# 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 W. Cosper Texas State Veterans Home

**Location:** 1300 Seven Oaks Rd., Bonham, Texas 75418

**Onsite / Virtual:** Onsite

**Dates of Survey:** 6/11/24 – 6/14/24

**NH / DOM / ADHC:** NH

**Survey Class:** Annual

**Total Available Beds:** 160

**Census on First Day of Survey**: 154

| VA Regulation Deficiency | Findings |
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| | A VA Annual Survey was conducted from June 11, 2024, through June 14, 2024, at the Clyde W. Cosper Texas State Veterans Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes. |
| **§ 51.70 (f) (1) – (2) Grievances.**<br>A resident has the right to—<br>(1) Voice grievances without discrimination or reprisal. Residents may voice grievances with respect to treatment received and not received; and<br>(2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** –Many | Based on record review, interviews, and facility policy review, the facility failed make prompt efforts to resolve grievances of hot food items being served hot when delivered to residents on four (4) of seven (7) halls for a timeframe of January 2024, through May 2024.<br><br>The findings included:<br><br>A review of the facility's Grievance policy, revised November 2017, revealed the facility would acknowledge the grievance/concern and actively work toward a prompt resolution of the grievance.<br><br>Review of the facility titled, "Food Temperatures," dated 2013, revealed:<br>"1. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135° [degrees] F [Fahrenheit]. Take temperatures often to monitor for safe food holding temperature ranges of at or below 41° F for cold foods; and at or above 135° F for hot foods. Hot food items may not fall below 135° F after |

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| | cooking, unless it is an item which is to be rapidly cooled to below 41° F and reheated to at least 165° F prior to serving.<br><br>3. Temperatures should be taken periodically to assure hot foods stay above $135^0$ F and cold \foods stay below $41^0$ during the portioning, transporting and delivery process until/ received by the individual recipient.<br><br>4. Foods should be transported as quickly as possible to maintain temperatures for delivery and service. If food transportation time is extensive, food should be transported using a method that maintains temperatures (i.e., hot/cold carts, pellet systems, insulated plate bases and domes, etc.)…<br><br>6. Foods sent to the units- for distribution (such as meals, snacks, nourishments, oral' supplements) will be transported and delivered to maintain temperatures at or below 41 F° for cold foods and at or above 135° F for hot foods."<br><br>A review of the facility's grievance report revealed complaints about hot food being delivered cold on the following dates: [DATES].<br><br>A review of the facility's food committee minutes revealed complaints of hot food being delivered cold in [DATES].<br><br>During an interview, on 6/13/24, at 12:15 p.m., Dietary Staff A stated that the [LOCATION] had warming boxes that kept the food warm while being delivered to the neighborhoods. Dietary Staff A further stated the warming boxes broke in November 2023, and the facility received an increase of complaints of hot food being cold as a result.<br><br>During an interview, on 6/13/24, at 12:20 p.m., Resident #22 stated that they complained daily to the Certified Nurse Aide. Resident #22 stated that they did not go to the Resident Council because the council did not listen to residents.<br><br>A review of an invoice revealed the warming boxes broke in November of 2023. The invoice stated: "10/31 Dispatched tech for two (2) hot boxes tripping gel. First proofer has bad humidity Element/T-Stat. Second proofer Tech was able to repair onsite. Unable to get parts for this."<br><br>Observations of food temperatures taken on 6/13/24, at 12:06 p.m., to 12:30 p.m., were as follows: Spanish Rice 112° Blackened Chicken 115°, Mechanical Soft Chicken 110° F, Taco Meat 116° F, and Mashed Potatoes 123° F. |
| **§ 51.120 (j) Nutrition.**<br>Based on a resident's comprehensive | Based on observations, interviews, record review, and review of facility policy, the facility failed to administer a supplement as |

