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: Georgia War Veterans Nursing Home

Location: 1101 Fifteenth St., Augusta, GA 30901

Onsite / Virtual: Onsite

Dates of Survey: 9/13/2022- 9/16/2022

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 192

Census on First Day of Survey: 124

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from 9/13/22, through 9/16/22, at the Georgia War Veterans Nursing Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.110 (c) Accuracy of assessments. (1) Coordination— (i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals. (ii) Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment. (2) Certification. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's status for two (2) of 22 sampled residents (Resident #3 and Resident #8) reviewed for Quality of Care/Treatment. The findings include: Record review of the facility's policy titled, "MDS – Minimum Data Set," revised 1/20/22, revealed: "Purpose: To provide guidelines for use of the MDS (Minimum Data Set) for a comprehensive assessment of each resident. Policy: …5. Assessments will be completed by MDS 3.0 guidelines." 1. Record review on 9/14/22, at 9:30 a.m., of Resident #3's Annual Minimum Data Set (MDS), dated [DATE], revealed the resident was assessed as having one fall with no injuries.

Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Record review on 9/14/22, at 9:30 a.m., of Resident #3's Progress Notes and Assessments from [DATE] to [DATE] revealed no documentation of a recent fall. During an interview on 9/14/22, at 11:30 a.m., Administrative Staff A stated they did not see a recent fall documented for Resident #3. They stated they reviewed the fall log for the past three months and there was no fall documented. They stated they completed the fall reports. During an interview on 9/15/22, at 1:55 p.m., Administrative Nurse A stated it was a transcription error. They stated the resident did not have a fall. They stated that they will be sending a correction MDS to change the error in coding. 2. On 9/14/22, at 2:00 p.m., review of the medical record for Resident #8 revealed an admission date in 2022, with readmissions in 2022. Diagnoses included, but were not limited to: Depression and Benign Prostatic Hypertrophy. Review of the Physician Orders revealed an order dated [DATE], for a Foley catheter to gravity drainage. Medication orders included Risperidone (antipsychotic), Melatonin (for sleep) and Bumex (antianxiety). A physician's order to discontinue Citalopram (antidepressant) was dated [DATE]. Review of the Nursing Progress Note, dated [DATE], at 4:30 p.m., noted: "New order obtain (sp) from Dr. (name of physician) for U/A (urinalysis) CBC (Complete Blood Count), CMP (Complete Metabolic Profile) and inserting indwelling catheter. Foley 18 FR (French) with 5 (five) cc (cubic centimeters) bulb inserted. Resident tolerated well. Output of 900 cc of clear yellow urine. Foley ordered for Urinary Retention. Labs to be collected in AM (morning)." [sic] Review of the Quarterly Minimum Data Set (MDS) assessment for Resident #8, dated [DATE], revealed the MDS was not coded for Resident #8's Foley catheter that was placed on [DATE]. The MDS noted Resident #8 was always continent of urine instead of having a Foley catheter. Review of the Admission MDS assessment for Resident #8, dated [DATE], revealed the MDS was not coded for Resident #8's Foley catheter that was placed on [DATE]. Continued review of the Admission MDS assessment revealed Resident #8 was coded to have received seven (7) doses of an antidepressant during the seven (7) day look back period for the assessment. The MDS noted Resident #8 was always incontinent of urine instead of having a Foley catheter. On 9/14/22, at 3:00 p.m., during an interview with Administrative Nurse B, they confirmed the MDS assessments dated [DATE], and [DATE], had been coded incorrectly for Resident #8's Foley Catheter and the MDS assessment, dated [DATE], was also coded incorrectly for the use of an antidepressant by Resident #8. They stated information is auto populated from the previous MDS assessment to the next one, and they forgot to uncheck the antidepressant. They also stated they overlooked the order

