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: Missouri Veterans Home – Warrensburg

Location: 1300 Veterans Road, Warrensburg, MO 64093

Onsite / Virtual: Onsite

Dates of Survey: 8/1/23 – 8/4/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 200

Census on First Day of Survey: 91

VA Regulation Deficiency	Findings
	A VA Annual Survey was conducted from 8/1/23 – 8/4/23, at the Missouri State Veterans Home - Warrensburg. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.110 (e) (2) Comprehensive care plans. A comprehensive care plan must be— (i) Developed within 7 calendar days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment. **Level of Harm** – No Actual Harm, with potential for more than minimal harm	Based on observation, interview, record review, and facility policy review, the facility failed to review and revise the Care Plan for one (1) of 17 sampled residents (Resident #5). The findings include: Review of Resident #5's Electronic Chart Dashboard revealed the facility admitted the resident with the following diagnoses: Neurocognitive Disorder with Lewy Bodies, Vascular Dementia, Polyneuropathy, Toxic Encephalopathy, Essential Hypertension, Heart Disease, Atrial Fibrillation, Type II Diabetes Mellitus with Neuropathy, Benign Prostatic Hyperplasia, Gastritis, and Urinary Incontinence. Review of the policy and procedure, dated 10/4/19, and titled, "Veteran Assessment Instrument (RAI) Minimum Data Set (MDS) – Care Plan," revealed: "10. The care plan is a guide to direct the overall care for each Veteran. It is the responsibility of the Unit Manager that any reviews and updates/concerns are relayed to the staff members and can be accessed by licensed nursing in the electronic health record and by nursing assistants via the kiosk at any time" [sic].

Residents Affected – Few	Review of a nursing note, dated [DATE], at 1:29 p.m., revealed: "Weekly Skin Assessment identified fluid filled intact blistered area to left heel. Area is boggy to palpation, with clear serous fluid present. Pink color visible to underlying wound bed. Measures five (5) centimeters (CM) by (x) six (6) point five (0.50) CM. No reported discomfort with assessment. Barrier prep applied and heel protector applied." Review, on 8/1/23, of Resident #5's Care Plan, dated [DATE], did not reveal a revision of the Care Plan related to the development of a wound to the resident's left heel on [DATE]. An interview with Licensed Nurse A, on 8/3/23, at 9:20 a.m., revealed the Plan of Care should be revised by either Administrative Nurse A or Administrative Nurse B. Licensed Nurse A stated the Care Plan should be current and have goals with measurable and specific interventions. An interview with Administrative Nurse B, on 8/3/23, at 9:43 a.m., revealed the purpose of the Care Plan was to direct the staff on how to care for each resident. They stated the Care Plan should be reviewed/revised within one (1) week of an event. An interview with Administrative Nurse C, on 8/3/23, at 11:20 a.m., revealed a resident's Care Plan would ideally be revised/updated on the day they received notification of a change with the resident. Administrative Nurse C revealed they had been made aware of Resident #5's heel wound on [DATE]; however, they had been out of the facility for a few days and needed to catch up on their duties.
§ 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** – Actual Harm that is not immediate jeopardy	Based on observation, interview, record review, and facility policy review, the facility did not ensure that a resident who entered the facility without pressure sores did not develop pressure sores for one (1) of 17 sampled residents (Resident #5). The findings include: Review of Resident #5's Electronic Chart Dashboard revealed the facility admitted the resident with the following diagnoses: Neurocognitive Disorder with Lewy Bodies, Vascular Dementia, Polyneuropathy, Toxic Encephalopathy, Essential Hypertension, Heart Disease, Atrial Fibrillation, Type II Diabetes Mellitus with Neuropathy, Benign Prostatic Hyperplasia, Gastritis, and Urinary Incontinence. Review of Resident #5's Annual Minimum Data Set (MDS), dated and signed [DATE], revealed the resident had a memory problem and the resident was not interviewable. Continued

