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: Alaska State Veterans and Pioneers Home

Location: 250 East Fireweed, Palmer, Alaska 99645

Onsite / Virtual: Virtual

Dates of Survey: 4/25/22-4/27/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 14

Census on First Day of Survey: 12

Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from April 25, 2022, to April 27, 2022, at the Alaska 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(b) Drugs and medicines for certain veterans (b) 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 - Some	The facility was unable to demonstrate that medications for residents receiving care at the State home were furnished subject to the limitation in §51.41(c)(2). Through discussions with facility leadership, it was identified that the facility could not validate that there was a process to determine for which residents the facility had the responsibility of paying the total medication cost. During a telephone interview with Administrative Staff A on 4/21/22, it was reported their third-party pharmacy was billing medication costs to residents' insurance plans, first. This process did not include a separate identification of residents for whom the facility received the prevailing rate of per diem reimbursement, and for whom the facility was thus responsible for all medication costs. Through a review on 4/26/22 of five (5) of five (5) residents for whom the facility received the prevailing rate of per diem reimbursement, it

	was identified that all five (5) residents' medication costs had been billed to the residents' insurance rather than the facility.
§ 51.110 (b) (4) Use. The results of the assessment are used to develop, review, and revise the resident's individualized comprehensive plan of care, under paragraph (d) of this section. Level of Harm – No Actual Harm, with potential for more than minimal harm. Resident Affected - Few	Based on interview, and record review, it was determined that for one (1) of nine (9) sampled residents (Resident #7) the facility failed to develop and implement a comprehensive care plan to address nutrition and weight loss. The findings include: Review of the facility policy "Health Care Services," dated 8/1/12, documented, "The Pioneer Homes ensure the provision interdisciplinary clinical services for the residents through assessment and documentation of needed services. B. A plan of care is established and maintained for each resident." Review of Resident #7's clinical record revealed an admission date of 2020 with a readmission date of 2021, with diagnoses which included: Dementia with Behavioral Disturbance, Weight loss, and Atrial Fibrillation. Review of Resident #7's most recent Quarterly Minimum Data Set (MDS) Assessment dated [DATE] revealed that the resident had a Brief Interview for Mental Status (BIMS) and was coded as 5, which indicated severely impaired cognition. The resident was also coded as needing supervision with set up, or one (1) person for help with most activities of daily living. The resident was coded as only needing supervision with eating. The MDS assessment revealed that the resident weighed 140 pounds and had no, or unknown, weight loss. Review of the Resident's documented weight list revealed Resident #7 experienced a seven (7) percent (12 pound) weight loss from [DATE] through [DATE], weighing 152 pounds on [DATE] and 140 pounds on [DATE]. Continued review of weights documented for Resident #7 revealed the resident experienced a 12% (percent) (19 pound) weight loss from [DATE] through [DATE], weighing 152 pounds on [DATE] and 133 pounds on [DATE]. Review of the Care Plan, revised on [DATE], revealed Resident #7's nutritional status and documented weight loss had not been identified as a problem deficit for the resident. There were no interventions developed to direct staff in the provision of services related to the resident's weight loss. Continued review of Resident #7's Care Plan, initiated [DATE], revealed Activities of Daily Living (ADL) had been identified as a focused concern area. Interventions had been developed to include Eating, set up Restorative Care, and encouraging the

	resident to choose snacks and beverages of choice. The Care Plan Indicated Resident #7 was getting snacks three times, per day. The Care Plan addressing ADLs for the resident did not identify weight loss as an identified concern. In an interview with Administrative Nurse A on 4/26/22 at 3:00 p.m., the nurse indicated that they had completed the nutritional portion of the [DATE] Quarterly MDS. Administrative Nurse A stated that the resident's weight loss should have been identified and a Care Plan developed with interventions to direct staff in the provision of services to address a potential for further weight loss.
§51.110(c) Accuracy of assessments (1) Coordination— (i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals. (ii) Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment. (2) Certification. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Level of Harm – No Actual Harm, with potential for more than minimal harm. Resident Affected - Some	Based on observation, interview, and record review, it was determined for six (6) of nine (9) sampled residents (Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7) the facility failed to conduct an assessment that accurately reflected each resident's status. The findings include: 1. Resident #2 was admitted to the facility in 2020, with diagnoses including End Stage Renal Disease (ESRD) and Diabetes Mellitus (DM). The most recent quarterly Minimum Data Set (MDS) assessment, dated [DATE], coded the resident as having bed rails as a restraint listed under section P of the assessment. Section O pertained to the Influenza Vaccine being coded incorrectly. Resident #2 was observed on 4/25/22 at 9:15 a.m. to be lying in bed. The bed was noted to have one-quarter bed rails up on both sides of the bed. On 4/26/22 at 7:55 p.m., Administrative Nurse A, stated that Resident #2 used the one-quarter bedrails for mobility while in bed. When asked why they coded the bedrails as restraints on the MDS assessment, they stated that they had made an error, and the MDS should not reflect the one-quarter bedrail as a restraint. Administrative Nurse A verified that the resident received an Influenza Vaccine on [DATE]. The MDS coded the resident as not having received the vaccine. 2. Resident #3 was admitted to the facility in 2017, with diagnoses including Non-Alzheimer's Dementia with Behaviors and Hospice. The most recent quarterly Minimum Data Set (MDS) assessment, dated [DATE], coded the resident as having bed rails as a restraint listed under section P of the assessment.

	Section O pertained to the Influenza Vaccine being coded incorrectly. On 4/26/22 at 7:55 p.m., the resident's bed was noted to have one-quarter bed rails up on both sides of the bed. Administrative Nurse A stated that Resident #3 used the one-quarter bedrails for mobility while in bed. When asked why they coded the bedrails as restraints on the MDS assessment, they stated that they had made an error, and the one-quarter bed rails did not restrain the resident. Administrative Nurse A verified the resident had received an Influenza Vaccine on [DATE]. The MDS coded the resident as having received the vaccine on [DATE]. 3. Resident #4 was admitted to the facility in 2021, with diagnoses including Depression and Adult Failure to Thrive. The most recent quarterly Minimum Data Set (MDS) assessment, dated [DATE], coded the resident as having bed rails as a restraint listed under section P of the assessment. On 4/26/22 at 7:55 p.m., the resident's bed was noted to have one-quarter bed rails up on both sides of the bed. Administrative Nurse A stated that Resident #4 used the one-quarter bedrails for mobility while in bed. When asked why they coded the bedrails as restraints on the MDS assessment, they stated that they had made an error, and the one-quarter bed rails did not restrain the resident. 4. Resident #5 was admitted to the facility in 2019 with diagnoses including Dementia with Behavioral disturbance, Heart Failure, and Atrial Fibrillation. The Quarterly Minimum Data Set (MDS), dated [DATE], coded the resident as having bed rails as a restraint. Resident #5 was observed on 4/25/22 at 1:00 p.m. to be lying in bed on their right side. The bed was noted to have one-quarter bed rails up on both sides of the bed. On 4/25/22 at 1:00 p.m., in an interview with Administrative Nurse A, they stated that Resident #5 used the one-quarter bedrails for mobility while in bed. When asked why they coded the bedrails as restraints on the MDS assessment, they stated that they had made an error, and the one-quarter bed rails did not restrain the resident.

	5. Resident #6 was admitted to the facility in 2021 with diagnoses of Alzheimer's, Atrial Fibrillation, and moderate protein/calorie malnutrition. The Annual Minimum Data Set (MDS), dated [DATE], indicated the resident utilized bed rails as a restraint. Furthermore, the MDS coded the resident as not assessed for getting the influenza (flu) vaccine and no date was listed to indicate it was given. Review of Resident #6's medical record revealed an "Updated Immunization" record which documented the Influenza vaccine was given on [DATE]. On 4/26/22 at 3:00 p.m., in an interview with Administrative Nurse A, they stated that they had made an error on the MDS. They stated that Resident #6 had quarter bed rails for mobility and that they were not a restraint. They also acknowledged that the resident was given a flu shot and that should have been listed on the MDS. 6. Resident #7 was admitted to the facility in 2020 with diagnoses that included Dementia with Behavioral Disturbance, Weight loss, and Diabetes. The Quarterly Minimum Data Set (MDS), dated [DATE], coded the resident as not being assessed for the influenza vaccine. The MDS also coded the resident as not having any weight loss. Review of the medical record revealed a form titled, "Update Immunization," dated [DATE], which documented that the resident received the vaccine on [DATE]. Review of Resident #7's clinical record revealed Resident #7 experienced a 12-pound weight loss from [DATE] through [DATE]. They weighed 152 pounds on [DATE] and 140 pounds on [DATE]. On 4/26/22 at 3:00 p.m., in an interview with Administrative Nurse A, they stated that the resident lost a lot of weight and the MDS needed to be corrected. They acknowledged that they had made an error in filling out the MDS for both the influenza section and the nutrition section.
§51.180(c)(2) Drug regimen review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (2) The pharmacist must report any	Based on observation, interview, record review and policy review, the facility failed to ensure Consultant Staff A reported an irregularity and the physician justified the continued use and duration of a psychotropic medication (Ativan) on an as needed (PRN) basis beyond 60 days for one (1) of one (1) Hospice resident, Resident #3.

