# 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:** Alaska State Veterans and Pioneers Home

**Location:** 250 East Fireweed, Palmer, AK 99645

**Onsite / Virtual:** Onsite

**Dates of Survey:** 5/24/24

**NH / DOM / ADHC:** DOM

**Survey Class:** Annual

**Total Available Beds:** 65

**Census on First Day of Survey:** 64

| VA Regulation Deficiency | Findings |
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| | Initial Comments:<br><br>A VA Annual Survey was conducted on 5/24/24, at the Alaska State Veterans and Pioneers Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes. |
| **§ 51.43(e) Drugs and medicines for certain veterans**<br>As a condition for receiving drugs or medicine under this section or under §17.96 of this chapter, the State must submit to the VA medical center of jurisdiction a completed VA Form 10-0460 with the corresponding prescription(s) for each eligible veteran.<br><br>**Level of Harm** – No Actual Harm, with potential for minimal harm<br>**Residents Affected** – Few | The facility was unable to demonstrate completion and submission of VA Form 10-0460 for Veterans who are be eligible to have medications provided by the VA of jurisdiction.<br><br>Based on interviews and record reviews, the facility obtained medications from the Veterans Affairs (VA) of jurisdiction for one Veteran who meets eligibility under 38 CFR §51.43. During interviews and record reviews, the facility was unable to produce a copy of a completed VA Form 10-0460 as required for each eligible Veteran. |
| **§ 51.140 (e) Therapeutic diets.**<br>Therapeutic diets must be prescribed by the primary care physician.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm | Based on staff interview, record review, and facility policy review, the facility failed to ensure two (2) of six (6) sampled residents (Resident #3 and Resident #5) had orders entered into their electronic health records (EHR) to specify what type and consistency of diets they each were to receive.<br><br>The findings include: |

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| **Residents Affected** – Few | Record reviews conducted on six (6) sampled residents found two (2) of the six (6) residents had no diet orders in their electronic health records.<br><br>Review of Resident #3's medical record found the resident was admitted to the facility on [DATE]. Review of the resident's Order Summary Report for [DATE], found no current diet order. A review of all diet orders entered into the resident's electronic health record, which included diet orders that had been discontinued or completed, found no diet order had been entered into the electronic health record since the resident's admission to the facility on [DATE].<br><br>The absence of a diet order in Resident #3's electronic health record was reported to Administrative Nurse A in an email at 1:54 p.m., on 5/24/24. At 1:57 p.m., on 5/24/24, Administrative Nurse A responded by email and verified that a diet order had not been entered into the resident's electronic health record.<br><br>Review of Resident #5's record found the resident was admitted to the facility on [DATE]. Review of the resident's Order Summary Report for [DATE], found no current diet order. A review of all diet orders entered into the resident's electronic health record, which included diet orders that had been discontinued or completed, found no diet order had been entered into the electronic health record since the resident's admission to the facility on [DATE].<br><br>The absence of a diet order in Resident #5's electronic health record was reported to Administrative Nurse A in an email at 3:01 p.m., on 5/24/24. At 3:08 p.m., on 5/24/24, Administrative Nurse A responded by email and verified that a diet order had not been entered into the resident's electronic health record. |
| **§ 51.140 (h) Sanitary conditions.**<br>The facility must:<br>(1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities;<br>(2) Store, prepare, distribute, and serve food under sanitary conditions; and<br>(3) Dispose of garbage and refuse properly.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Some | Based on observation and staff interview, the facility failed to maintain a commercial grade roll-through refrigerator (which was accessible to staff from inside the [LOCATION], and to residents from inside the [LOCATION]) with a gasket to create an effective seal, and with an internal thermometer for monitoring the refrigerator's temperature. This had the potential to affect all residents in the facility who ate their meals in the [LOCATION]. The facility had a census of 64 residents.<br><br>The findings include:<br><br>Observation of the [LOCATION], at 11:30 a.m., on 5/24/24, found a commercial grade refrigerator with a door that opened into the [LOCATION]. On the refrigerator's door was a printed sign that stated, "Please remember the food in this refrigerator is for our Residents – Thanks!!!" Examination found a gasket on |

