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: Southeastern Veterans' Center

Location: 1 Veterans Drive, Spring City, PA 19475

Onsite / Virtual: Onsite

Dates of Survey: 2/27/23 through 3/2/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 238

Census on First Day of Survey: 154

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from February 27, 2023 through March 2, 2023 at the Southeastern Veterans' Center. 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. 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 more than minimal harm **Residents Affected** – Few	The facility was unable to demonstrate that the VA only furnishes drugs and medicines to a State home for Veterans who are eligible to receive such medications. Based on interviews and subsequent record reviews, it was identified that two (2) of the 41 residents and one (1) of the 37 residents for whom the VA of jurisdiction paid all medication costs in March 2022 and June 2022, respectively, was a non-Veteran civilian and thus not eligible for VA payment of medications. Communication with the facility leadership revealed the facility had been operating under the understanding that these non-Veterans civilians were eligible due to being in receipt of VA survivor benefits, to include increased pension categorized as Aid & Attendance. The facility leadership confirmed that the three identified residents were not Veterans.
§ 51.43 (d) Drugs and medicines for certain veterans. VA may furnish a drug or medicine under this section and under §17.96 of	The facility was unable to demonstrate that there was a contract between the VA and the third-party vendor who furnishes drugs and medicines to the State home for whom the home seeks

this chapter by having the drug or medicine delivered to the State home in which the veteran resides by mail or other means and packaged in a form that is mutually acceptable to the State home and to VA set forth in a written agreement. Level of Harm – No Actual Harm, with potential for minimal harm **Residents Affected** – Some	reimbursement from VA for Veterans which are eligible to receive such medications per § 17.96. Based on interviews with facility administrative and pharmacy leadership, it was identified a third-party vendor supplies some medications to residents of the State home as the VA Medical Center of jurisdiction is unable to provide these medications in a form mutually acceptable to both entities. The state home seeks reimbursement monthly from the VA for those residents deemed eligible to receive drugs and medicines. The facility leadership could not validate that any prescription, which is not part of authorized Department of Veterans Affairs hospital or outpatient care, for drugs and medicines ordered by a private or non-Department of Veterans Affairs doctor of medicine or doctor of osteopathy duly licensed to practice in the jurisdiction where the prescription is written, shall be filled by a non-VA pharmacy under contract with VA.
§ 51.70 (n) Self – Administration of Drugs. An individual resident may self - administer drugs if the interdisciplinary team, as defines by § 51.110(d)(2)(ii) of this part, has determined that this practice is safe. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interviews, and facility policy review, the facility failed to ensure each resident who had self-administered medication was safe in doing so, for one (1) of four (4) residents (Resident #28) reviewed for medication administration. The Interdisciplinary Team (IDT) did not determine that the practice of self-administration of medications was safe for Resident #28. The findings include: Review of a facility policy titled, "Self- Administration of Medication," [sic] revised 10/21, documented the following: "**PROCEDURE:** 2. The Interdisciplinary Team will assess the Resident's physical and cognitive abilities to determine if self-administration of medications/treatments is a safe practice within 7 days of the resident request. 3. If the Resident can self-administer medications safely, the Resident will be educated to include the following: a. proper methods of administration, b. infection control measures, c. amount of each medication to be administered, d. the expected effects and possible side effects of each medication and e. proper storage. f. Documentation of above will be included in the resident's Medical Record…4. When the Interdisciplinary Team determines the Resident may self-administer medications/treatments safely, the resident's ability to Self-Administer will be reevaluated at least quarterly for the Nursing Care residents and annually for the Personal Care residents. 5. A self-administration order will be obtained by the attending provider and written in the Resident's medical record, permitting the Resident to self-administer medications." On 2/28/23, at 7:45 a.m., Resident #28's medication administration was observed. It was revealed that Resident #28 self-administered Biotene mouthwash.

