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: Douglas Jacobson State Veterans' Nursing Home

Facility Location: 21281 Grayton Terrace, Port Charlotte, FL 33954

Onsite / Virtual: Virtual

Dates of Survey: 3/14/22 through 3/17/22

Nursing Home / Domiciliary/ Adult Day Health Care: NH

Survey Type: Annual

Total VA Recognized Beds: 120

Census on First Day of Survey: 84

Regulation #	Statement of Deficiencies
	Initial Comments: A VA Annual survey was conducted from March 14, 2022, through March 17, 2022, at the Douglas Jacobson State Veterans' Nursing Home. The survey revealed the facility was not in compliance with 38 CFR part 51 Federal Regulations for State Veterans Homes.
§ 51.43 (e) Drugs and medications for certain veterans (e) 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. Level of Harm – No Actual Harm, with potential for minimal harm Residents Affected – Some	The facility was unable to demonstrate submission to the VA medical center of jurisdiction a completed VA Form 10-0460 for each eligible Veteran. Based on interviews and record review, the facility obtained medications from the VA of jurisdiction for Veterans who meet eligibility under 38 CFR §51.43. During interviews and record review, the facility failed to complete and submit VA Form 10-0460 as required for all eligible Veterans. During interviews with the facility Administrative Staff A and Administrative Staff B on 3/17/22 and 3/16/22, it was reported that the facility is not utilizing VA Form 10-0460 for any eligible Veterans whose medications are provided by the VA of jurisdiction.

§ 51.190 (b) Preventing spread of infection (1) When the infection control program determines that a resident needs 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	Based on interviews, observations, and record review, the facility failed to maintain contact precautions for one (1) of one (1) resident reviewed for transmission-based precautions (TBP). Resident #1 was on contact precautions related to Methicillin-Resistant Staphylococcus Aureus Infection (MRSA) in his/her wound. Licensed Nurse A failed to maintain contact precautions while performing wound and incontinent care. The findings include: Review of facility policy titled, "Managing Infections: Transmission Based Precautions (Isolation)" dated 4/20/2020 revealed, "Standard precautions will be used when caring for residents at all times. Transmission based precautions will be initiated when a resident develops signs and symptoms of a transmissional infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to others. Appropriate infection prevention and control equipment and supplies will be obtained, stored and used in accordance with current guidelines and manufacturer instructions. The facility will make every effort to use the least restrictive approach to managing individuals with potentially communicable infections." Under contact precautions: "1. Contact precautions may be implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the residence... 4. Staff and visitors will wear gloves (clean, non-sterile) a. While caring for a resident staff will change gloves after having contact with infective material (for example fecal material and wound drainage) b. Gloves will be removed and hand hygiene performed before leaving the room. c. Staff will avoid touching potentially contaminated environmental surfaces or items in the residence room after gloves are removed….5. Staff and visitors will wear a disposable gown (when indicated) upon entering the resident room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed…." Review of training in-service dated 2/2/22 revealed under detailed description of the in-service "chain of infection and how to break, types of infections, standard precautions, and transmission-based precautions, caring for a resident in isolation, hand hygiene, guidelines for handling clean/dirty linen, wearing proper PPE [personal protective equipment], multi-drug resistant organisms and precautions to take." The in-service sign-in sheet revealed a completion signature for Licensed