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| | the leading edge of the door; approximately 10 inches of the gasket from the bottom of the door, and up the side of the leading edge, was split open.<br><br>At 12:00 p.m., on 5/24/24, the surveyor showed the gasket to Maintenance Staff A, who confirmed it was damaged. At that time, the [LOCATION] facing door to the refrigerator was opened to view the contents of the refrigerator, and the internal temperature was checked. Observation inside the refrigerator found a wheeled rack containing multiple plastic tumblers that contained pre-poured beverages. Further observation found no thermometer inside the unit. The surveyor accompanied Maintenance Staff A into the [LOCATION] to check the temperature via the exterior digital temperature display. Per the exterior display, the internal temperature of the roll-through refrigerator was 33 degrees Fahrenheit. Further examination of the roll-through refrigerator in the presence of Maintenance Staff A by an unidentified Dietary Staff found there was no thermometer inside. The unidentified Dietary Staff confirmed a thermometer should have been present, and they went to locate one. |
| **§ 51.200 (c) (2) Space and equipment.**<br>(2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Many | 1. Based on observation, records review, and interview, the facility failed to properly inspect and test all components of the emergency generator. The deficient practice affected five (5) of five (5) smoke compartments, staff, and all residents. The facility had a capacity for 65 beds with a census of 64 on the day of the survey.<br><br>The findings include:<br><br>Records review, on 5/21/24, at 11:14 a.m., revealed the facility did not have any documentation of specific gravity or conductance test readings for the battery for the emergency generator. Additional records review revealed the words "sealed battery" was written in on the monthly generator testing log sheet.<br><br>Observation, on 5/21/24, at 11:30 a.m., revealed the facility had a maintenance free generator battery.<br><br>The facility failed to perform conductance testing on the maintenance free generator battery in lieu of specific gravity testing as required by section 8.3.7.1 of NFPA 110, Standard for Emergency and Standby Power Systems.<br><br>An interview, on 5/21/24, at 11:30 a.m., with Maintenance Staff A revealed the facility had recently had the maintenance free battery installed and was unaware of the requirement to perform conductance testing in lieu of specific gravity testing for maintenance free type generator batteries. |

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| | The census of 64 was verified by Administrative Staff A on 5/21/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 5/24/24, at 4:00 p.m.<br><br>**Actual NFPA Standard: NFPA 101, Life Safety Code (2012)**<br>**19.5 Building Services.**<br>**19.5.1 Utilities.**<br>**19.5.1.1** Utilities shall comply with the provisions of Section 9.1.<br>**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.<br>**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.<br><br>**Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems (2010)**<br>**8.3.7.1** Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted.<br><br>2. Based on records review and interview, the facility failed to conduct annual fuel quality testing in accordance with the code. The deficient practice affected one (1) of one (1) smoke compartments, staff, and all residents. The facility had a capacity for 65 beds with a census of 64 on the day of the survey.<br><br>The findings include:<br><br>Records review, on 5/21/24, at 12:00 p.m., of the generator inspection, testing, and maintenance records for the 12 months prior to the day of survey revealed the facility did not have documentation of a fuel quality test being performed within the last year. There was no record of any annual fuel quality testing occurring within the last 12 months preceding the survey, as required by section 8.3.8 of NFPA 110, Standard for Emergency and Standby Power Systems.<br><br>An interview with Maintenance Staff A, on 5/21/24, at 12:00 p.m., revealed the facility was not aware of the requirement to perform annual fuel quality testing of the fuel for the emergency generator.<br><br>The census of 64 was verified by Administrative Staff A on 5/21/24, at 9:30 a.m. The findings were acknowledged by |