	On 2/28/23, a review of Resident #28's clinical records revealed that Resident #28 did not have an order to self-administer Biotene, and had not been assessed to self-administer Biotene. In an interview, on 2/28/23, at 2:18 p.m., with Administrative Nurse A, they stated, "usually in Care Plan or in the order, will say can self-administer, will have an evaluation." During a follow up interview with Administrative Nurse A, on 3/1/23, at 9:00 a.m., they stated, "I checked on the information for you from yesterday and there was no evaluation done, and it's not on [their] Care Plan that [they] can self-administer the mouthwash." In an interview, on 3/1/23, at 2:09 p.m., Administrative Nurse B stated, "We have a process. The IDT team meets, decides on if they can self-administer, we have a discussion, then the process is observation of self-administration, cover all acts, the provider has to sign off, then education with resident, an evaluation and then an evaluation every six months after that, while they are still self-administering medication." Administrative Nurse B also reported that they were not aware Resident #28 had Biotene in their room. Administrative Nurse B mentioned, going forward the facility would educate all licensed staff that all medications should be kept in treatment carts or medication carts until the process was followed per self-administration policy protocols. Administrative Nurse B said that the facility was currently in the process of correcting and working on the current situation.
§ 51.120 (d) Pressure sores. Based on the comprehensive assessment of a resident, the facility management must ensure that— (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interviews, record review, and facility policy review, the facility failed to ensure each resident who had pressure sores was safe from risk of infection, for one (1) of (1) resident (Resident #21) reviewed for pressure sores. The facility did not ensure the necessary treatment and services to prevent a risk of infection during wound care was done for Resident #21. The findings include: Review of a facility policy titled, "Wound Care," revised 10/20, documented the following: "**PROCEDURE:** 5. Prepare work area by cleaning workstation, preparing packages, readying for disposal, etc." On 2/28/23, at 11:32 a.m., Resident #21's wound care was observed. Licensed Nurse A did not prepare their work area by cleaning off the bedside table prior to putting the wound care supplies on it. On 2/28/23, a review of Resident #21's clinical records revealed that Resident #21 was followed by the wound care team for left

	lateral calf surgical incision, left heel ulcer, and a Stage IV (four) pressure injury to the sacrum. In an interview, on 2/28/23, at 11:57 a.m., with Licensed Nurse A, they stated, "I forgot to clean. It's not a sterile procedure but it is clean." In an interview, on 3/2/23, at 11:26 a.m., with Administrative Nurse B, they reported that the expectation for wound care was that the bedside table (or wherever the supplies are placed) should be cleaned before putting the supplies in place.
§ 51.180 (c) 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 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 **Residents Affected** – Few	Based on record review and interview, the facility failed to complete a drug regimen review at least once a month for Resident #22, #23, and #24. The facility failed to act upon Consultant Staff A recommendations for Resident #8. Four (4) of four (4) residents were reviewed for Drug Regimen Reviews. The findings include: A review of the facility policy titled, "Drug Regimen & Medical Chart Review," dated 3/25/19, revealed: "Skilled Nursing: It is the policy of [name of facility] and the DMVA [Department of Military and Veterans Affairs] to have resident's medication regimen and medical chart reviewed at least monthly by a licensed pharmacist. The intent is to maintain the resident's highest practicable level of physical, mental and psychosocial well-being and prevent or minimize adverse consequences related to mediation therapy. Irregularities will be report to the Provider, medical director and [Administrative Nurse B]. Timeframes and procedures for submitting irregularity reports and reviews for short term residents are established…Skilled Nursing Guidelines: 1. A least once a month the resident's medical record will be reviewed concurrently with the drug regimen review (DRR) by a [Consultant Staff A]…10. The attending physician or [Licensed Nurse B] will document in the resident's medical record that the identified irregularity has been reviewed and acted upon. If the Provider disagrees with the recommendation the Provider must document in the clinical record the rationale." Resident #8 was admitted to the facility on [DATE], with diagnoses including, but not limited to: End Stage Heart Failure, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified Arterial Fibrillation, Other Chronic Sinusitis, Pain in Unspecified Lower Leg, Unspecified Dementia, Cellulitis of Right Upper Limb, Encounter for Therapeutic Drug Level Monitoring. A review of Resident #8's [Consultant Staff A] Drug Regimen Review, dated [DATE], revealed: "Resident Scr [Serum Creatinine] 1.5 on [DATE] (eGFR [estimated glomerular filtration

	rate] 44). Recommend reducing Metformin dosage to a maximum of 500mg [milligram] BID [twice a day] with close monitoring of kidney function. No specific dosage adjustments recommended for Mucinex, however guaifenesin's metabolite is renally eliminated, and therefore, accumulation is possible with long-term chronic use; use with caution in severe kidney impairment. Recommendation for Spironolactone: eGFR 30 to 50 mL [milliliter]/minute/1,73 m2: 12.5 mg once daily or every other day initially; may double the dose every 4 [four] weeks if serum potassium remains < [less than] 5 [five] mEq [milliequivalent]/L [litter] and renal function is stable, up to a maximum target dose of 25 mg/day." The [Consultant Staff A] Drug Regimen Review was not signed by a provider, and recommendations were not acted upon. A review of Resident #8's [Consultant Staff A] Drug Regimen Review, dated [DATE], revealed: "Acetaminophen PRN (as needed) regimens – Consider adding instructions limiting dose 3 [three] grams from all APAP [Acetaminophen] sources. The [Consultant Staff A] Drug Regimen Review was not signed by a provider, and recommendations were not acted upon. A review of Resident #8's [Consultant Staff A] Drug Regimen Review, dated [DATE], revealed: "Acetaminophen PRN regimens – Consider adding instructions limiting dose 3 [three] grams from all APAP sources. Form was not signed by Provider." The [Consultant Staff A] Drug Regimen Review was not signed by a provider, and recommendations were not acted upon. A review of Resident #8's [Consultant Staff A] Drug Regimen Review, dated [DATE], revealed: "Recommend obtaining updated serum creatinine. Resident Scr 1.5 on [DATE] (eGFR 44). Recommend reducing Metformin dosage to a maximum of 500mg BID with close monitoring of kidney function. No specific dosage adjustments recommended for Mucinex, however guaifenesin's metabolite is renally eliminated, and therefore, accumulation is possible with long-term chronic use; use with caution in severe kidney impairment. Recommendation for Spironolactone: eGFR 30 to 50 mL/minute/1,73 m2: 12.5 mg once daily or every other day initially; may double the dose every 4 (four) weeks if serum potassium remains <5 (five) mEq/L and renal function is stable, up to a maximum target dose of 25 mg/day." The [Consultant Staff A] Drug Regimen Review was not signed by a provider, and recommendations were not acted upon. Review of Resident #8's Provider Orders revealed the following:

	"Acetaminophen [OTC [over the counter]] suppository; 650 mg; amt [amount]: 650 mg; rectal. Special Instructions: fever Q [every] 4 [four] hours PRN. Start date [DATE]. Tylenol (acetaminophen) [OTC] tablet; 325 mg: amt: 650 mg: oral. Special Instructions: for pain. Record pain level 1-10. Every 4 [four] Hours – PRN. Start date [DATE]. Tylenol (acetaminophen) [OTC] tablet; 325 mg: amt: 650 mg: oral Special Instructions: For temp >100.1F. Every 4 [four] Hours – PRN. Start date [DATE]. Metformin tablet; 1,000 mg; amt: 1 [one] tablet; oral. Twice a day. Start date [DATE]. Mucinex (guaifenesin) [OTC] tablet extended release 12 hr [hour]; 600mg; amt: 1 [one] tablet; oral. Twice a day. Start date [DATE]. Spironolactone tablet; 25 mg; amt: 1 tablet; oral once a day. Start date [DATE]." Review of resident records and [Consultant Staff A] Drug Regimen Reviews for Residents #22, #23, and #24 revealed that recommendations made by Consultant Staff A were not acknowledged. Review of Resident #22's records and drug regimen reviews for the months of [DATES] and [DATES] revealed Consultant Staff A made recommendations to the provider; however, there was no signature or evidence provided to ensure that the recommendations had been acknowledged. A recommendation for Resident #22 by Consultant Staff A was: "D/C Fleet Enema (sodium phosphate) PRN order-Na content is 4.3 Gram. Contraindicated in poor renal perfusion." Further review revealed a drug regimen review for the month of [DATE] was missing. Review of Resident #23's records and drug regimen reviews for the months of [DATES] revealed the Consultant Staff A made recommendations to the provider; however, there was no signature or evidence provided to ensure that the recommendations had been acknowledged. A recommendation that was made by Consultant Staff A stated: "Please consider DC-ing PRN albuterol inhaler (no use in previous 14 days)." Further review revealed a drug regimen review for the month of [DATE] was missing. Review of Resident #24's records and drug regimen reviews for the months of [DATES] revealed Consultant Staff A made recommendations to the provider; however, there was no

	signature or evidence provided to ensure that the recommendations had been acknowledged. A recommendation for Resident #24 by Consultant Staff A was: "Acetaminophen PRN regimens review-Consider adding instructions limiting dose 3 grams per day from all APAP sources." Further review revealed a drug regimen review for the month of [DATE]was missing. During an interview, on 3/1/23, at 9:36 a.m., with Licensed Nurse B, they stated that they started at the facility on [DATE], and was the only provider reviewing Consultant Staff A recommendations. Licensed Nurse B stated they did not review all Consultant Staff A recommendations, and that Consultant Staff A would bring them urgent concerns. An inquiry was made regarding the [Consultant Staff A] Drug Regimen Reviews not being signed as reviewed, and recommendations not acted upon, for Residents #8, #22, #23, and #24; Licensed Nurse B stated, "I believe it." Licensed Nurse B confirmed being the only provider completing the reviews and having so many Consultant Staff A reviews, they were not able to review them all.
§ 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 observation, interview, and facility policy review, the facility failed to ensure each staff member who had direct contact with residents performed hand hygiene for one (1) of one (1) resident (Resident #21) reviewed for wound care. Licensed Nurse C did not perform hand hygiene between glove changes during wound care for Resident #21. The findings include: Review of a facility policy titled, "Infection Prevention Processes and Procedure," revised 2/23, documented the following: "**V. Procedure: A. Standard Precautions – Use for ALL Residents** 1. Hand Hygiene: a. During the delivery of resident care services, avoid unnecessary touching of surfaces near the resident to prevent both contamination of clean hands from environmental surfaces and transmission of pathogens from contaminated hands to surfaces. b. Perform hand hygiene in accordance with the BVH Hand Hygiene Process.docx. c. Keep fingernails trimmed to fingertip length or less." Review of the facility policy titled, "Wound Care," revised 10/2020, documented the following: "**Procedure:** 4. Wash hands before, after, and as needed during procedure, examples before/after preparing surfaces, after removal of old dressing, etc. a. Apply and change gloves as needed throughout procedure. b. Gloves must be worn when changing a dressing and/or when handling items contaminated with blood, body fluids, or potentially ineffective materials."