Residents Affected – Few	review of the MDS revealed the resident required limited assistance of one (1) person with bed mobility and transfers, and extensive assistance of one (1) person with dressing. The resident was assessed to have no pressure ulcers or skin conditions. Review of the policy and procedure titled, "Wound-Skin Care Assessment Treatment Policy," dated 10/4/19, revealed: "Purpose: …2. To identify high-risk Veterans, develop and implement measures to maintain and improve tissue tolerance to pressure in order to prevent injury." Review of the Braden Scale II Score, dated [DATE], revealed Resident #5's assessment score was 13, and the resident was at moderate risk for pressure injury. Review of a Nursing Note, signed and dated [DATE], at 1:29 p.m., by Licensed Nurse B revealed: "Weekly Skin Assessment identified fluid filled intact blistered area to left heel. Area is boggy to palpation, with clear serous fluid present. Pink color visible to underlying wound bed. Measures five (5) centimeters (CM) by (x) six (6) point five (0.50) CM. No reported discomfort with assessment. Barrier prep applied and heel protector applied." Review, on 8/1/23, of Resident #5's Care Plan, dated [DATE], did not reveal the development of a Care Plan related to the wound on their left heel, which had been identified on [DATE]. An observation, on 8/1/23, at 10:15 a.m., revealed Resident #5 in their room and they were sitting up in a wheelchair. A family member stood next to the resident. A heel protector was observed on the resident's left heel, and the resident's heel was sitting on top of the anterior side of the metal footrest. An interview with the family member, on 8/1/23, at 10:20 a.m., revealed the resident had recently developed an ulcer on the heel of the left foot while being a resident at the facility. An observation of Resident #5's left heel, on 8/1/23, at 10:25 a.m., revealed a large, fluid filled blister. An observation of Resident #5, with Administrative Nurse B, on 8/1/23, at 12:00 p.m., revealed the resident and their family member sitting in the dining room. Continued observation revealed the resident's left heel sitting on top of the anterior aspect of the wheelchair's metal footrest. An interview with Consultant Staff A, on 8/1/23, at 1:47 p.m., revealed pressure relief to a resident's heels could be

	maintained when the heels were allowed to "float off" of a surface. Review of the document titled, "Wound Care Plus," signed and dated [DATE], at 7:21 p.m., by Licensed Nurse C revealed: "Wound Assessment (s) Wound #1 left heel is a partial thickness open wound and had received a status of not healed. Initial wound encounter measurements are six (6) CM length x eight (8) CM width with no measurable depth…my preliminary impression of this skin breakdown/ulceration is as follows: The ulcer is mixed etiology including pressure." An interview with Licensed Nurse A, on 8/3/23, at 9:20 a.m., revealed the placement of pillows under a resident's calf and knee would prevent pressure ulcers because the resident's heel(s) would "float off" of a surface. An interview with Certified Nurse Aide A, on 8/3/23, at 9:40 a.m., revealed residents at risk for pressure ulcers should have their heels "floated off" a surface with either heel risers or by floating the heels off a surface with pillows placed behind the resident's calves. An interview with Administrative Nurse B, on 8/3/23, at 9:43 a.m., revealed they did not think Resident #5's wheelchair was appropriate for them due to the fact that the resident was tall and kept scooting down in the current wheelchair, making it impossible to keep their heels floated. An interview with Administrative Nurse C, on 8/3/23, at 11:20 a.m., revealed they had been made aware of Resident #5's heel wound on [DATE]. They stated that Care Plans should be updated on the same day, or the following day, that a resident concern had been identified. An interview with Administrative Nurse D, on 8/3/23, at 12:05 p.m., revealed it was their expectation that residents at risk for the development of pressure ulcers were provided care, such as offloading, in order to prevent skin breakdown.
§ 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.	Based on observations and interviews, the facility failed to adhere to professional standards for food service safety as indicated by unlabeled and/or undated, opened packages of food, staff personal food items stored with resident food, and food items not used or disposed of by the use by or expiration date. The findings include: During the initial [LOCATION] tour, on 8/1/23, that started at 1:45 p.m., accompanied by Dietary Staff A, observations

