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: Baldomero Lopez Veterans Nursing Home

Location: 6919 Parkway Boulevard Land O Lakes, FL 34639

Onsite / Virtual: Onsite

Dates of Survey: 9/20/22 through 9/23/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 120

Census on First Day of Survey: 83

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from 9/20/22, through 9/23/22, at Baldomero Lopez Veterans Nursing Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.110 (e) (2) Comprehensive care plans. A comprehensive care plan must be— (i) Developed within 7 calendar days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment	Based on interviews and record review, the facility failed to revise the comprehensive Care Plan to reflect actual levels of assistance required by residents for activities of daily living for one (1) (Resident #14) resident reviewed. The findings include: Review of Resident #14's medical record revealed an admission date of 2017. Resident #14's primary medical diagnosis was Poisoning by Unspecified Drugs resulting in a Hypoxic Brain Injury. Secondary medical diagnoses included: Dysphagia, Aphasia, Contracture of the Left Hand, and Contracture of the Right Hand. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident had a severe cognitive impairment. Resident #14 was assessed as requiring extensive assistance of one (1) staff member for eating.

Level of Harm – Actual Harm that is not immediate jeopardy Residents Affected – Few	An "Investigation Report Template" prepared by the facility was reviewed. The report was generated after Resident #14 suffered a suspected choking incident and expired. The report indicated that on the day of the incident, Resident #14 was "awake and alert, but would not verbally converse with staff." The report went on to explain that Licensed Nurse A set up Resident #14's tray and Resident #14 held their utensil and began to feed themself. The report added that, about five minutes later, at 11:55 a.m., Licensed Nurse A entered Resident #14's room and noted that Resident#14 was "not acting normally." Licensed Nurse A noted Resident #14 making "retching sounds," and also noted Resident #14 did not respond when Licensed Nurse A asked if Resident #14 was ok. Licensed Nurse A then noted Resident #14's lips turning blue and performed the Heimlich Maneuver twice. Licensed Nurse B entered the room and performed the Heimlich Maneuver four times. All attempts to clear Resident #14's airway were unsuccessful. Subsequently, Resident #14 became unresponsive and Cardiopulmonary Resuscitation (CPR) was initiated. Staff continued CPR until paramedics arrived and took over. Resident #14 was transferred to the hospital where they expired. Review of the most recent "Resident Acuity Instrument," dated [DATE], authored by Licensed Nurse A, indicated Resident #14 required, "Constant attendance by staff to hand feed and to ensure adequate intake." The assessment also indicated Resident #14 "needs constant supervision." Review of the care flow records for [DATE] revealed a total of 26 entries of Resident #14's requirements for assistance with eating. Of the 26 entries, nine (9) indicated total dependence, four (4) indicated supervision, four (4) indicated limited assistance, and eight (8) indicated "activity did not occur." Review of Resident #14's comprehensive Care Plan revealed a focus area for self-care deficit. An intervention, dated [DATE], indicated Resident #14 was able to feed themselves "at times" after the meal tray had been set up. The intervention did not specify assessment data that staff should consider when determining whether Resident #14 would be able to feed themself at the time of each meal.
§ 51.120 (a) (4) Reporting of Sentinel Events The facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event	Based on interviews and record review, the facility failed to submit a written report of a sentinel event investigation within 10 working days following an event that occurred on [DATE]. The findings include: Review of Resident #14's medical record revealed an admission date of 2017. Resident #14's primary medical diagnosis was Poisoning by Unspecified Drugs resulting in a Hypoxic Brain

