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: Missouri Veterans Home – Mt. Vernon

Location: 1600 S. Hickory, MT Vernon, MO 65712

Onsite / Virtual: Onsite

Dates of Survey: 10/31/23 – 11/3/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 200

Census on First Day of Survey: 123

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from 10/31/23, to 11/3/23, at the Missouri State Veterans Home – Mt. Vernon. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.100 (a) Dignity. (a) Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, record review, and policy review, the facility failed to promote care for one (1) of six (6) sampled residents in a manner that maintained or enhanced each resident's dignity and respect in full recognition of their individuality. The findings include: Review of the policy titled, "Missouri Veterans Homes Veteran Rights," dated 9/1/23, stated: "Missouri Veterans Commission protects and promotes the rights of each Veteran admitted to one of our Veterans Homes in order to provide a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility shall protect and promote the rights of each Veteran and ensure each is treated with respect and dignity." Review of Resident #1's Face Sheet revealed the facility admitted Resident #1 on [DATE], with the following diagnoses: Atherosclerotic Heart Disease, Aphasia, Diabetes Mellitus Type

	II, Cerebral Infarction, Depression, Anxiety, and Neuromuscular Dysfunction of the Bladder. Review of the Quarterly Minimum Data Set (MDS), dated and signed on [DATE], revealed the resident had an indwelling catheter. Continued review revealed a Brief Interview for Mental Status Score (BIMS) of 12, which indicated the resident was cognitively intact. Review of the Care Plan, dated [DATE], revealed: "Indwelling Foley Catheter; I have an indwelling foley catheter and am at risk for Urinary Tract Infection. Dx (diagnosis); Neurogenic Bladder. Intervention: 1. Dignity Bag Cover- Discipline: Direct Support, [Licensed Nurse], [Licensed Nurse]." Observation of Resident #1 in their room, on 10/31/23, at 12:00 p.m., revealed the resident to be alert, awake, and talkative. The resident was observed to be sitting in a chair and watching television. A urinary drainage bag with amber urine in it was observed laying on the floor next to the resident and no Dignity Bag Cover was observed. Observation of Resident #1, on 11/1/23, at 9:30 a.m., revealed the resident resting in a chair in their room. The resident was alert and awake. A urinary drainage bag was noted on the chair side without a Dignity Bag Cover. Amber urine was observed in the tubing and the drainage bag. An interview with Administrative Nurse A, on 11/2/23, at 9:45 a.m., revealed staff should have placed a Dignity Bag Cover over the resident's urinary drainage bag. An interview with Certified Nurse Aide A, on 11/2/23, at 2:30 p.m., revealed staff had received training on the use of Dignity Bags, and the bags should be used on resident's urinary drainage bags so everyone could not see their urine.
§ 51.140 (g) Assistive devices. The facility management must provide special eating equipment and utensils for residents who need them. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, record review, and interviews, it was determined that one (1) of 22 sampled residents did not receive the necessary built-up utensils for meals, as recommended by Restorative Therapy. The adaptive device was needed to assist the resident with eating (Resident #14). The findings include: Review of the facility policy, "Restorative Dining Program," dated 9/1/23, documented: "The Restorative Dining Program at the Missouri Veterans Home is a team effort to enhance and/or improve the independent dining experience by providing needed cueing and adaptive equipment that is necessary based on the assessment of the [Consultant Staff A], in conjunction with

	implementing swallowing guidelines as outlined by Speech Therapy and/or recommendations of the Interdisciplinary team." Resident #14 was admitted to the facility on [DATE], with diagnoses including: Major Depressive Disorder, Peripheral Neuropathy, and Dementia. The most recent significant change Minimum Data Set (MDS) assessment revealed the resident had a Brief Interview for Mental Status (BIMS) score of three (3), which indicated severely impaired cognition. The MDS also coded the resident as needing assistance with eating. Review of Resident #14's Care Plan, dated [DATE], documented: "Nutritional Needs: I have Diabetes. At risk for fluctuations in weight due to diagnosis (DX): Heart Failure at risk for weight loss. At risk for chewing difficulty and dental discomfort due to dental decay. Related to history of choking on milk." Listed under "goals" was the following: "I will be able offered optimal nutrition and tolerate consistency of diet through next review with no chewing or swallowing problems." Listed under "Interventions," was the following: "Red build up foam utensils." Further review of the medical record revealed a "Therapy Request," dated [DATE], which recommended: "Red foam built up utensils for all meals." Observation of Resident #14 during the noon meal, on 11/1/23, at approximately 12:00 p.m., revealed the resident did not receive red foam utensils. The resident's "Diet Card" documented: "Adaptive Equip: Red Foam Built Up Utensils." Certified Nurse Aide B, who was attempting to assist Resident #14, stated the resident really didn't use the built-up utensils. Resident #14 stated that their hands and fingers didn't work that well anymore. Observations and interview with Certified Nurse Aide C, on 11/2/23, at 12:18 p.m., revealed Resident #14 did not receive the red built up utensils again. Certified Nurse Aide C was passing out trays on the unit at this time and stated that dietary was supposed to bring down all the adaptive utensils, and they had never seen red built-up utensils on the unit. Certified Nurse Aide C went to look for the utensils, but couldn't find them. On 11/2/23, at 1:00 p.m., in an interview with Administrative Nurse B, they stated that they couldn't find the utensils, and the therapy department was going to order some. On 11/3/23, at 11:00 a.m., in an interview with Consultant Staff B, they stated that Resident #14 was supposed to get the built-up utensils, and that the resident was doing really well with them.