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	revealed three (3) dented #10 cans of fruit cocktail on the "for-use" storage rack and an opened, undated/unlabeled bag of dry pasta in the dry storage; an employee lunch in a plastic bag on the shelf of the walk-in cooler; opened and unlabeled breadsticks; and a container of strawberry sauce in the walk-in freezer. Additionally observed were an opened, plastic jug of corn syrup, with dating that could not be determined, but the jug had dust on it that indicated it had not recently been opened; and two (2) 56-ounce cans, one (1) opened and one (1) unopened, of sesame oil, with received dates of December, 2019 in the food preparation area. In interviews during the observation, Dietary Staff A stated that all opened food products should be labeled/dated at the time they were opened, and all expired food products should be disposed of by the best use date.
§ 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 observation, interview, record review and facility policy review, the facility failed to store all drugs and biologicals in locked compartments for two (2) of six (6) medication carts. The findings include: Review of the policy and procedure, dated 7/21/22, and titled, "LTC [Long Term Care] Facility's Pharmacy Services and Procedures Manual 5.3 Storage and Expiration Dating of Medications and Biologicals," found stated: "3.3 Facility should ensure that all medications and biologicals including treatment items are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors." In an observation, on 8/1/23, at 10:30 a.m., this surveyor entered the unit and requested to speak with Licensed Nurse D or Administrative Nurse A. A trainee at the [LOCATION] reported that they had gone to assist a resident. After waiting several minutes and speaking to residents who passed or sat near the [LOCATION], this surveyor stood on the opposite side of the counter where the unit's medication cart was located. This surveyor observed that the cart was unlocked and remained at the cart until Licensed Nurse E returned. When Licensed Nurse E was asked if the medication cart, which was out of their line of sight for this observation, was in use and if it was locked, they stated they had been using it and that it was not locked. Licensed Nurse E opened each drawer for the surveyor to confirm the cart contained medications. Licensed Nurse E stated that they had stepped away to handle several tasks, and confirmed that the cart should have been locked. An observation of a medication cart on the [LOCATION], on 8/2/23, at 3:07 p.m., revealed the cart to be unlocked. Continued observation revealed a medication cup on top of the

	cart that contained crushed medications. No staff were observed in the area of the medication cart. An observation, on 8/2/23, at 3:08 p.m., revealed Licensed Nurse F run from the [LOCATION] and through the double doors to the medication cart. An interview with Licensed Nurse F, on 8/2/23, at 3:10 p.m., revealed they had left the medication cart unlocked, unattended, and with crushed medications on top of the cart, unsupervised. Licensed Nurse F stated they should not have left the medication cart unlocked, nor should they have left crushed medications on top of the cart. Licensed Nurse F stated the crushed medication was apixaban 2.5 milligrams (MG) (a medication used to prevent blood clots) and cyclobenzaprine HCL (hydrochloride) 5 MG (used to treat muscle spasms). The nurse revealed other residents could have gotten into the medication cart or could have consumed the crushed medications. An interview with Licensed Nurse A, on 8/3/23, at 9:20 a.m., revealed medication carts should be locked when not attended to by the appropriate staff. They stated so much could go wrong, such as a resident taking medications and suffering very serious side effects. An interview with Administrative Nurse B, on 8/3/23, at 9:43 a.m., revealed their expectations were that staff kept medication carts locked when unattended, and it was never acceptable for staff to leave medications unattended and on top of the cart. They stated that if staff did not follow the policy and procedure related to medication storage, anything could happen, such as a confused resident taking the medication. An interview with Administrative Nurse D, on 8/3/23, at 11:49 a.m., revealed it was their expectation staff followed the policies and procedures of the facility in regard to keeping medications secured. They revealed that the safety of the residents was their number one (1) priority. Administrative Nurse D went on to state that ingestion of unsecured medications could be detrimental to some residents.
§ 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	**<u>Smoke Barriers and Sprinklers</u>** Based on observations and interview, the facility failed to properly install portable fire extinguishers. The deficient practice affected one (1) of 14 smoke compartments, staff, and no residents. The facility had a capacity for 200 beds with a census of 91 on the first day of the survey. The findings include:

Residents Affected – Many	Observation during the building inspection tour, on 8/2/23, at 12:11 p.m., revealed the K type extinguisher in the [LOCATION] was installed above eye level, and the facility staff measured the top of the K extinguisher to be at 5' (feet) 3" (inches) from the floor, as prohibited by section 6.1.3.8.2 of NFPA 10, Standard for Portable Fire Extinguishers. An interview with Maintenance Staff A, on 8/2/23, at 12:11 p.m., revealed the facility was not aware of installation height requirements for portable fire extinguishers. The census of 91 was verified by Administrative Staff A on 8/1/23, at 9:00 a.m. The findings were acknowledged by Administrative Staff A and Administrative Nurse B, and verified by Maintenance Staff A during the exit interview on 8/4/23, at 12:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.5.12** Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. **9.7.4 Manual Extinguishing Equipment.** **9.7.4.1*** Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. **Actual NFPA Standard: NFPA 10, Standard for Portable Fire Extinguishers (2010)** **6.1.3.8 Installation Height.** **6.1.3.8.1** Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. **6.1.3.8.2** Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be installed so that the top of the fire extinguisher is not more than 3½ ft (1.07 m) above the floor. **6.1.3.8.3** In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 in. (102 mm).
§ 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	**Electrical Systems** Based on observation and interview, the facility failed to maintain the remote annunciator for the emergency generator in a location readily observed by operating personnel. The deficient practice affected 14 of 14 smoke compartments, staff, and all residents. The facility had the capacity for 200 beds with a census of 91 on the first day of survey.

illumination. (2) The system must be the appropriate type essential electrical system in 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	The findings include: Observation during the building inspection tour, on 8/2/23, at 11:45 a.m., revealed the remote annunciator for the emergency generator was installed at the [LOCATION] in [LOCATION] of the facility, which was a regular duty station but currently vacant/unoccupied, as prohibited by section, 6.4.1.1.17 of NFPA 99. Health Care Facilities Code. An interview with Maintenance Staff A, on 8/2/23, at 11:45 a.m., revealed the [LOCATION] at [LOCATION], where the generator annunciator was installed, was currently not occupied, but was last year until recently when the position became vacant. Additional interview revealed the facility had not filled the vacant position that occupied the [LOCATION] in [LOCATION]. The census of 91 was verified by Administrative Staff B on 8/1/23, at 9:00 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 8/4/23, at 12:00 p.m. **Actual NFPA Standard: NFPA 99, Health Care Facilities Code (2012)** **6.4.1.1.17 Alarm Annunciator.** A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular workstation (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: **(1)** Individual visual signals shall indicate the following: **(a)** When the emergency or auxiliary power source is operating to supply power to load **(b)** When the battery charger is malfunctioning **(2)** Individual visual signals plus a common audible signal to warn of an engine−generator alarm condition shall indicate the following: **(a)** Low lubricating oil pressure **(b)** Low water temperature (below that required in 6.4.1.1.11) **(c)** Excessive water temperature **(d)** Low fuel when the main fuel storage tank contains less than a 4-hour operating supply **(e)** Overcrank (failed to start) **(f)** Overspeed **6.4.1.1.17.1*** A remote, common audible alarm shall be provided as specified in 6.4.1.1.17.4 that is powered by the storage battery and located outside of the EPS service room at a work site observable by personnel. [110:5.6.6] **6.4.1.1.17.2** An alarm-silencing means shall be provided, and the panel shall include repetitive alarm circuitry so that, after the audible alarm has been silenced, it reactivates after the fault

	condition has been cleared and has to be restored to its normal position to be silenced again. [110:5.6.6.1] **6.4.1.1.17.3** In lieu of the requirement of 5.6.6.1 of NFPA110, a manual alarm-silencing means shall be permitted that silences the audible alarm after the occurrence of the alarm condition, provided such means do not inhibit any subsequent alarms from sounding the audible alarm again without further manual action. **6.4.1.1.17.4** Individual alarm indication to annunciate any of the conditions listed in Table 6.4.1.1.16.2 shall have the following characteristics: **(1)** It shall be battery powered. **(2)** It shall be visually indicated. **(3)** It shall have additional contacts or circuits for a common audible alarm that signals locally and remotely when any of the itemized conditions occurs. **(4)** It shall have a lamp test switch(es) to test the operation of all alarm lamps.