	On 2/28/23, at 11:32 a.m., Resident #21's wound care was observed. Licensed Nurse A did not prepare their work area by cleaning off the bedside table prior to putting the wound care supplies on it. During wound care, Licensed Nurse C changed gloves twice, no hand sanitizer was used, and they checked three (3) different wounds. On 2/28/23, a review of Resident #21's clinical records revealed that Resident #21 was followed by the wound care team for left lateral calf surgical incision, left heel ulcer, Stage IV (four) pressure injury to the sacrum. In an interview, on 3/2/23, at 11:26 a.m., with Administrative Nurse B, they reported that the expectation for wound care was that the bedside table (or wherever the supplies are placed) should be cleaned before putting the supplies in place. During the same interview, Administrative Nurse B stated that the expectation was for staff to sanitize their hands with glove changes.
§ 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** – Many	**<u>Smoke Barriers and Sprinklers</u>** 1. Based on observations and interview, the facility failed to maintain the smoke barrier walls. The deficient practice affected two (2) of three (3) smoke compartments, staff, and 154 residents. The facility had a capacity for 238 beds with a census of 154 on the day of the survey. The findings include: Observation during the building inspection tour, on 2/27/23, at 1:10 p.m., of the wall located inside [LOCATION] was found to have two (2) large holes in the rear wall below the ceiling, and one above the ceiling from plumbing work that was done and not protected with a joint system that was 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, as required by section 8.5.7.4 of NFPA 101, Life Safety Code. An interview with Maintenance Staff A and Maintenance Staff B, on 2/27/23, at 1:15 p.m., revealed that the facility was not aware of the penetrations in the wall. The census of 154 was verified by Administrative Staff A on 2/27/23, at 9:00 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff C during the exit conference on 2/27/23, at 4:00 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. **<u>Electrical Systems</u>** 2. Based on observations and interview, the facility failed to maintain the ventilation in the oxygen storage rooms as required. The deficient practice affected three (3) of six (6) smoke compartments, staff, and 154 residents. The facility had a capacity for 238 beds with a census of 154 on the day of the survey. The findings include: While inspecting the [LOCATION] it was observed that there was no ventilation in the room with oxygen tanks on 2/27/23, at 1:24 p.m. An interview with Maintenance Staff A, on 2/27/23, at 1:25 p.m., revealed that they were not aware of the missing ventilation register in the ceiling. The census of 154 was verified by Administrative Staff A on 2/27/23, at 9:00 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff C during the exit conference on 2/27/23, at 4:00 p.m. **Actual NFPA Standard: NFPA 99**, Health Care Facilities Code (2012).

	9.3.7.5.3.7 A means of make-up air shall be provided according to one of the following: (1) Air shall be permitted vi a noncombustible ductwork to be transferred from adjacent spaces, from outside the building, or from spaces that do not contain combustible or flammable materials via noncombustible ductwork (2) Air shall be permitted to be transferred from a corridor under the door up to the greater of 24 L/sec (50 cfm) or 15 percent of the room exhaust in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. (3) Supply air shall be permitted to be provided from any building ventilation system that does not contain flammable or combustible vapors. **9.3.7.6** Discharge from the natural and mechanical ventilation systems shall be sited by a minimum separation distance in accordance with NFPA 55, Compressed Gases and Cryogenic Fluids Code. 9.3.7.7 A storage room shall maintain a temperature not greater than 52°C (125°F). 9.3.7.8 A transfer or manifold room shall maintain a temperature not greater than 52°C (125°F) and not less than −7°C (20°F). 9.3.7.6 Discharge from the natural and mechanical ventilation systems shall be sited by a minimum separation distance in accordance with NFPA 55, Compressed Gases and Cryogenic Fluids Code. 9.3.7.7 A storage room shall maintain a temperature not greater than 52°C (125°F). 9.3.7.8 A transfer or manifold room shall maintain a temperature not greater than 52°C (125°F) and not less than −7°C (20°F).