	for the Foley catheter and did not properly code the MDS for the Foley catheter on [DATE], and [DATE]. On 9/15/22, at 1:55 p.m., Administrative Nurse A stated corrections for the presence of a Foley catheter would need to be submitted for the MDS assessments dated [DATE], and [DATE]. They also stated the MDS assessment, dated [DATE], would need the correction for Resident #8 receiving antidepressants, since it had been discontinued [DATE].
§ 51.120 Quality of care. Each resident must receive, and the facility management must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 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 ensure each resident received quality of care by failing to complete and document daily weights as ordered by the physician for one (1) (Resident #8) of six (6) residents reviewed for weight loss. The findings include: Review of the facility policy titled, "Weights-Standing scale and Mechanical Lift," dated 1/20/22, revealed the section titled, "Purpose," noted: "It is the policy of Georgia War Veterans Nursing Home for each resident to be weighed once a month unless otherwise ordered by the physician or contraindicated by resident's medical condition." On 9/14/22, at 2:00 p.m., review of the medical record for Resident #8 revealed an admission date of 2022, with hospitalization on [DATE], at 3:25 p.m., and readmitted on [DATE], at 3:00 p.m., and hospitalized again on [DATE], at 6:00 a.m., and readmitted on [DATE], at 2:30 p.m. Diagnoses included, but were not limited to: Coronary Artery Disease (CAD) Hypertension (HTN), Chronic Kidney Disease (CKD) and Heart Failure. Review of the Physician Orders for Resident #8 revealed an order dated [DATE], for "Daily Weights." Additional review of Resident #8's medical record revealed 42 of 226 daily weights were documented since [DATE]. On 9/15/22, at 9:15 a.m., during an interview with Licensed Nurse A, they stated that additional weights for Resident #8 were on the Nursing Assignment sheet and had been added to the daily weight records. This included 15 additional weights for a total of 57 out of 226 daily weights documented since [DATE]. They stated they had spoken to the physician and a new order was obtained to discontinue the daily weights for Resident #8 and to do weights on Monday-Wednesday and Friday. They also stated the physician had given an order to decrease Resident #8's diuretic. They confirmed the daily weights had not been completed as ordered. Review of those daily weights on 9/15/22, at 9:30 a.m., included weight documented on [DATE], and [DATE]. These were dates that Resident #8 was hospitalized and not in the facility.

	On 9/16/22, at 8:50 a.m., during an interview with Administrative Nurse C, they stated weights were completed by the night shift and recorded in the medical record by Administrative Staff B. They stated Resident #8 would have been weighed on [DATE], by the night shift prior to being sent to the hospital at 6:00 a.m. They had no explanation how the documented weight on [DATE], was obtained while Resident #8 was hospitalized, but stated the monthly weights were done the last four (4) days of each month and Administrative Staff B recorded them all on the first of each month and that was probably how the weight was completed and documented. Administrative Nurse C confirmed the daily weights ordered by the physician for Resident #8 were not completed and documented as ordered. The facility failed to obtain and document 169 daily weights out of 226 daily weights ordered by the physician on [DATE].
§ 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) 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>Means of Egress</u>** Based on observation and interview, the facility failed to ensure the path of egress was free and clear of all obstructions. The deficient practice affected one (1) of 10 smoke compartments, staff, and some residents. The facility had a capacity for 192 beds with a census of 124 on the day of the survey. The findings include: Observation during the building inspection tour on 9/13/22, at 12:58 p.m., of the path of egress in the cafeteria leading to an exit door revealed a dining table and six (6) chairs located in front of the exit door, as prohibited by section 7.1.10.1 of NFPA 101, Life Safety Code. An interview at that time with Maintenance Staff A revealed that environmental services moved the table to perform cleaning of the cafeteria and the dining table was not located in that position normally. The census of 124 was verified by Administrative Staff C on 9/13/22. The findings were acknowledged by Administrative Staff C and verified by Maintenance Staff A during the exit interview on 9/16/22. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.2 Means of Egress Requirements.** **19.2.1** General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. **7.1.10 Means of Egress Reliability.** **7.1.10.1*** General. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

§ 51.210 (c) (7) Required Information. Annual State Fire Marshall's report; Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Many	Based on records review and interview, the facility failed to ensure the annual State Fire Marshal inspection was completed in accordance with VA Nursing Home Care Regulation. The deficient practice affected 10 of 10 smoke compartments, staff, and all residents. The facility had the capacity for 192 beds with a census of 124 on the day of survey. The findings include: Records review on 9/13/22, at 10:46 a.m., revealed the last inspection from the City Fire Inspector was conducted November 14th of 2020. The facility had no documentation of a State Fire Marshal inspection in the 12-month period prior to the survey. An interview with Maintenance Staff A at that time revealed that the facility was aware of the requirement to be inspected on an annual basis and had two prior inspections scheduled with the State Fire Marshal; however, the facility was unable to allow visitations during both scheduled times of inspection because of COVID-19. The census of 124 was verified by Administrative Staff C on 9/13/22. The findings were acknowledged by Administrative Staff C and verified by Maintenance Staff A during the exit interview on 9/16/22.