residents with weight loss. They explained that they typically reviewed the nutritional assessment conducted by Dietary Staff B and reviewed "pretty much anyone that had a weight change." When asked if the facility should determine residents' calorie and protein needs, Dietary Staff C stated, "That is kind of old school. I don't really look at that too much." Regarding Resident #1, Dietary Staff C explained that the facility, "had been reviewing [them]," due to, "recent weight loss." They added, "I remember in the very beginning [they] went from 232 [pounds] to like 210 [pounds]. We thought in the very beginning that it was edema-related, but I remember discussing and telling [Dietary Staff B] that I didn't think it was related to edema." Dietary Staff C further explained that they had initially recommended the Ensure supplement but had been told that the resident "wasn't that into it." Dietary Staff

	C stated that they were not aware the physician had discontinued Resident #1's Ensure supplements due to concerns about edema, and acknowledged that they had not communicated with the physician regarding Resident #1's weight loss. Dietary Staff C then added that they felt the resident's weight loss was "probably due to multiple issues," but acknowledged that no cause for Resident #1's weight loss had been identified.
51.200(a) Physical Environment The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. (a) Life safety from fire. 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>Smoke Barriers and Sprinklers</u>** Based on records review, observation, and interview the facility failed to ensure the dry sprinkler system was properly inspected and tested. The deficient practice affected four (4) of four (4) smoke compartments, staff, and all residents. The facility had a capacity for 60 beds with a census of 40 on the day of the survey. The findings include: Records review on 7/19/22, at 11:15 a.m., of the Contractor's Material and Test Certificate for Aboveground Piping test report, dated 6/28/22, revealed that the dry pipe sprinkler system was hydrostatically tested with 200 psi for two (2) hours. Additional records review at that time revealed that the facility had not completed an air pressure leakage test with 40 psi for 24 hours, as required by section 24.2.2.1. of NFPA 13, Standard for the Installation of Sprinklers. Observation during the tour of the facility on 7/20/22, at 11:48 a.m., revealed a nitrogen pressure system was recently installed for the facility's dry sprinkler system. The riser room where the nitrogen system was installed revealed all new dry system riser piping and gauges with backflow preventer. The installation tag on the riser for the dry sprinkler system was dated 6/29/22. An interview on 7/20/22, at 2:00 p.m., with Maintenance Staff A revealed that the sprinkler system was recently installed, and they were not aware of why the air pressure leakage test was not completed as required. The census of 40 was verified by Maintenance Staff A on 7/19/22. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 7/21/22. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012) Chapter 19 Existing Health Care Occupancies** **19.3.5.1** Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler

	system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. **9.7 Automatic Sprinklers and Other Extinguishing Equipment.** **9.7.1 Automatic Sprinklers.** **9.7.1.1*** Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: (1) NFPA 13, Standard for the Installation **Actual NFPA Standard: NFPA 13, Standard for the Installation of Sprinkler Systems (2010) Chapter 24 Systems Acceptance** **24.2** Acceptance Requirements. **24.2.2** Dry Pipe and Double Interlock Preaction System(s) Air Test. **24.2.2.1** In addition to the standard hydrostatic test, an air pressure leakage test at 40 psi (2.8 bar) shall be conducted for 24 hours. Any leakage that results in a loss of pressure in excess of 1½ psi (0.1 bar) for the 24 hours shall be corrected.