	On 11/3/23, at 11:30 a.m., in an interview with Dietary Staff A, they stated that Resident #14 should have been provided the adaptive equipment listed on the diet card.
§ 51.200 (a) Life safety from fire. (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** – Some	**Smoke Barriers and Sprinklers** Based on record review, observations, and interview, the facility failed to maintain the smoke barrier walls. The deficient practice affected two (2) of two (2) smoke compartments in [LOCATION], staff, and 33 residents. The facility had a capacity for 200 beds with a census of 123 on the first day of the survey. The findings include: Record review of the facility's plans, on 11/2/23, at 9:15 a.m., noted that all four (4) of the resident halls: [LOCATIONS] were identical. All had a one (1) hour rated smoke barrier creating two (2) smoke compartments for each neighborhood. During the building inspection tour, on 11/3/23, at 9:13 a.m., an observation of the smoke barrier wall between resident rooms [LOCATIONS] and [LOCATIONS] in [LOCATION], located inside of [LOCATION], revealed that a sprinkler pipe had a gap around it of two (2) to three (3) inches. On the other side of the smoke barrier wall, in [LOCATION], the same sprinkler pipe had a gap around it of 3 to 4 inches. The smoke barrier would not resist the passage of smoke as required by section 8.5.7.4 of NFPA 101, Life Safety Code. An interview with Maintenance Staff A, on 11/3/23, at 9:15 a.m., revealed all the sprinkler piping in the facility had been replaced in the last two (2) years, and they were unaware of the penetrations around the sprinkler piping. The census of 123 was verified by Administrative Staff A on 11/2/23, at 9:15 a.m. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff A during the exit interview on 11/3/23, at 12:45 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.7.3** Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1⁄2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor.

	(2) *Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. 8.5 Smoke Barriers. 8.5.6 Penetrations. 8.5.6.1 The provisions of 8.5.6 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations of smoke barriers. 8.5.6.2 Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. 8.5.6.3 Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless the requirements of 8.5.6.4 are met. 8.5.6.4 Where sprinklers penetrate a single membrane of a fire resistance–rated assembly in buildings equipped throughout with an approved automatic fire sprinkler system, noncombustible escutcheon plates shall be permitted, provided that the space around each sprinkler penetration does not exceed 1⁄2 in. (13 mm), measured between the edge of the membrane and the sprinkler. 8.5.6.5 Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be securely set in the smoke barrier, and the space between the item and the sleeve shall be filled with a material capable of restricting the transfer of smoke. 8.5.6.6 Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: (1) It shall be provided on either side of the smoke barrier. (2) It shall be designed for the specific purpose. 8.5.7 Joints. 8.5.7.1 The provisions of 8.5.7 shall govern the materials and methods of construction used to protect joints in between and at the perimeter of smoke barriers or, where smoke barriers meet other smoke barriers, the floor or roof deck above, or the outside walls. The provisions of 8.5.7 shall not apply to approved existing materials and methods of construction used to protect existing joints in smoke barriers, unless otherwise required by Chapters 11 through 43.

	8.5.7.2 Joints made within or at the perimeter of smoke barriers shall be protected with a joint system that is capable of limiting the transfer of smoke. 8.5.7.3 Joints made within or between smoke barriers shall be protected with a smoke-tight joint system that is capable of limiting the transfer of smoke. 8.5.7.4 Smoke barriers that are also constructed as fire barriers shall be protected with a joint system that is designed and tested to resist the spread of fire for a time period equal to the required fire resistance rating of the assembly and restrict the transfer of smoke. 8.5.7.5 Testing of the joint system in a smoke barrier that also serves as fire barrier shall be representative of the actual installation suitable for the required engineering demand without compromising the fire resistance rating of the assembly or the structural integrity of the assembly. **Electrical Systems** Based on observation and interview, the facility failed to properly secure compressed gas cylinders. The deficient practice affected one (1) of two (2) smoke compartments in [LOCATION], staff, and no residents. The facility had a capacity for 200 beds with a census of 123 on the day of the survey. The findings include: Observation during the building inspection tour, on 11/2/23, at 1:48 p.m., revealed six (6) Oxygen “E” cylinders and two (2) Oxygen “D” cylinders unsecured in [LOCATION],, as prohibited by section 11.6.2.3 (11) of NFPA 99 Health Care Facilities Code. During an interview, on 11/2/23, at 1:48 p.m., with Maintenance Staff A, when asked about the unsecured oxygen cylinders, they stated, “We will get racks.” The census of 123 was verified by Administrative Staff A on 11/2/23, at 9:15 a.m. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff A during the exit interview on 11/3/23, at 12:45 p.m. **Actual NFPA Standard: NFPA 99 Health Care Facilities Code (2012)** 11.3.2.6 Cylinder or container restraints shall comply with 11.6.2.3. 11.6.2.3 Cylinders shall be protected from damage by means of the following specific procedures: (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart.