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: Alexander “Sandy” Nininger State Veterans’ Nursing Home

Location: 8401 W. Cypress Drive, Pembroke Pines, FL 33025

Onsite / Virtual: Onsite

Dates of Survey: 7/12/22-7/15/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 120

Census on First Day of Survey: 88

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual survey was conducted from July 12, 2022, through July 15, 2022, at the Alexander “Sandy” Nininger State Veterans’ Nursing Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes. On 7/15/22, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. Administrative Staff A was informed of the immediate jeopardy on 7/15/22, at 10:30 am. The noncompliance related to the immediate jeopardy was identified to have existed on 7/15/22. The immediate jeopardy continued through 7/15/22, and was removed on 7/15/22. The facility implemented a Plan of Removal related to the immediate jeopardy on 7/15/22. The immediate jeopardy is outlined as follows: Upon record review of an expired resident, it was discovered that they died from a choking event. The resident had a Care Plan to be supervised during mealtime. The resident had two (2)

	choking events, with the second one being fatal. The resident was not supervised during these two (2) incidents. A current resident of the facility had a Care Plan for supervision during meals. The resident was observed for an extended period of time to not have any supervision during two (2) different meals. Immediate jeopardy was identified to exist in the facility on 7/15/22, at 10:30 a.m. On 7/15/22, at 6:20 p.m., the facility submitted an Abatement Plan for the removal of the immediate jeopardy that was accepted, and the immediate jeopardy was lowered.
§ 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 – Some	The facility was unable to demonstrate that medications were only furnished subject to the limitation in § 51.41(c)(2). Based on interviews and record reviews, it was identified that the facility was receiving medications from the VA of jurisdiction for one (1) resident for which the facility received the prevailing rate. The findings include: Review of records for July and October 2021, revealed that the facility listed the resident as being in receipt of Aid and Attendance and the VA of jurisdiction was providing the medication for the one (1) prevailing rate resident. Administrative Staff A and Administrative Staff B verified that the resident was admitted under the prevailing rate in 2020, and reported they correctly listed the resident as prevailing rate in February 2022.
§ 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 – Immediate Jeopardy to resident health or safety Residents Affected – Few	Based on interview and record review the facility failed to supervise a resident while eating who required 91-100% supervision with meals, to ensure the resident (Resident #18) received the appropriate supervision and assistance to prevent the resident from choking during a meal. The lack of supervision with meals had the potential to affect one (1) sampled resident of 49 residents who had a Care Plan in place to have supervision during mealtime. The findings include: On 3/28/22, a Nurse's Note revealed that during lunch time rounding, Resident #18 was found choking on a sandwich and was unable to talk. A staff member initiated the Heimlich Maneuver. The resident was referred to Speech Language Pathology for therapy to target safety with oral intake. Recommended

	supervision/assistance at mealtime due to swallow safety was 91-100% of the time. On 5/30/22, Resident #18, diagnosed with Parkinson's disease, Anxiety Disorder, Chronic Obstructive Pulmonary Disease and Dysphasia, suffered a fatal choking event. On 5/30/22, during lunchtime, Licensed Nurse A was in the hallway by the resident's room when they heard a gurgling sound coming from the resident's room. They observed that the resident was alone in their room, was unable to talk, and was holding their throat. Licensed Nurse A entered the room and immediately started performing the Heimlich maneuver, and another staff member came to assist and gave several abdominal thrusts. The resident began to cough up pieces of watermelon and then became unresponsive. As a result, the resident passed away. During an interview with Administrative Nurse A, they stated that 91-100% supervision does not mean that the staff have to watch the resident eat, but instead, staff can set up the tray and leave the resident and periodically check in on the resident. On 7/14/22, Resident #19 was observed from 5:38 p.m., to 6:03 p.m., eating alone in their room. The resident's room was the last room on the right side at the end of the unit hallway approximately 30 yards from the unit nurse's station. A nurse was observed completing charting mid-way down the hallway. At no point did a staff member check on the resident during the observation. On 7/15/22, Resident #19 was continuously observed by the surveyor from the time their breakfast was served at 8:59 a.m., until 9:33 a.m. The privacy curtain was drawn around the resident so that they were not visible from the hallway. The resident was served sausage gravy, a large biscuit, served dry and cut into four quarters, and eggs which were cut into bite size pieces. The resident was not checked on by any staff members from 9:01 a.m., to 9:31 a.m. Throughout the observation, there were no staff members in the hallway. During an interview with Consultant Staff A, they stated that the facility had not defined what supervision was. Consultant Staff A stated that their expectation was that if a resident was at high risk for choking with meals, then they should be in line of sight 100% of the time. The facility had 49 residents, out a total census of 88, who had a diagnosis of dysphagia and had the potential for risk of choking and/or aspiration while eating. The facility needed to take immediate action to ensure residents who were at risk of

	choking or aspiration received proper care and supervision to avoid choking and/or aspiration during meals.
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Many	Based on observation, interview, and review of the facility food storage policy it was determined that the facility failed to ensure proper storage of food. This had the potential to affect sanitation and food safety for all the residents in the facility. The findings include: A review of the facility's policy and procedure, "Food Receiving and Storage," dated 11/27/17, revealed, "7. All foods stored in the refrigerator or freezer will be covered, labeled, and dated ("use by" date)." On 7/12/22, at 11:21 a.m., during a tour of the facility's kitchen, a jar of maraschino cherries was observed with a date of 1/11/22. During an interview at that time, Dietary Staff A stated that the staff should have put a "use by" date on the jar. Also, during the same tour at 11:46 a.m., a reach-in refrigerator used to store prepared foods was observed to have a hotel pan with the dimensions of 12" wide X 20" long X 8" deep full of water on the top shelf. When asked what the pan was used for, Dietary Staff A stated that the pan was there to catch condensation as it dripped from the inside top of the refrigerator. During an interview at 4:20 p.m., Administrative Staff A observed the condensation drip from the top of the refrigerator, hit the side of the hotel pan, and it splashed onto strawberries on the shelf next to it. Administrative Staff A stated that they did not know why the staff were using the refrigerator and stated that the refrigerator was to be removed by the end of the day. On 7/12/22, at 12:00 p.m., during a tour of the facility's dining room, a reach-in refrigerator was found to have four (4) plastic containers of sliced apples dated 7/8 and one (1) glass container of apple puree labeled with a date of 7/7. During an interview at that time, Dietary Staff A stated that the contents of the containers should have been thrown away after 72 hours, as was facility policy.
§ 51.120 (l) Special needs. The facility management must ensure that residents receive proper treatment and care for the following special services: (1) Injections; (2) Parenteral and enteral fluids; (3) Colostomy, ureterostomy, or ileostomy care; (4) Tracheostomy care; (5) Tracheal suctioning;	Based on observations, interviews, and record reviews, the facility failed to ensure that residents received proper treatment and care for respiratory services for one (1) resident out of one (1) resident reviewed for respiratory care services (Resident #3). The facility failed to change out Resident #3's oxygen tubing and humidifier as ordered by the physician. The findings include:

(6) Respiratory care; (7) Foot care; and (8) Prostheses. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected: Few	On 7/14/22, at 3:45 p.m., it was reported, per Administrative Nurse A, that the facility did not have a policy and/or procedure for the administration of oxygen therapy or respiratory care. Review of Resident #3's medical record revealed an admission date of 2022, with a medical history to include diagnoses of Chronic Obstructive Pulmonary Disease (COPD), Dependence on Supplemental Oxygen, Essential Primary Hypertension, Gastro-esophageal Reflux Disease, Wheezing, Nasal Congestion and Allergic Rhinitis. A [DATE] Minimum Data Set (MDS) assessment revealed the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) assessment of 15 out 15. A Physician Order dated [DATE] ordered, "change oxygen tubing/humidifier weekly on Sunday." On 7/12/22, at 12:11 p.m., Resident #3 was observed lying in bed utilizing oxygen therapy via nasal cannula. The oxygen tubing was labeled with a date of 6/29/22, and the sterilized water in their humidifier was approximately three (3) quarters empty and was labeled with a date of 7/3/22. On 7/13/22, at 1:18 p.m., Resident #3 was observed lying in bed utilizing oxygen therapy via nasal cannula. The oxygen tubing was still labeled with a date of 6/29/22, and the humidifier remained labeled with a date of 7/3/22. Licensed Nurse B was interviewed on 7/13/22, at 1:23 p.m. They said that oxygen tubing should be changed out weekly. They said that oxygen therapy should be administered as ordered by a physician. Administrative Nurse B was interviewed on 7/13/22, at 1:28 p.m. They said that they thought the tubing and humidifier were changed out every other week. Administrative Nurse B then checked Resident #3's medical record and said that the oxygen tubing and humidifier should be changed out weekly according to the Physician Order. On 7/14/22, at 10:20 a.m., Resident #3 was observed lying in bed receiving oxygen therapy via nasal cannula. Their oxygen tubing had been changed out and was dated 7/13/22. Their humidifier remained nearly three (3) quarters empty and dated 7/3/22. Licensed Nurse C was interviewed on 7/14/22, at 10:32 a.m. They entered Resident #3's room and observed that the humidifier was nearly empty and dated 7/3/22. They then checked Resident #3's orders and said that the humidifier should be changed weekly. They said, "it's not safe," for the

	tubing and humidifier to not be changed as ordered, “because it can cause an infection.” On 7/15/22, at 8:21 a.m., Resident #3 was observed to be in bed receiving oxygen therapy via nasal cannula. Their humidifier was still dated 7/3/22, and less than one (1) quarter of the sterilized water remained in the humidifier.