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| | Administrative Staff A and verified by Maintenance Staff A during the exit interview on 5/24/24, at 4:00 p.m.<br><br>**Actual NFPA Standard: NFPA 101, Life Safety Code (2012)**<br>**19.5 Building Services.**<br>**19.5.1 Utilities.**<br>**19.5.1.1** Utilities shall comply with the provisions of Section 9.1.<br>**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.<br>**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.<br><br>**Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems (2010)**<br>**8.3.8** A fuel quality test shall be performed at least annually using tests approved by ASTM standards.<br>**8.4.2*** Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:<br>**(1)** Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer<br>**(2)** Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating<br>**8.4.2.3** Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. |
| **§ 51.200 (h) (1) Other environmental conditions.**<br>The facility management must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must—<br>(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. | Based on observation and interview, the facility failed to provide a safe environment for the residents, staff, and the public. The deficient practice affected three (3) of five (5) smoke compartments, staff, and two (2) residents. The facility had a capacity for 65 beds with a census of 64 on the day of the survey.<br><br>The findings include:<br><br>1. Observation, on 5/24/24, at 11:30 a.m., of the wooden roof beam supporting a section of the eve of the building outside of [LOCATION] on the [LOCATION] revealed that approximately 50% of the beam appeared to be rotten due to what appeared to be water damage. |

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| **Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Few | An interview with Maintenance Staff A, on 5/24/24, at 11:30 a.m., revealed the facility was aware of the damage to the wooden beam and had reported the damage to the state.<br><br>2. Observation, on 5/24/24, at 11:45 a.m., of the wooden roof beam supporting a section of the eve of the building outside of [LOCATION] on the [LOCATION] revealed that approximately 10% of the beam appeared to be rotten due to what appeared to be water damage.<br><br>An interview with Maintenance Staff A, on 5/24/24, at 11:45 a.m., revealed the facility was aware of the damage to the wooden beam and had reported the damage to the state.<br><br>3. Observation, on 5/24/24, at 12:00 p.m., of the drywall ceiling in the [LOCATION] revealed a large section of drywall ceiling had received significant water damage and was in need of repair.<br><br>An interview with Maintenance Staff A, on 5/24/24, at 12:00 p.m., revealed the facility was aware of the damage to the ceiling in the [LOCATION] and had reported the damage to the state.<br><br>The census of 64 was verified by Administrative Staff A on 5/21/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 5/24/24, at 4:00 p.m. |
| **§ 51.210 (q) (1) Disaster and emergency preparedness.**<br>(1) The facility management must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Many | Based on records review and interview, the facility failed to have detailed written plans and procedures to meet all potential emergencies and disasters. The deficient practice affected one (1) of one (1) smoke compartments, staff, and all residents. The facility had a capacity for 65 beds with a census of 64 on the day of the survey.<br><br>The findings include:<br><br>1. Records review, on 5/24/24, at 9:00 a.m., of facility's Hazard Vulnerability Analysis (HVA) revealed the facility's HVA did not include elopement or missing residents as a potential facility-based hazard.<br><br>An interview with Maintenance Staff A, on 5/24/24, at 9:00 a.m., revealed the facility was not aware the facility's HVA needed to include elopement or missing residents as a potential facility-based hazard.<br><br>2. Records review, on 5/24/24, at 9:30 a.m., of the facility's Emergency Preparedness Plan revealed the facility did not have |

