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: Indiana Veterans' Home

Location: 3851 N River Rd, West Lafayette, IN 47906

Onsite / Virtual: Onsite

Dates of Survey: 07/19/22-07/21/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 212

Census on First Day of Survey: 107

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from July 19, 2022, through July 21, 2022, at the Indiana Veterans' Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on observation, interviews, record review and nursing manual review, the facility failed to appropriately administer bladder irrigations for two (2) of two (2) residents reviewed (Resident #117 and Resident #118). The findings include: Review of the provided *10th Edition Lippincott Manual*, copyright 2014, included the following steps to irrigate a catheter: "3. Clean around catheter and drainage tubing connection with alcohol swabs. 4. Disconnect catheter from drainage tubing. Cover tubing with a sterile cap. 5. Place a sterile drainage basin under the catheter. 6. Connect a large-volume syringe to the catheter and irrigate catheter using prescribed amount of sterile solution. 7. Remove syringe and place end of catheter over drainage basin, allowing returning fluid to drain into basin. 8. Repeat irrigation procedure until fluid is clear or according to order. 9. Disinfect the distal end of the catheter and end of drainage tubing, reconnect the catheter and tubing."

	In an interview with Administrative Nurse A on 7/21/22, at 9:15 a.m., they stated that the nurses were supposed to use the *Lippincott Manual* for guidance on how to complete procedures. For catheter irrigations the *Lippincott Manual* said to open the catheter system to flush the bladder, but that was what we used to do. Now (nursing practice) was to keep the catheter system a closed system. In an interview with Administrative Nurse B on 7/21/22, at 10:31 a.m., they stated that they went over catheter irrigation with the annual skills. They stated that the nurse should clamp the catheter tubing to prevent the flush from going away from the bladder. 1. Review of Resident #117's clinical record revealed an admission date of [DATE], and the diagnoses included: Diabetes, Chronic Kidney Disease Stage Three (3), and Neuromuscular Dysfunction of Bladder. Review of Resident #117's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. The resident required extensive assistance with toileting and had the presence of an indwelling catheter. Review of Resident #117's Care Plan, dated [DATE], for indwelling catheter, listed an intervention to administer flushes as ordered with the start date of [DATE]. Review of Resident #117's Physician Order dated [DATE] documented an order to flush the catheter with 60 cubic centimeters (cc) of acetic acid three (3) times a day. Observation on 7/20/22, at 9:50 a.m., revealed that Licensed Nurse A provided the catheter flushing with Administrative Nurse A present. Licensed Nurse A inserted the syringe containing the 60 ccs of acetic acid into the catheter tubing and pushed the solution into the catheter tubing with most of acetic acid going downward into the drainage bag prior to Administrative Nurse A instructing Licensed Nurse A to pinch off the tubing. Licensed Nurse A responded that there was not an order to clamp off the tubing. Administrative Nurse A stated that with the irrigation/flush they wanted the solution to go into the bladder and not directly into the catheter bag. Licensed Nurse A then pinched off the tubing and instilled the remaining acetic acid, approximately 10 ccs. 2. Review of Resident #118's clinical record revealed an admission date of [DATE] and the diagnoses included: Alzheimer's, History of Urinary Tract Infection, Presence of