	Nurse A. Training material used during the in-service revealed, "Preventing the spread of infection is the responsibility of all care team members. Nursing home staff must know and follow their facility's policies relating to infection prevention and control." "The primary route of disease transmission within the healthcare setting is on the hands of healthcare workers" "Isolation: PPE cannot be worn outside the resident's room, remove PPE and place it in the appropriate container before exiting a resident's room. Perform hand hygiene following removal of PPE and again after exiting the resident's room." "The correct order for Donning (putting on) PPE is: wash hands, put on gown, put on mask, put on goggles or face shield, put on gloves. The correct order for Doffing (taking off) PPE is: remove and discard gloves, removed goggles or face shield, remove and discard gown, wash hands, washing hands is always the final step after removing and discarding PPE." Resident #1 was admitted to the facility on [DATE] with diagnoses including, but not limited to, Other Staphylococcus as The Cause of Disease Classified Elsewhere, Pressure Ulcer Of Sacral Region, Pressure-Induced Deep Tissue Damage Of Left Heel, Pressure-Induced Deep Tissue Damage Of Other Sites, and Methicillin-Resistant Staphylococcus Aureus Infection. Review of Resident #1's Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Statue (BIMS) of 12 out of 15, indicating the resident had moderate impairment. The resident had unhealed pressure ulcers/injuries. While a resident at the facility, Resident #1 was on isolation or quarantine for active infectious disease. During an observation on 3/14/22 at 10:58 a.m., Resident #1's room door revealed the door was closed and had signs titled, "How to safely remove personal protective equipment (PPE) Example 1" and "Contact Precautions." A PPE rack with supplies was hanging on the door. Further review of the sign posted on the outside of Resident #1's room door titled, "How to safely remove personal protective equipment (PPE) Example 1" revealed "…Remove PPE in the following sequence: 1. Gloves … 2. Goggles or Face Shield … 3. Gown... 4. Mask or respirator… 5. Wash hands or use an alcohol-based hand sanitizer immediately after removing all PPE. Perform hand hygiene between steps if hands become contaminated and immediately after removing all PPE." Review of the sign titled "Stop Contact Precautions (in addition to standard precautions)" revealed, "when you enter and each time you leave the room, either: use waterless foam or wash hands."

	Review of Resident #1's Physicians Orders revealed contact isolation: wound infection/staphylococcus aureus start date [DATE]. During an observation on 3/15/22 at 9:37 a.m. of wound care on Resident #1 provided by Licensed Nurse A, before wound care began, Resident #1 had a bowel movement (BM) while lying in bed. Licensed Nurse A provided bowel incontinent care. During incontinent care, Licensed Nurse A removed the resident's wound dressing to Resident sacrum. Licensed Nurse A did not change their gloves prior to removing the bandage or after removing the bandage. After completing bowel incontinent care, Licensed Nurse A washed their hands and donned new gloves. Licensed Nurse A then removed the soiled linens from the resident's bed. Licensed Nurse A did not have a yellow bag to place the linens in and asked staff for assistance. Licensed Nurse A stood in the doorway of Resident #1's room waiting for staff to bring them a bag for the linens. While waiting, Licensed Nurse A touched their face mask and eyeglasses with their right gloved hand that was previously holding the soiled linen. After placing the soiled linens in a yellow bag, Licensed Nurse A went to the cabinet by the sink in the resident's room to get additional cleaning cloths. Resident #1 had a second BM while lying in bed. Licensed Nurse A began to provide bowel incontinent care. Licensed Nurse A gown was observed to be on the outside of her gloves, exposed to the BM, and came in contact with the resident. A Certified Nurse Aide A entered the room to assist with incontinent care. While the Certified Nurse Aide A was providing incontinent care, Licensed Nurse A changed their gloves and began to clean the resident's sacral wound. BM was still visible on the resident's buttock and on the pad beneath the resident. Licensed Nurse A then applied ointment, packed the wound with calcium alginate, and applied a clean dressing. Licensed Nurse A did not change their gloves after wound care and before returning to help the Certified Nurse Aide A finish incontinent care. With the same gloves, Licensed Nurse A turned around and opened the resident's closet to get a clean brief and went to the cabinet by the sink to get more cloths for cleaning. When incontinent care was completed, Licensed Nurse A went to the doorway and stepped out of the room with a clear trash bag. Licensed Nurse A removed their gloves at the treatment cart located outside of the resident's room. Licensed Nurse A did not change their gown and began to go through the treatment cart to gather supplies for wound care to the resident's left heel. Licensed Nurse A entered the room, washed their hands, donned gloves, and provided wound care to the resident's left heel. Licensed Nurse A completed the wound care and went to the door to remove their PPE. Licensed Nurse A removed their gloves and attempted to remove their gown. The gown was tied tight, and Licensed Nurse A used scissors to cut the gown off. Licensed Nurse A then pushed the gown and

