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: Clyde Lassen State Veterans' Nursing Home

Location: 4650 State Road 16 St. Augustine, FL 32092

Onsite / Virtual: Onsite

Dates of Survey: 1/10/23 - 1/13/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 120

Census on First Day of Survey: 105

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from January 10, 2023 through January 13, 2023 at the Clyde Lassen 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.
§ 51.100 (i) (1) Environment. The facility management must provide— (1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible; **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment one (1) of 17 sampled residents reviewed for compliance with a clean and homelike environment (Resident #1). In Resident #1's room there was a used catheter leg bag with urine remaining in it lying on top of the resident's dresser. The findings include: The surveyor requested facility policies on clean environments for residents on 1/12/23, and was provided copies by Administrative Nurse A of policies on Resident Rights and Notifications as well as a policy on Resident's Personal Property on 1/13/23. Record review of the facility policy on "Resident Rights and Notification," revised on 10/18/17, revealed: "the facility must treat each resident with respect and dignity and care of each

	resident in a manner and in an environment that promotes maintenance or enhancement of [their] quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident." Record review of Resident #1's face sheet revealed the resident was admitted to the facility on [DATE], with diagnoses which included: Major Depressive Disorder, Hemiplegia and Hemiparesis, Dermatitis, Anxiety Disorder, Transient Ischemic Attack, Muscle Spasm, and Epididymitis. A quarterly Minimum Data Set (MDS) assessment for Resident #1, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of seven (7), indicating the resident was severely cognitively impaired. Resident #1 required the total assistance of two staff for bed mobility, toileting, and eating. The record also indicated the resident did not utilize a catheter but did have moisture associated skin damage. During the initial tour, on 1/10/23, at 9:56 a.m., in Resident #1's room, Resident #1 was laying in the bed asleep with the covers pulled over their face and the room lights on. Further observation revealed on the resident's dresser a catheter bag turned over and exposing the white, back part of the bag. There were no staff members, only Resident #1, in the room. During an interview with Licensed Nurse A, on 1/10/23, at 10:00 a.m., in Resident #1's room, Licensed Nurse A confirmed the leg catheter bag on the resident's dresser. When Licensed Nurse A picked up the leg catheter bag, a yellow substance was visible in the bag. Licensed Nurse A reported they could remember Resident #1 had an order for a urine analysis for their albumin to be drawn and that the catheter bag could have been used to collect the sample from the resident. Licensed Nurse A confirmed the catheter bag should not have been left in the resident's room and that they would dispose of it. Record review of Resident #1's progress notes for [DATES], did not reveal a note for the urine collection for the microalbumin lab. However, there was a Nursing Progress Note, written on [DATE], at 12:12 p.m., which stated, "new order given to R/S [reschedule] collection for urine albumin to [DATE]." Further review of Resident #1's medical record revealed laboratory results for a urine albumin lab, which noted it was collected on [DATE], at 2:30 a.m., and received by the laboratory on [DATE]. During an interview, on 1/12/23, at 2:40 p.m., Licensed Nurse A reported that from a review of Resident #1 medical record, the urine analysis (UA) for albumin shows that it was collected on

	[DATE], and was received by the lab on [DATE], and reported on [DATE]. Licensed Nurse A reported that they were not the nurse who collected this lab, but they confirmed the nurse should have disposed of the catheter bag after it was used to collect the specimen and that they should not have left it in the resident's room. During an interview, on 1/12/23, at 10:57 a.m., Administrative Nurse A reported they were not aware of Resident #1's room being found with a used catheter leg bag containing urine. Administrative Nurse A confirmed none of those items should be left in the room unattended. During an interview on 1/12/23, at 4:07 p.m., Administrative Nurse A reported that they believed maybe one of the Certified Nurse Aides may have left the catheter bag in the room. They reported that that Licensed Nurse B and Licensed Nurse A have denied that they were the one to leave the catheter bag in the resident's room.
§ 51.180 (e) (1) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on record review, staff interview, and review of the facility's policies, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for one (1) of 17 sampled residents reviewed for medication management. (Resident #1). The findings include: The surveyor requested facility policies on unsecured medications for residents on 1/12/23, and was provided copies by Administrative Nurse A of policies on Resident Rights and Notifications as well as a policy on Resident's Personal Property on 1/13/23. Record review of the facility policy on "Resident Rights and Notification," dated as revised on 10/18/17, revealed: "the resident has the right to receive adequate and appropriate health care and protective and supportive services, if available, planned recreational activities, and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards with community, and with rules adopted by the agency." Record review of Resident #1's face sheet revealed the resident was admitted to the facility on [DATE], with diagnoses which included: Major Depressive Disorder, Hemiplegia and Hemiparesis, Dermatitis, Anxiety Disorder, Transient Ischemic Attack, Muscle Spasm, and Epididymitis.