	Foley Catheter, Injury of Urethra, Chronic Kidney Disease Stage Three (3), Dysuria, and Obstructive and Reflux Uropathy. Review of Resident #118's Quarterly MDS Assessment dated [DATE], revealed the resident's short and long-term memory was not assessed and the resident had severely impaired decision-making skills. The resident required extensive assistance of two (2) people with toileting and had the presence of an indwelling catheter. Review of Resident #118's Care Plan dated [DATE], for indwelling catheter listed an intervention to administer flushes as ordered with the start date of [DATE]. Review of Resident #118's Physician Order dated [DATE], documented an order to flush the suprapubic catheter with 60 cubic centimeters (cc) of acetic acid four (4) times a day. Observation on 7/20/22, at 3:15 p.m., revealed Licensed Nurse A provided the catheter flushing for Resident #118. Licensed Nurse A inserted the syringe with the 60 ccs of acetic acid to the catheter tubing, pinched off the tubing and instilled 40 ccs of the acetic acid and then released the pinched tubing and instilled the remaining 20 ccs of the acetic acid into the tubing, which flowed downward towards the catheter drainage bag.
§ 51.120 (a) (3) Reporting of Sentinel Events The facility management must report sentinel events to the director of VA medical center of jurisdiction within 24 hours of identification. The VA medical center of jurisdiction must report sentinel events by calling VA Network Director (10N 1-22) and Office of Geriatrics and Extended Care in VA Central Office within 24 hours of notification. Level of Harm – N Actual Harm, with potential for more than minimal harm. Residents Affected - Few	Based on interview and record review, the facility failed to report to the Director of Veterans Affairs (VA) Medical Center a sentinel event involving one (1) of one (1) resident reviewed for sentinel events (Resident #122). The findings include: Review of Resident #122's clinical record revealed an admission date of [DATE] and the diagnoses included: Repeated Falls, Chronic Kidney Disease Stage Four (4), Alzheimer's, and Major Depressive Disorder. Review of Resident #122 Nurse's Note, dated [DATE], documented that the resident was in the dining room and slid out of the wheelchair to the floor. Review of Resident #122's Nurse's Note, dated [DATE], documented the resident was admitted to the hospital with a left femur fracture. Review of Resident #122's Nurse Note, dated [DATE], documented the resident's daughter called and reported the resident was placed on hospice and was "actively passing at this time."

	Review of Resident #122's Nurse Note, dated [DATE], documented the resident expired at the hospital. Review of the "Death Certificate" documented Resident #122's cause of death was, "complication of closed left hip fracture," and the second cause of death was, "fall." In an interview with Administrative Nurse A on 7/21/22, at 11:18 a.m., they stated that the facility was told that sentinel events only pertained to veterans, and Resident #122 was not a veteran, so it was not reported to the VA.
§ 51.120 (a) (4) Reporting of Sentinel Events The facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility. Level of Harm – N Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on interview and record review, the facility failed to send to the Director of Veterans Administration (VA) Medical Center the investigation of the sentinel event involving one (1) resident of the sample (Resident #122). The findings include: Review of Resident #122's clinical record revealed an admission date of [DATE] and the diagnoses included: Repeated Falls, Chronic Kidney Disease Stage Four (4), Alzheimer's, and Major Depressive Disorder. Review of Resident #122's Nurse's Note, dated [DATE], documented the resident was in the dining room and slid out of the wheelchair to the floor. Review of Resident #122's Nurse's Note, dated [DATE], documented the resident was admitted to the hospital with a left femur fracture. Review of Resident #122's Nurse Note, dated [DATE], documented the resident's daughter called and reported the resident was placed on hospice at the hospital and was "actively passing at this time." Review of Resident #122's Nurse Note, dated [DATE], documented the resident expired at the hospital. Review of the "Death Certificate" documented Resident #122's cause of death was, "complication of closed left hip fracture," and the second cause of death was, "fall." In an interview with Administrative Nurse A, on 7/21/22, at 11:18 a.m., they stated that the facility was told that sentinel events only pertained to veterans, and Resident #122 was not a veteran, therefore an investigation was not sent to the VA.
§ 51.120 (n) Medication Errors The facility management must ensure that—	Based on observations, interviews, record review, and review of facility policy, the facility failed to administer medications as ordered or in an appropriate manner for three (3) of seven (7)