	the gloves into the trash can with their bare hands. Licensed Nurse A removed the trash bag from the trash can, opened the room door, pushed the treatment cart out of the way, went down the hall to the soiled utility room, punched in the code to enter the soiled utility room, put the soiled utility in a bin and then sanitized their hands with gel. Licensed Nurse A failed to wash their hands before leaving the resident's room and did not change their mask. During an interview on 3/15/22 at 10:12 a.m. with Licensed Nurse A, stated they had worked for the facility for 17 years and had received infection control training every year. When the Surveyor's observations were read back to Licensed Nurse A regarding wound care and infection control, Licensed Nurse A stated, "I am sorry", stated that they had training on infection control but was overwhelmed with the resident having a bowel movement. During an interview on 3/16/22 at 8:35 a.m. with the Administrative Nurse A who was also the Consultant Staff A, the Administrative Nurse A was informed of concerns with observations made during wound and incontinent care for Resident #1. The Administrative Nurse A stated Licensed Nurse A should have changed their gloves after removing the dirty wound dressing and starting incontinent care. Gloves should be changed after each task. The Administrative Nurse A stated Licensed Nurse A should have stopped the wound care and addressed the bowel incontinence and that nurses know not to touch surfaces with soiled gloves and hands. Licensed Nurse A should have asked for help from a supervisor or floor nurse to assist with keeping the area a little cleaner if they felt overwhelmed. The Administrative Nurse A stated it was not proper donning of PPE for contact precautions to have the gown on the outside of the gloves and that the gowns have holes on them where the thumbs can be inserted before donning gloves so that the gown stays under the gloves. There were instructions on the resident's door for donning and doffing PPE. The Administrative Nurse A stated, you can see feces, but you cannot see MRSA. Never leave the room without washing your hands. You never know what you are going to touch. This is why Resident #1 is on isolation. Everything is to be limited or contained to his/her room.
§ 51.120 (e)(2) Urinary and Fecal Incontinence (e) Urinary and Fecal Incontinence. Based on the resident's comprehensive assessment, the facility management must ensure that— (2) A resident who is incontinent of urine receives appropriate treatment	Based on interviews, observations, and record review, the facility failed to provide appropriate catheter care and follow physicians' orders for one (1) of three (3) residents reviewed for catheter care. Licensed Nurse A provided catheter care to Resident #1 and failed to use a clean gauze to clean the catheter tube, failed to clean in one (1) direction, and failed to pat dry after cleansing per physicians' orders.

and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	The findings include: Review of the facility policy titled, "Urinary Catheter Indication and Maintenance" dated 6/9/2017 revealed, "…For those residents with indwelling urinary catheter, the facility will provide maintenance of the catheter to minimize the risk of infection." Resident #1 was admitted to the facility on [DATE] with diagnoses including, but not limited to, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Disorder of Kidney and Ureter, Obstructive and Reflux Uropathy, Malignant Neoplasm of Prostate, Urinary Tract Infection, Infection and Inflammatory Reaction due to Indwelling Urethral Catheter, Extended Spectrum Beta Lactamase (ESBL) Resistance. Review of Resident #1's Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Statue (BIMS) of 12 out of 15, indicating the resident had moderate cognitive impairment. The resident had an indwelling catheter. A review of Resident #1's Physician Orders revealed "cleanse suprapubic site with normal saline, pat dry apply split gauze and secure with tape daily." During an observation on 3/15/22 at 9:26 a.m. of catheter care on Resident #1 by Licensed Nurse A, Licensed Nurse A squirted normal saline on the area around the exit site of the catheter. Licensed Nurse A wiped around the catheter exit site with a piece of gauze. Licensed Nurse A used the same gauze to clean the catheter tubing, sliding the gauze down and back up towards the catheter exit site. Licensed Nurse A then placed a split gauze dressing around the catheter site and taped it down. Licensed Nurse A failed to pat the area dry before placing the split gauze. During an interview on 3/15/22 at 10:12 a.m. with Licensed Nurse A, stated they had worked for the facility for 17 years and has received training on catheter care. When the surveyor observations were read back to Licensed Nurse A regarding catheter care, Licensed Nurse A stated did use the same gauze to clean the exit site and the catheter tubing. Licensed Nurse A forgot to pat dry before applying the split gauze and that he/she was sorry. During an interview on 3/16/22 at 8:35 a.m. with the Administrative Nurse A who is also the Consultant Staff A, the Administrative Nurse A was informed of concerns with observations made during catheter care on Resident #1. The Administrative Nurse A stated that it was not acceptable to clean the catheter tubing with the same gauze that was used to clean the catheter exit site and not acceptable to slide the gauze down the catheter tube and back up towards the exit site. A separate clean gauze should have been used to clean the tubing and Licensed Nurse A should not slide the gauze back