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| | Memos of Understanding (MOUs) with the following key suppliers to make every effort to make delivery of emergency supplies during disasters:<br><br>A. The facility's food delivery supplier<br>B. The facility's diesel fuel delivery supplier<br>C. A company to deliver a temporary generator in the event of generator failure<br><br>An interview with Maintenance Staff A, on 5/24/24, at 9:30 a.m., revealed the facility was not aware the facility needed MOUs with key suppliers to assure the facility was prioritized in the event of natural and man-made disasters in order for the facility to receive food, fuel, and temporary generator power services.<br><br>The census of 64 was verified by Administrative Staff A on 5/21/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview at 4:00 p.m., on 5/24/24. |
| **§ 51.300 (d) (5) Timing of the notice.**<br>(i) The notice of transfer or discharge required by paragraph (d)(4) of this section must be made by the facility at least 30 calendar days before the resident is transferred or discharged, except when specified in paragraph (d)(5)(ii) of this section, (ii) Notice may be made as soon as practicable before transfer or discharge when<br>(A) The safety of individuals in the facility would be endangered;<br>(B) The health of individuals in the facility would be otherwise endangered;<br>(C) The resident's health improves sufficiently so the resident no longer needs<br>the services provided by the domiciliary; or<br>(D) The resident's needs cannot be met in the domiciliary.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Few | Based on staff interview, record review, and facility policy review, the facility failed to provide a written notice of transfer to one (1) of six (6) sampled residents who was transferred to the hospital for an acute change in condition (Resident #2).<br><br>The findings include:<br><br>Record review revealed Resident #2 was admitted to the facility on [DATE], and was transferred to the hospital on three (3) different occasions since admission.<br><br>On [DATE], Resident #2 transferred to the hospital for a possible Gastrointestinal (GI) Bleed. A written transfer notice, dated [DATE], was completed for this transfer, and was uploaded into the resident's electronic health record. The resident returned the same day.<br><br>On [DATE], Resident #2 again transferred to the hospital for a possible GI Bleed. A written transfer notice, dated [DATE], was completed for this transfer, and was uploaded into the resident's electronic health record. The resident returned to the facility on [DATE].<br><br>Review of Progress Notes in the resident's electronic health record found a Health Status Note, dated [DATE], at 8:22 p.m., which stated: "Resident sent to the ER [emergency room] regarding right hand and arm weakness. Resident is currently admitted to [Name] Regional Hospital for stroke and UTI [urinary tract infection]. family [sic] and PCP [primary care provider] informed." No written transfer notice was found in the resident's electronic health record for this transfer. The resident was |

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| | subsequently admitted to the hospital and did not return to the facility until [DATE].<br><br>The absence of a written transfer notice in Resident #2's electronic health record, for [DATE], was reported to Administrative Nurse A in an email at 2:28 p.m., on 5/24/24. At 3:11 p.m.; on 5/24/24, Administrative Nurse A responded by email verifying that no written transfer notice had been uploaded into the resident's electronic health record for the transfer that occurred on [DATE]. |
| **§ 51.300 (e) Notice of bed-hold policy and readmission – notice before transfer.**<br>The State home must have a written bed-hold policy, including criteria for return to the facility. The facility management must provide written information to the resident about the State home bed-hold policy upon enrollment, annually thereafter, and before a State home transfers a resident to a hospital. A Resident has the right to decide whether to have the State home notify his or her legal representative or interested family member of transfers.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Many | Based on staff interview, record review, and facility policy review, the facility failed to provide a written bed hold policy/written notice to one (1) of six (6) sampled residents (Resident #2) upon the resident's transfer to the hospital for an acute change in condition on three (3) separate occasions.<br><br>The facility also failed to develop and implement a written bed-hold policy that ensured each resident received a copy of the bed-hold policy before the facility transferred the resident to a hospital, and ensured each resident was provided written information about the facility's bed-hold policy annually after a resident's enrollment as required by this regulation. This deficient practice had the potential to affect all residents of the facility. The facility had a census of 64 residents.<br><br>The findings include:<br><br>Review of the facility's policy titled, "Bed Hold," dated 1/13/21, revealed the following:<br><br>"PROCEDURES:<br>1. The Bed-Hold Operating Procedure applies to hospitalization or social/therapeutic leave. The right to exercise a bed-hold is applicable to all skilled unit residents and may not be used as a condition for admission or re-admission.<br><br>2. Upon admission, the resident and/or resident's representative(s) is/are informed of the facility bed hold provision via the Bed-Hold Acknowledgement. The resident and/or the resident's representative(s) will sign the Bed-Hold Acknowledgement. The Acknowledgement will be scanned the AVPH Electronic Health Record (EHR) system.<br><br>3. A bed-hold circumstance is one whereby AVPH [Alaska Veterans and Pioneers Home] holds a specific vacant bed for a resident who is temporarily absent, or scheduled to be temporarily absent from the Home, in cases where that bed would/will likely be filled with another resident admission. A bed-hold is used when the resident is, or scheduled to be, |