is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Injury. Secondary medical diagnoses included Dysphagia, Aphasia, Contracture of the Left Hand, and Contracture of the Right Hand. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed a BIMS score of 99, which indicated the resident had a severely impaired cognition or was rarely understood. Resident #14 was assessed as requiring extensive assistance of one (1) staff member for eating. An "Investigation Report Template" prepared by the facility was reviewed. The report was generated after Resident #14 suffered a suspected choking incident and expired. The report was dated [DATE]. According to communication with the Veterans Administration (VA) Central Office, the facility submitted initial notification of the Sentinel Event within 24 hours but failed to submit a written report of investigation findings within 10 working days. During an interview with Administrative Staff A and Administrative Staff B, on 9/23/22, at 1:15 p.m., both parties explained that they were unsure which person at the VA Medical Center was supposed to receive the Sentinel Event investigation report and that the report was sent on [DATE], to a person believed to be a liaison at the medical center. According to further communication with the VA Central Office, staff (including the person the facility alleged the report was sent to) at the VA Medical Center had confirmed that, as of [DATE], the report had not been received.
§ 51.120 (i) Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. Level of Harm – Actual Harm that is not immediate jeopardy Residents Affected – Few	Based on interviews and record review, the facility failed to provide the necessary supervision and assistance during meals to prevent an incident of choking for one (1) of one (1) resident reviewed for accidents (Resident #14). The findings include: According to the Mayo Clinic (https://www.mayoclinic.org/drugs-supplements/lorazepam-oral-route/side-effects/drg-20072296?p=1 accessed 9/23/22), Ativan is a Central Nervous System Depressant which slows down the nervous system: "This medicine may cause drowsiness, trouble with thinking, trouble with controlling movements, or trouble with seeing clearly." Review of Resident #14's medical record revealed an admission date of 2017. Resident #14's primary medical diagnosis was Poisoning by Unspecified Drugs resulting in a Hypoxic Brain Injury. Secondary medical diagnoses included Dysphagia, Aphasia, Contracture of the Left Hand, and Contracture of the Right Hand.

	A quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident had a severe cognitive impairment. Resident #14 was assessed as requiring extensive assistance of one (1) staff member for eating. An "Investigation Report Template" prepared by the facility was reviewed. The report was generated after Resident #14 suffered a suspected choking incident and expired. The report indicated that on the day of the incident, Resident #14 was "awake and alert, but would not verbally converse with staff." The report went on to explain that Licensed Nurse A set up Resident #14's tray and Resident #14 held their utensil and began to feed themself. The report added that about five minutes later, at 11:55 a.m., Licensed Nurse A entered Resident #14's room and noted that they were "not acting normally." Licensed Nurse A noted Resident #14 making "retching sounds," and also noted Resident #14 did not respond when Licensed Nurse A asked if Resident #14 was ok. Licensed Nurse A then noted Resident #14's lips turning blue and performed the Heimlich Maneuver twice. Licensed Nurse B entered the room and performed the Heimlich Maneuver four times. All attempts to clear Resident #14's airway were unsuccessful. Subsequently, Resident #14 became unresponsive and Cardiopulmonary Resuscitation (CPR) was initiated. Staff continued CPR until paramedics arrived and took over. Resident #14 was transferred to the hospital where they expired. On 9/22/22, at 12:12 p.m., an interview was conducted with Licensed Nurse A. Licensed Nurse A confirmed they were familiar with Resident #14 and explained that Resident #14 was on a regular diet with thin liquids. Licensed Nurse A identified Resident #14 as having bilateral hand contractures and explained that Resident #14 “still had some use of fingers on both hands and was able to finagle a two-handled sip cup or a spoon.” Licensed Nurse A explained that Certified Nurse Aide A had set up Resident #14’s tray and soon after, Licensed Nurse A brought in Resident #14’s room mate’s tray. Licensed Nurse A noted Resident #14 making audible retching sounds and stated, “I knew something wasn’t right and I asked [Resident #14] if [they] were ok.” Licensed Nurse A added that Resident #14 did not respond when questioned. Licensed Nurse A performed the Heimlich Maneuver twice but was thrown off the bed by Resident #14. Licensed Nurse B then entered the room and performed the Heimlich Maneuver four more times before initiating CPR as Resident #14 went unconscious. Licensed Nurse A explained that Resident #14 was initially upright in the bed. They were unsure whether the call light was within reach at the time of the incident and described Resident #14 as “not really able to use the call light.” Licensed Nurse A then recalled