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| assessment, the facility management must ensure that a resident—<br>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and<br>(2) Receives a therapeutic diet when a nutritional deficiency is identified<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Few | ordered, failed to follow-up on the dietician's recommendation, and failed to assist one (1) resident (Resident #4), who had a history of weight loss, with meals. The sample included three (3) residents for nutrition/weight loss.<br><br>The findings include:<br><br>Review of the facility policy titled, "Weights," with no date, revealed: "9. Following Dietician visit review [their] recommendations and obtain orders."<br><br>Review of the facility policy titled, "Feeding Assistance," dated 10/12, revealed: "Procedure: …8. Position a chair next to the resident's bed, allowing face to face conversation with the resident." The policy further revealed: "10. Cut the food into small pieces and season according to the resident's preference or dietary restrictions. 11. Talk with the resident, explaining what is on the tray. 12. Alternate food and fluids."<br><br>Review of the facility policy titled, "Nutrition at Risk Program," with no date, revealed: "2) Mealtime …b) During Meal…ii) Observe during meal (1) Not eating – Why (a) Fix problem (b) Offer alternative (c) Assist as needed." Further review of the policy revealed: "c) Weekly review (2) Recommendations? (d) Supplements…(i) Require an order (ii) Should be on MAR [Medication Administration Record] with percentage of completion."<br><br>Review of Resident #4's clinical record listed an admission date of [DATE], with diagnoses which included Dementia, Chronic Kidney Disease Stage Three (3), Hypertension, and Diabetes.<br><br>Review of Resident #4's Annual Minimum Data Set (MDS) Assessment, dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was a 10, which indicated the resident had moderate cognitive impairment. Resident #4 required setup or clean-up assistance with eating, was dependent for personal hygiene and transfers, and did not walk. Per the MDS, Resident #4 did not have swallowing problems, had experienced weight loss, and was on a mechanically altered therapeutic diet.<br><br>Review of Resident #4's Quarterly MDS Assessment, dated [DATE], revealed the resident's BIMS score was an eight (8), which indicated the resident had moderate cognitive impairment. Resident #4 required setup or clean-up assistance with eating, was dependent with personal hygiene and transfers, and did not walk. The resident had no swallowing problems, had no, or unknown, weight loss, and received a mechanically altered therapeutic diet. |

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| | Review of Resident #4's Care Plan, dated [DATE], revealed the listed nutrition interventions: "Allow resident time to feed self. Assist as needed to complete meals. Diet as ordered: Fortified Meal Plan diet, Mechanical Soft Texture with Regular/Thin liquids. Dietician to evaluate nutritional status as needed. Document food intake at each meal. Offer resident food alternatives as needed. Offer verbal praise when resident consumes majority of food served. Provide verbal encouragement with meals. Supplement as ordered: Magic Cup one time a day. Sandwiches-choice two times a day for Weight loss. Weigh per facility protocol/as ordered." The Care Plan also listed the intervention that Resident #4 required assistance with meals/feeding.<br><br>Review of Resident #4's Weights list revealed the following:<br><br>[DATE] – 155.6 pounds (lbs.)<br>[DATE] – 150.6 lbs.<br>[DATE] – 142.2 lbs.<br>[DATE] – 141 lbs.<br>[DATE] – 143.6 lbs.<br>[DATE] – 150 lbs.<br>[DATE] – 147 lbs.<br>[DATE] – 148.2 lbs.<br>[DATE] – 148 lbs.<br><br>Review of Resident #4's Physician Orders included the orders:<br><br>[DATE] – sandwiches-choice, two (2) times a day for weight loss.<br>[DATE] – fortified meal plan diet, mechanical soft texture, regular/thing liquid choice.<br>[DATE] – Magic Cup one (1) time per day for supplement.<br>[DATE] – Boost, 90 cubic centimeters (cm) two (2) times per day for supplement.<br><br>Review of the monthly MAR, from [DATE], to [DATE], revealed a Physician Order for Boost two (2) times a day for supplement, 90 ml (milliliters) scheduled for 8:00 a.m., and 8:00 p.m. Further review of the clinical record lacked documentation the resident received any of the physician ordered Boost.<br><br>Review of the Dietary Staff B Nutritional Assessment, dated [DATE], revealed a recommendation of increased Med Pass 2.0/Boost to 120 ml two (2) times per day.<br><br>Review of Resident #4's clinical record lacked evidence the facility followed up on the recommendation to increase the amount of Med Pass/Boost that was given. |

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| | Continuous observation of the lunch meal for Resident #4, on 6/12/24, from 12:13 p.m., to 12:45 p.m., revealed staff served the resident eight (8) ounces each of chocolate milk, cranberry juice, and water; along with foods that included a brisket sandwich with cheese, tater tots, cream corn, strawberry short cake, Magic cup, and pudding. Staff left the food on the overbed table. Observation revealed staff did not reenter the room until 12:45 p.m., and when they entered, the staff member stated, "you not going to eat?" then picked up the resident's tray and placed it in the cart. Resident #4 was observed to only drink the chocolate milk, and no staff sat down or attempted to feed the resident, or offer any alternate foods.<br><br>Continuous observation of the lunch meal for Resident #4, on 6/13/24, from 12:28 p.m., to 12:48 p.m., revealed the staff served the resident their lunch meal and left the room. Staff then reentered the room at 12:48 p.m., and removed the tray. Staff left the glass of chocolate milk and glass of tea on the overbed table. Staff did not attempt to feed the resident or offer any alternatives.<br><br>During an interview with Certified Nure Aide A, on 6/13/24, at 12:49 p.m., they stated Resident #4 required assistance to eat. Certified Nure Aide A also stated sometimes the resident's mind did not go with what they were supposed to do.<br><br>During an interview with Licensed Nurse A, on 6/13/24, at 2:25 p.m., they stated sometimes Resident #4 did not eat and the staff had to encourage them or "spoon feed" the resident. Licensed Nurse A also confirmed the resident had not received the ordered Boost since [DATE].<br><br>During an interview with Administrative Nurse A, on 6/13/24, at 3:00 p.m., they stated the dietary recommendations were sent to the Administrative Nurses and then to Administrative Nurse A. They also stated that if the Dietary Staff B recommended a supplement, the staff would provide it. In addition, Administrative Nurse A stated if the resident was not eating, they expected the staff to assist the resident to eat. Administrative Nurse A also confirmed Resident #4 had not received the Boost since [DATE]. |
| **§ 51.120 (n) Medication Errors.**<br>The facility management must ensure that—<br>(1) Medication errors are identified and reviewed on a timely basis; and<br>(2) strategies for preventing medication errors and adverse reactions are implemented. | Based on observation, interviews, record review, and review of facility policy, the facility failed to administer medication to one (1) resident appropriately and at the correct dosage (Resident #19). The medication pass included 28 opportunities with one (1) error.<br><br>The findings include: |

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| **Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Few | Review of the facility policy titled, "Medication Administration," dated 10/12, revealed: "Procedure: Always follow five [5] rights: Right medication Right resident Right time Right amount Right route."<br><br>According to www.flonasenasalspray.com: "Instructions for using FLONASE, 1. Gently blow your nose to clear your nostrils. 2. Place the tip of the nozzle in one [1] nostril and close the other nostril with your finger. 3. Aim slightly away from the center of your nose, press the white nozzle and sniff the mist in gently. 4. Exhale through your mouth."<br><br>Review of Resident #19's Physician Orders revealed the order for Flonase Nasal Spray, one (1) spray in both nostrils two (2) times a day related to allergic rhinitis, with the start date of [DATE].<br><br>Observation during the medication pass, on 6/12/24, at 7:48 a.m., revealed Certified Medication Aide A administered medications to Resident #19. Further observation revealed Certified Medication Aide A handed Resident #19 the Flonase nasal spray. Resident #19 administered two (2) sprays into each naris and did not hold the opposite naris when administering the nasal spray. Further observation revealed Certified Medication Aide A did not instruct the resident how to administer the Flonase, and did not instruct the resident on how many sprays the physician ordered.<br><br>In an interview with Certified Medication Aide A , on 6/12/24, at 10:24 a.m., they stated they had shown Resident #19 how to administer the nasal spray in the past.<br><br>In an interview with Administrative Nurse A, on 6/12/24, at 3:18 p.m., they stated the resident/staff should hold the opposite naris when administering the nasal spray if the instructions told them to do so. |
| **§ 51.140 (d) Food.**<br>Each resident receives and the facility provides—<br>(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br>(2) Food that is palatable, attractive, and at the proper temperature;<br>(3) Food prepared in a form designed to meet individual needs; and<br>(4) Substitutes offered of similar nutritive value to residents. | Based on record reviews and interviews, the facility failed to ensure proper temperatures of food delivered to residents, specifically hot foods were not delivered hot for four (4) out of the seven (7) halls reviewed for food temperatures at the time of delivery.<br><br>The findings include:<br><br>A review of the facility's policy "Food Temperatures," dated © 2013, revealed: "1. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least $135^0$ F. Take temperatures often to monitor for safe food holding temperature ranges of at or below $41^0$ F for cold foods; and at or above $135^0$ F for hot foods. a. |

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| **Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Some | Cooking temperatures must be reached and maintained according to regulations, laws, and standardized recipes while cooking. b. Hot food items may not fall below $135^0$ F after cooking, unless it is an item which is to be rapidly cooled to below $41^0$ F and reheated to at least $165^0$ F prior to serving. Caution should be taken to avoid serving food and liquids at temperatures that are too hot. (Avoid the risk of burning the resident or patient.)" Further review of the policy revealed: "3. Temperatures should be taken periodically to assure hot foods stay above $135^0$ F and cold foods stay below $41^0$ during the portioning, transporting and delivery process until received by the individual recipient. 4. Foods should be transported as quickly as possible to maintain temperatures for delivery and service. If food transportation time is extensive, food should be transported using a method that maintains temperatures (i.e., hot/cold carts, pellet systems, insulated plate bases and domes, etc.)" Per the policy: "6. Foods sent to the units for distribution (such as meals, snacks, nourishments, oral supplements) will be transported and delivered to maintain temperatures at or below 41° F for cold foods and at or above 135° F for hot foods."<br><br>A review of the facility's grievance report revealed complaints about hot food being delivered cold on the following meeting dates: [DATES].<br><br>A review of the facility's food committee minutes revealed complaints of hot food being delivered cold in [DATES].<br><br>During an interview, on 6/13/24, at 12:15 p.m., Dietary Staff A stated that the [LOCATION] had warming boxes that kept the food warm while being delivered to the neighborhoods. Dietary Staff A stated the boxes broke in November of last year, and the facility saw an increase in complaints of hot food being cold as a result.<br><br>A review of facility records revealed the warming boxes broke in November of 2023. A review of an invoice revealed the warming boxes broke in November of 2023. The invoice stated: "10/31 Dispatched tech for two (2) hot boxes tripping gel. First proofer has bad humidity Element/T-Stat. Second proofer Tech was able to repair onsite. Unable to get parts for this."<br><br>Temperatures were taken on 6/13/24, at 12:06 p.m., and again at 12:30 p.m. The temperatures were as follows: Blackened Chicken 115° F, Mechanical Soft Chicken 110° F, Spanish Rice 112° F, Taco Meat 116° F, and Mashed Potatoes 123° F. |
| **§ 51.180 (d) Labeling of drugs and biologicals.**<br>Drugs and biologicals used in the facility management must be labeled in | Based on observation, interview, and review of facility policy, the facility failed to dispose of expired heparin flushes in one (1) of three (3) medication rooms observed. |

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| accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Few | The findings include:<br><br>Review of the facility policy titled, "Storage and Expiration Dating of Medications, Biologicals," dated revised 8/7/23, revealed: "Procedure…4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier…5.2 Medications with a manufacturer's expiration date expressed in month and year (e.g. May, 2022) will expire on the last day of the month…17. Facility personnel should inspect [LOCATIONS] for proper storage compliance on a regularly scheduled basis."<br><br>Observation of the [LOCATION] on [LOCATION], on 6/13/24, at 1:02 p.m., revealed 20 individually wrapped, five (5) cubic centimeter (cc) Heparin Flushes with the expiration date of 1/24.<br><br>During an interview with Administrative Nurse A, on 6/13/24, at 3:23 p.m., they stated Licensed Nurse B, or the Administrative Nurses, were responsible for checking the medication rooms for expired medications. |
| **§ 51.210 (h) Use of outside resources.**<br>(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.<br>(2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for—<br>(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and<br>(ii) The timeliness of the services.<br>(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 | Based on interview and review of the facility's contracts and service agreements, the facility failed to obtain a mental health sharing agreement for 39 residents who received mental health services from the Veterans Administration (VA).<br><br>The findings include:<br><br>Review of the facility's contracts and service agreements revealed there was no sharing agreement for mental health services for residents who received mental health services from the VA.<br><br>Review of the facility's list of residents who received mental health services from the VA revealed there were 39 residents who received mental health services from the VA.<br><br>During an interview, on 6/14/24, at 10:55 a.m., Administrative Staff A confirmed the facility did not have a sharing agreement with the VA for residents who received mental health services from the VA. Administrative Staff A confirmed there were several Veterans who received mental health services from the VA. Administrative Staff A stated the facility was currently working with the VA to expedite a Sharing Agreement for mental health services. |

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| 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.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br><br>**Residents Affected** – Many | |