	and forth on the tubing. It is their expectation that nurses follow the physicians' orders, and that Licensed Nurse A should have patted the area dry before applying the split gauze dressing. Administrative Nurse A stated otherwise, moisture can get trapped in there.
§ 51.200 (a) Life safety from fire The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (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 – Many	Based on record review and interview, the facility failed to perform the fire drills in accordance with the code. The deficient practice affected seven (7) of seven (7) smoke compartments, staff, and all residents. The facility has a capacity for 120 beds with a census of 84 on the day of the survey. The findings include: Records reviewed on 3/14/22 at 10:32 a.m. of the quarterly fire drill reports, revealed the reports did not include the method used for the transmission of a fire alarm signal and the type of simulation of emergency conditions as required by section 19.7.1.4 of NFPA 101, Life Safety Code. Interview at that time with the Maintenance Staff A revealed the facility was not aware of the requirements of section 19.7.1.4 of NFPA 101, Life Safety Code. Maintenance Staff A indicated that they would update the fire drill report to include the information noted in the finding. The census of 84 was verified by the Administrative Staff A on 3/14/22. The findings were acknowledged by the Administrative Staff A and verified by the Maintenance Staff A during the exit interview on 3/17/22 at 1:00 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.7 * Operating Features.** **19.7.1 Evacuation and Relocation Plan and Fire Drills.** **19.7.1.4 *** Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.
§ 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	Based on record review and interview, the facility failed to operate the transfer switch monthly in accordance with the code. The deficient practice affected seven (7) of seven (7) smoke compartments, staff, and all residents. The facility has a capacity for 120 beds with a census of 84 on the day of the survey The findings include: Records reviewed on 3/14/22 at 11:04 a.m. revealed the facility was not operating the transfer switch monthly, as required by

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	section 8.4.6 of NFPA 110, Standard for Emergency and Standby Power Systems. Interview at that time with the Maintenance Staff A confirmed the records of the monthly generator test did not indicate the operation of the transfer switch. Maintenance Staff A went on to reveal during the monthly generator test, the facility utilized the main power disconnect to have the generator at full load (100 percent) for the test. A new automatic transfer switch (ATS) was onsite and scheduled for installation by the end of the month. The new ATS will transfer the full load during the generator monthly test. The census of 84 was verified by the Administrative Staff A on 3/14/22. The findings were acknowledged by the Administrative Staff A and verified by the Maintenance Staff A during the exit interview on 3/17/22 at 1:00 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)** **5.2.5** The EPS shall be installed in accordance with NFPA 70, National Electric Code. **8.3 Maintenance and Operational Testing.** **8.3.1 *** The EPSS shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. **8.3.2** A routine maintenance and operational testing program shall be initiated immediately after the EPSS has passed acceptance tests or after completion of repairs that impact the operational reliability of the system. **8.3.2.1** The operational test shall be initiated at an ATS and shall include testing of each EPSS component on which maintenance or repair has been performed, including the transfer of each automatic and manual transfer switch to the alternate power source, for a period of not less than 30 minutes under operating temperature.

	8.3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established. **8.3.4** A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. **8.4 Operational Inspection and Testing.** **8.4.1** * EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. **8.4.6** Transfer switches shall be operated monthly. **8.4.6.1** The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.