	A quarterly Minimum Data Set (MDS) assessment for Resident #1, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of seven (7), indicating the resident was severely cognitively impaired. Resident #1 required the total assistance of two (2) staff for bed mobility, toileting, and eating. The record also indicated the resident did not utilize a catheter but did have moisture associated skin damage. Record review of Resident #1's Physician Order Report for [DATES], revealed the following orders: "-Vitamin A and D [OTC] ointment- apply one thin layer topically every shift. With special instructions to Apply thin layer Vit A and D [Vitamin A and D] ointment on genitals for skin integrity." This order had a start date of [DATE], and an open-ended end date. "-Nystatin powder 100,000 unit/gram- give 5 cubic centimeters[cc] topically twice a day. Special Instructions to cleanse abdominal fold with soap and water and apply nystatin powder until healed. For a diagnosis of fungal infection." This order had a start date of [DATE], and an open-ended end date. During the initial tour, on 1/10/23, at 9:56 a.m., in Resident #1's room, Resident #1 was laying in the bed asleep with the covers pulled over their face and the room lights on. Further observation revealed on the resident's dresser there were two (2) medication pill cups with one (1) having a white powder and the other a petroleum jelly substance. There were no staff members, only Resident #1, in the room. During an interview with Licensed Nurse A on 1/10/23, at 10:00 a.m., in Resident #1's room, Licensed Nurse A confirmed there were two medication pill cups on the resident's dresser with one (1) having a white powder substance and the other a substance resembling petroleum jelly. Licensed Nurse A reported they were not sure what the medications were, but they thought the substance resembling petroleum jelly may have been the resident's Vitamin A and D ointment. Licensed Nurse A reported that they did not leave these medications in the resident's room and that they would dispose of them. Record review of Resident #1's January Medication Administration Record (MAR) revealed the resident was administered the Vitamin A and D and Nystatin on [DATE], and [DATE]. During an interview, on 1/12/23, at 2:40 p.m., Licensed Nurse A reported from a review of Resident #1 medical record the UA for albumin showed that it was collected on [DATE], and was received by the lab on [DATE], and reported on [DATE]. Licensed Nurse A reported that they were not the nurse that collected this lab, but they confirmed the nurse should have

	disposed of the catheter bag after it was used to collect the specimen and that they should not have left the A&D ointment and nystatin in the resident's room. Licensed Nurse A confirmed that the resident was bedbound. During an interview, on 1/12/23, at 10:57 a.m., Administrative Nurse A reported they were not aware of Resident #1's room being found with two unidentified medication pill cups, one containing a petroleum jelly looking substance and the other a white powder substance. Administrative Nurse A confirmed none of those items should have been left in the room unattended. They stated the petroleum jelly was probably A&D, which does not require a prescription, but the nystatin would. They said that they would do some investigation and get back to the surveyor. Administrative Nurse A stated the nurse would have had to fill the nystatin to give to the Certified Nurse Aide to put on for the resident. During an interview, on 1/12/23, at 12:01 p.m., Licensed Nurse C reported they worked with Resident #1 on Monday, but on Tuesday they worked on another unit. Licensed Nurse C reported that the catheter bag and the nystatin shouldn't have been left in the resident's room, but they were not the one that did it. During an interview with Administrative Nurse A, on 1/12/23, at 3:25 p.m., they reported they spoke with Licensed Nurse B, and they were not aware of the incidents concerning the catheter or the medications left in the room. During an interview, on 1/12/23, at 4:07 p.m., Administrative Nurse A reported that they believed maybe one of the Certified Nurse Aides may have left the catheter bag in the room. They reported that Licensed Nurse B and Licensed Nurse A have denied that they were the ones to leave the medication or catheter in the resident's room. During an interview, on 1/12/22, at 4:26 p.m., Licensed Nurse B noted it was hard for them to remember working with the resident, but they looked at their time sheet and it showed they had worked with the resident on [DATE], but they didn't remember dealing with a catheter nor leaving any nystatin or A&D in the resident's room.
§ 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.	**<u>Fire Safety and Operations</u>** Based on records review, observation, and interview, the facility failed to maintain the smoke barrier in accordance with the code. The deficient practice affected one (1) of 3 smoke

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	compartments, staff, and 40 residents. The facility had the capacity for 120 beds with a census of 105 on the day of survey. The findings include: Observation during the building inspection tour, on 1/10/23, at 10:23 a.m., of the hallway ceiling near [LOCATION] revealed it had a 3" round hole that was caused by contractors working in the attic. An interview, on 1/10/23, at 10:51 p.m., with Maintenance Staff A revealed that they were aware of the hole and were making arrangements to have it repaired. The census of 105 was verified by Administrative Staff A on 1/10/23. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 1/12/23.
§ 51.210 (h) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section. (2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. (3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed	Based on interview and review of the facility's service agreements, the facility failed to obtain a dental sharing agreement for 13 facility residents who received dental services from the Veterans Administration (VA) and/or from a private dentist, and two (2) facility residents who received psych services from a private psychiatrist/psychologist. The findings include: During the entrance conference meeting, on 1/10/23, at 9:32 a.m., Administrative Staff A reported there were two (2) residents in the facility who received psychiatric services. Review of the facility's service/vendor contracts revealed the facility did not have a written agreement for residents who received dental services in the community. During an interview, on 1/11/23, at 1:28 p.m., Administrative Staff A and Administrative Staff B reported the facility did not have a mental health service agreement nor had a psychiatrist or psychologist that came into the facility, but there was Administrative Nurse B who reviewed resident medication for behavioral management that came into the facility. Administrative Staff A and Administrative Staff B also reported the facility did not have a dental services agreement and there was not a dentist who came into the facility. Administrative Staff A stated residents went out of the facility to receive dental and mental health services that were set up on their own. During an interview, on 1/13/23, at 2:38 p.m., Administrative Staff A reported they did not have a written agreement for dental services with the VA, nor an agreement with any private dentists;

services and will notify the veteran or the authorized representative of the veteran. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	they also had no sharing agreement with the VA or a private psychiatrist/psychologist. During an interview, on 1/13/23, at 11:14 a.m., Administrative Staff A reported that there were 13 residents in the facility who received dental services from the VA and/or from a private dentist.