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| | absent from the facility at midnight. No bed will be held without bed-hold authorization.<br><br>4. The resident has the option to invoke the Bed-Hold Operating Procedure, if declined; they will be admitted to the next available bed following the usual admission screening process. The resident's belongings will be packed for safekeeping and kept in a secure location. The facility is only able to hold the resident's belongings for 72 hours, after which time the facility will determine the appropriate disposition of the belongings.<br><br>5. In situations where the Bed-Hold Agreement is not reviewed prior to hospital transfer or social/therapeutic leave, the Home will make every effort to contact the resident and/or resident's representative(s) within two [2] business days. The resident will have the option of holding the bed they currently occupy. The bed-hold is for a specific number of days as stated on the Bed-Hold Agreement.<br><br>A. If contact is made by telephone, the Bed-Hold Agreement will be noted as such.<br><br>C. In situations where the resident is incapable of signing [their] name, staff must secure the resident's mark 'X' followed by the name of the resident and the signature of two [2] witnesses.<br><br>D. If the time the resident is out of the facility exceeds the days authorized on the Bed-Hold Agreement, the resident and/or the resident's representative(s) will be contacted, and a new form will be completed, or the current one [1] amended.<br><br>E. The executed Bed-Hold Agreement will be scanned into their EHR (electronic health record)" [sic].<br><br>1. Record review revealed Resident #2 was admitted to the facility on [DATE], and was transferred to the hospital on three (3) different occasions since admission.<br><br>On [DATE], Resident #2 transferred to the hospital for a possible Gastrointestinal (GI) Bleed. The resident returned the same day. No written bed-hold notice was found in the resident's EHR for this hospital transfer.<br><br>On [DATE], Resident #2 again transferred to the hospital for a possible GI Bleed. The resident returned to the facility on [DATE]. No written bed-hold notice was found in the resident's EHR for this hospital transfer.<br><br>Review of Progress Notes in the resident's electronic health record found a Health Status Note, dated [DATE], at 8:22 p.m., |

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| | which stated: "Resident sent to the ER [emergency room] regarding right hand and arm weakness. Resident is currently admitted to [Name] Regional Hospital for stroke and UTI [urinary tract infection]. family [sic] and PCP [primary care provider] informed." The resident was subsequently admitted to the hospital and did not return to the facility until [DATE]. No written bed-hold notice was found in the resident's EMR for this hospital transfer.<br><br>The absence of bed-hold notices in Resident #2's EHR for the hospital transfers that occurred on [DATES], were reported to Administrative Nurse A in an email at 2:28 p.m., on 5/24/24. At 3:11 p.m., on 5/24/24, Administrative Nurse A responded by email verifying that no bed-hold notices could be found for any of the hospital transfers.<br><br>2. Record reviews for all six (6) sampled residents found all had resided at the facility for greater than 12 months, with admission dates as follows:<br><br>Resident #1 – [DATE]<br>Resident #2 – [DATE]<br>Resident #3 – [DATE]<br>Resident #4 – [DATE]<br>Resident #5 – [DATE]<br>Resident #6 – [DATE]<br><br>Each resident's EHR was reviewed for documentation demonstrating they had been provided written information about the facility's bed-hold policy on an annual basis. This was confirmed in an email from Administrative Nurse A at 3:11 p.m., on 5/14/24.<br><br>Review of the facility's bed-hold policy found no mention of the need to provide written information regarding the policy to a resident before the facility transferred the resident to a hospital, nor did the policy address the need to provide written information about the bed-hold policy to residents annually.<br><br>During the facility's exit conference, at 4:15 p.m., on 5/24/24, the executive leadership of the facility, including Administrative Staff A, Administrative Nurse A, and Consultant Staff A, reported being unaware of the requirement to provide written information about the facility's bed-hold policy to residents upon enrollment and annually thereafter. |