irregularities to the primary physician and the director of nursing, and these reports must be acted upon. Level of Harm – No Actual Harm, with potential for more than minimal harm. Resident Affected - Few	The findings include: Review of the facility's policy titled, "Pharmacy General Information," dated 1/1/11, documented the following: "Pharmacists review resident charts and medication regimens and make recommendations to prescribers." Resident #3 was readmitted to the facility in 2017, with diagnoses to include Dementia with Behaviors and Anxiety. Review of the medical record revealed that Resident #3 had an active order, dated [DATE] for Ativan 1 milligram (mg) every eight (8) hours as needed (PRN) for anxiety with no stop date. Review of the Order Summary Report dated [DATE], revealed the 60-day duration for the PRN medication should have been [DATE]-[DATE]. The order remained active with no stop date for a total of 118 days past the initial PRN order of [DATE]. During a review of Resident #3's medication in the medication cart on 4/26/22 at 10:05 a.m., Licensed Nurse A verified the presence of the original Controlled Medication Inventory Log for Ativan, 1 milligram (mg) every eight (8) hours as needed (PRN) for an order of 20 pills. The medication count verified 20 pills. No pills from the original order had ever been administered. Licensed Nurse A indicated the pharmacy should have reviewed the medication for Resident #3, realized the order was past the review date, and made a recommendation to discontinue the medication. During a telephone call on 4/27/22 at 8:15 a.m., Consultant Staff A stated PRN psychotropic drug orders for Hospice residents are limited to 60 days unless prescriber documents the diagnosed specific condition being treated, the rationale for the extended period, and the duration of the PRN order: "The Ativan order for Resident #3 was ordered as part of the pre-order protocol for all Hospice residents. As part of the monthly review, the pharmacist would be looking to see if the medication would have been administered. If after 60 days with no administration, the recommendation would have been to discontinue the medication. I was able to verify that the medication was never administered, and the recommendation was never made to discontinue the medication after 60 days."
§51.190 (b)(3) Preventing spread of infection (1) When the infection control program determines that a resident needs	Based on medication administration observations, interviews, and facility policy review, the facility failed to ensure a Licensed Nurse changed gloves and sanitized between the administration of Insulin and eyedrops, and removed their gloves before exiting a resident's room to prevent cross contamination. This affected

isolation to prevent the spread of infection, the facility management must isolate the resident. (2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease. (3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected - Few	one (1) resident of three (3) sampled residents reviewed during medication administration, Resident #2. The findings include: Review of a facility policy titled, “Standard Precautions,” dated 8/1/12, documented the following: “PURPOSE: To describe precautions designed to reduce the risk of transmitting microorganisms from both identified and unidentified sources of infection… PROCEDURE … C. Standard Precautions are used when providing resident care: 1. Hand Hygiene a. The most important procedure for preventing cross contamination from person to person or object to person. b. Refers to both washing with soap and water and to using alcohol gel to decontaminate the hands. c. Always wash hands: … 2. Before and after contact with a resident. 3. Immediately after touching … contaminated items. 4. Immediately after removing gloves. 5. When moving from contaminated body site to clean body site during care. 6. After touching objects and equipment in the resident’s room” On 4/26/22 at 7:40 a.m., Licensed Nurse B was observed administering medications to Resident #2. Also present during the observation was Licensed Nurse A. Licensed Nurse B prepared five (5) by mouth (PO) medications at the medication cart. They also prepared an Insulin injection for the resident and Refresh eyedrops. Licensed Nurse B did put on gloves prior to the Insulin administration to prevent cross contamination, but did not remove, sanitize, and apply new gloves before administering the eyedrops. Continued observation revealed that Licensed Nurse B did not remove their gloves prior to exiting the resident’s room. During an interview with Licensed Nurse A on 4/26/22 at 8:05 a.m., who also observed the medication administration, they stated that facility staff were expected to wash and/or sanitize their hands prior to going into the resident’s room and prior to exiting the room. Continued interview revealed that facility staff were expected to sanitize their hands between residents. During an interview with Licensed Nurse C on 4/26/22 at 8:10 a.m., who also observed the medication administration, they stated that staff were expected to wash and/or sanitize their hands prior to going into the resident’s room and prior to exiting

	the room. Continued interview revealed that facility staff were expected to put on gloves prior to encountering resident's body fluids and change, sanitize, and replace gloves between injections and eyedrop administration.
§51.200(h)(2) Other environmental conditions. Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. 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 provide adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two (2) in the Dirty utility room. The deficient practice affected one (1) of seven (7) smoke compartments, staff, and 12 residents. The facility had the capacity for 14 beds with a census of 12 on the day of survey. The findings include: Observation during the virtual tour on 04/26/2022 at 10:27 a.m. revealed the Dirty utility room was used to store two (2) soiled linen barrels, two (2) trash cans, and one (1) biological barrel for waste. Further observation revealed the one (1) trash can had trash in it; the two (2) soiled linen barrels had dirty linen in them; and the biological waste barrel was empty. Additionally, the Dirty utility room did not have outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. An interview at that time with Maintenance Staff A indicated that the Dirty linen room was used to store two (2) soiled linen barrels, two (2) trash cans and one (1) biological barrel for waste. They further said the barrels were emptied out at 6:00 a.m., on a daily basis, and throughout the day. When asked how this could affect the residents, they indicated that it could expose residents and staff to foul odors. The census of 12 was verified by Administrative Staff A Maintenance Staff A on 04/25/2022. The findings were acknowledged by Administrative Staff A and Maintenance Staff A during the exit interview on 04/26/2022.