(1) Medication errors are identified and reviewed on a timely basis; and (2) strategies for preventing medication errors and adverse reactions are implemented. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Some	residents observed during the medication pass (Resident #123, Resident #124, Resident #125). The findings include: Review of the facility policy titled, "Medication Administration General Guidelines," dated 1/1/11, documented: "Medications are administered as prescribed in accordance with good nursing principles and practices…B. Administration… 2. Medications are administered in accordance with written orders of the attending physician." Review of the facility policy titled, "Eye Drop Administration," dated 1/1/11, documented: "G. Instruct resident to look upward, and place one (1) drop into the pocket, continuing to hold the eyelid for a moment to allow the medication to distribute. H. Release the eyelid and instruct the resident to close the eye slowly and keep it closed for one (1) or two (2) minutes. Do not allow the resident to squeeze the eye shut or rub the eye." Review of the facility policy titled, "Nasal Inhaler Spray and Pump Administration," dated 1/1/11, documented: "E. 3. Use finger of other hand to close the nostril that is not receiving medication by gently pressing the side of the nostril." 1. Observation on 7/20/22, at 8:05 a.m., revealed Certified Nurse Aide A mixed 17 grams of MiraLAX (used to treat constipation) in approximately two (2) ounces of water and administered it to Resident #123. Certified Nurse Aide A also administered Artificial Tears, one (1) drop into each eye. Certified Nurse Aide A did not instruct the resident to close their eyes to allow time for the Artificial Tears time to be absorbed. Review of Resident #123's Physician Order revealed an order for MiraLAX 17 grams mixed in eight (8) ounces of water or juice. In an interview with Administrative Nurse A on 7/21/22, at 9:15 a.m., they stated that staff should mix the MiraLAX in eight (8) ounces of water. 2. Observation on 7/20/22, at 8:37 a.m. revealed that Certified Nurse Aide B administered Ocean Nasal Spray to Resident #124. Observation revealed that Certified Nurse Aide B administered one (1) spray into each nostril without holding the opposite nostril when administering the Ocean Nasal Spray. In an interview with Administrative Nurse A on 7/21/22, at 9:15 a.m., they stated that staff should always hold the opposite nostril when administering nasal spray.

	3. Observation on 7/20/22, at 11:05 a.m., revealed Certified Nurse Aide C administered to Resident #125 Artificial Tears, one (1) drop in each eye, waited 12 minutes, administered one (1) drop of Prednisone eye drops in the right eye, waited 10 minutes, administered one (1) drop of Ciproflaxin eye drops in the right eye, waited approximately ten (10) minutes and then administered one (1) drop of Tropicamide eye drop in the right eye. Observation revealed Certified Nurse Aide C did not hold the inner canthus or instruct Resident #125 to hold their eyes shut. Review of the pharmacy provided information sheet for Tropicamide, dated 7/1/22, revealed that the lacrimal sac should be compressed by digital pressure for two (2) to three (3) minutes after instillation to avoid excessive systemic absorption. In an interview with Certified Nurse Aide C on 7/20/22, at approximately 11:50 a.m., they stated that they had never seen in the Physician Order to hold the inner canthus and they did not hold the inner canthus. In an interview Administrative Nurse A on 7/21/22, at 9:15 a.m., they stated that they did not know for sure about holding the inner canthus or having the resident hold their eyes closed after the administration of eye medications was required. They stated that Administrative Nurse B completed one (1) on one (1) skills annually with all nursing staff. Review of the "Skills Checklist" for Certified Nurse Aide B, dated [DATE], and Certified Nurse Aide A, dated [DATE], documented they each passed the administration of inhalers, nasal medications, and eye drops. Review of the "Clinical Assessment" for Certified Nurse Aide C, dated [DATE], documented that they had the proficiency score of four (4) out of four (4) with administration of eye medications, oral medications, and nasal medications.
§ 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	Based on interview and record review, the facility didn't have a written sharing agreement with the Veterans Administration (VA) for the provision of psychological services, and written provider agreements with any dental providers. The findings include: An interview with Administrative Staff A was conducted on 7/19/22, at approximately 10:49 a.m., Administrative Staff A confirmed that at least one (1) resident received mental health services at the VA Community Based Outpatient Clinic (CBOC). Administrative Staff A stated that there was no written sharing agreement with the VA for psychological services.

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 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	An interview with Administrative Staff B, Administrative Staff C, and Administrative Nurse C was conducted on 7/20/22, at approximately 4:15 p.m., during the daily exit. The staff confirmed that the facility did not have a sharing agreement with the VA for a resident receiving mental health services at the CBOC. The staff also stated residents have the freedom to select their preferred dentist, but confirmed that there were no written provider agreements with any dental service providers.