	that Resident #14 had received a dose of Ativan (anti-anxiety) on the overnight shift by another nurse, and that Licensed Nurse A had administered the scheduled 9 a.m. dose, which was not effective. Licensed Nurse A added that a second dose had to be administered around 11 a.m., and stated, “I had never had to do that before for [Resident #14]. Licensed Nurse A explained that Resident #14 was rocking back and forth in the bed much more than usual and that “something was definitely different that day.” On 9/22/22, at 12:22 p.m., an interview was conducted with Certified Nurse Aide A. Certified Nurse Aide A confirmed that they were familiar with Resident #14 and confirmed that they were on duty on the day of the incident. Certified Nurse Aide A also confirmed that Resident #14 had bilateral hand contractures. Certified Nurse Aide A stated they delivered Resident #14's meal tray, set up the tray, and cut up the food. Certified Nurse Aide A stated they then placed the utensil in Resident #14's hand and Resident #14 began to feed themself. Certified Nurse Aide A stated that they then left the room. Certified Nurse Aide A added that Resident #14 was in bed and that the head of the bed was upright. Certified Nurse Aide A was unable to recall whether the call light was within reach of Resident #14 or whether Resident #14 was able to use the call light. Certified Nurse Aide A described Resident #14 as being able to feed themself "sometimes." When asked how they determined whether Resident #14 needed assistance, Certified Nurse Aide A stated, "sometimes if [Resident #14] was awake and alert and talking then [Resident #14] would usually feed [themself] but if [they were] quiet and just staring then we would have to feed [them]." Certified Nurse Aide A stated Resident #14 was alert and talking on the day of the incident. Review of the most recent "Resident Acuity Instrument," dated [DATE], authored by Licensed Nurse A, indicated Resident #14 required "Constant attendance by staff to hand feed and to ensure adequate intake." The assessment also indicated Resident #14 "need[ed] constant supervision." Review of the care flow records for [DATE] revealed a total of 26 entries of Resident #14's requirements for assistance with eating. Of the 26 entries, nine (9) indicated total dependence, four (4) indicated supervision, four (4) indicated limited assistance, and eight (8) indicated "activity did not occur." Review of Resident #14's comprehensive Care Plan revealed a focus area for self-care deficit. An intervention, dated [DATE], indicated Resident #14 was able to feed themself "at times" after the meal tray had been set up. Continued review of the comprehensive Care Plan revealed a focus area for nutritional status. An intervention, dated [DATE],

	indicated Resident #14 had a "self-feeding deficit" due to bilateral hand contractures.
§ 51.200 (b) Emergency power. **(**1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination. (2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. (3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Health Care Facilities Code. (4) The source of power must be an on site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with 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	Based on observation and interview, the facility failed to ensure that an emergency remote stop switch was installed for the emergency generators. The deficient practice affected six (6) of six (6) smoke compartments, staff, and all residents. The facility had a capacity for 120 beds with a census of 83 on the day of the survey. The findings include: Observation during the building inspection tour, on 9/20/22, at 11:16 a.m., revealed that the facility's emergency generator one and generator two were not provided with a remote manual stop station located elsewhere on the premises, as required by section 5.6.5.6 and 5.6.5.6.1 of NFPA 110, Standard for Emergency and Standby Power Systems. An interview with Maintenance Staff A at that time revealed the facility was not aware of the requirement and would contact the contractor. The census of 83 was verified by Administrative Staff B on 9/20/22. The findings were acknowledged by Administrative Staff B and Maintenance Staff A during the exit interview on 9/20/22, at 4:06 p.m. **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. **Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems (2010)** **5.6.5.6*** All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. **5.6.5.6.1** The remote manual stop station shall be labeled.