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:

SVH Name: Frank M. Tejeda Texas State Veterans Home

SVH Location: 200 Veterans Dr, Floresville, TX 78114

Onsite / Virtual: Virtual

Dates of Survey: 2/22/22-2/25/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 160

Census on First Day of Survey: 128

Line Item #/Deficiency	Findings
	Initial Comments: A VA Annual survey was conducted from February 22, 2022, through February 25, 2022, at Frank M. Tejeda Texas State Veterans Home. The facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
Standard 51.110 (e) 2 Resident Assessment (2) 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	Based on observations, interviews, and record review, the facility failed to develop a care plan for Resident #7 to address the resident's use of a Foley Catheter. This deficient practice affected Resident #7; one of two sampled residents reviewed for a Foley Catheter. The findings included: Record review revealed Resident #7 was admitted to the facility on 2019. Resident #7 has a medical history to include diagnoses of Chronic Kidney Disease, Benign Prostatic Hyperplasia (BPH) with lower urinary tract symptoms, and personal history of Urinary Tract Infections. Review of Resident #7's Clinical Physician Orders revealed an order for a Foley Catheter with a start date of [DATE]. Review of Resident #7's medical record revealed the absence of a care plan to address the resident's use of a Foley Catheter and catheter care needs.

a team of qualified persons after each assessment. Scope and Severity – No Actual Harm, with potential for more than minimal harm Residents Affected - Few	During an observation on 2/22/22 at 12:50 p.m. in the presence of the Administrative Nurse A, Resident #7 was observed not having a catheter leg strap to secure and anchor the catheter tubing. During an interview on 2/22/22 at 3:10 p.m., the Administrative Nurse A was asked to provide a copy of Resident #7's care plan to address the use and care needs for the Foley Catheter. During an interview on 2/23/22 at 2:44 p.m., Administrative Nurse D confirmed and verified that Resident #7's Foley Catheter care plan was created after it was requested by the surveyor on [DATE]. The Administrative Nurse D explained the care plan had been discontinued in [DATE} when the resident's catheter was removed and when the catheter was reinserted the care plan was not developed. Review of Resident #7's medical record revealed a care plan with a focus of "I have a Catheter r/t (related to): BPH with obstructive uropathy …" created on [DATE] by the Administrative Nurse D with a goal and appropriate interventions/tasks. In an interview on 2/25/22 at 3:05 p.m., the Administrative Nurse A stated it was Administrative Nurse A's expectation that a Foley Catheter care plan be created for each resident with a catheter.
Standard 51.120 (a) 4. Quality of Care (4) 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. Scope and Severity – No Actual Harm, with potential for more than minimal harm Residents Affected - Many	Based on record review, and interview, it was determined the facility failed to implement a corrective action plan after review of a Sentinel Event determined the need for intervention. Resident #12 experienced a fall, and the facility determined the incident met the criteria of a Sentinel Event. An analysis of the Sentinel Event determined staff should be in-serviced to prevent and/or minimize fall risks for residents. Staff were not provided the in-service training. This failed practice has the potential to affect 12 of 14 residents sampled as being at risk for falls. The findings included: Resident #12 was admitted to the facility on 2021. The Quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) of 13. The MDS indicated the resident had a fall without injury. Review of the facility completed "VHA (Veterans Health Administration) Issue Brief", titled "Fall with x-ray, sutures, or hospitalization", dated [DATE], documented "… Nurse alerted and noted Resident (Resident #12) lying in hallway on left side with legs under Resident and crossed at the doorway to

	Resident's room. W/C (wheelchair) in doorway with wheel jammed between door and door jam …Resident was argumentative and alert at baseline. "I fell get me up." when asked what Resident was doing when Resident fell "I was trying to get the housekeeper because they took my trash." Fall was witnessed by Admissions coordinator who observed resident standing in doorway and fall forward. ACTIONS, PROGRESS, AND RESOLUTION Resident assisting to sitting position and two lacerations noted to forehead, and top of nose, cleaned resident and applied pressure dressing, 911 called, DON (Director of Nursing), MD (Medical Doctor), DOR and RP (representative) notified. Transferred to (name) Memorial Hospital ER (Emergency Room). Hospital verbal report stating Resident was transferred to (name of hospital) for C1 and C2 fxs (fractures)... Findings: Upon investigation of incident, Veteran was chasing after Nurse aid who had picked up his lunch tray from room. Nurse aid unaware resident was chasing her out of the room. Veteran's wheelchair lodged in door frame due to his haste causing him to stand from wheelchair and fall. Veteran is non-ambulatory at baseline … Fall was witnessed by Admissions director … Lessons Learned: Team concluded the cause of fall is related to Veteran not understanding why Lunch tray was being removed from room. All Veterans would benefit from staff reeducation to ensure Veteran understands what staff member is going to do before it happens and seek assistance from additional staff when needed." In an interview on 2/25/22 at 11:03 a.m., the Administrative Nurse A stated the resident had never stood up like that before. Resident was non ambulatory at baseline. Administrative Nurse A stated they were working the unit that day because the regular nurse called in sick. Administrative Nurse A stated the resident was looking for the regular nurse the whole shift because they were Resident's favorite nurse. Administrative Nurse A stated Resident had a Urinary Tract Infection (UTI) at the time of the fall, and it wasn't normal for Resident to call the nurses' assistant a housekeeper like Resident did that day. When asked about in- servicing, Administrative Nurse A stated they did a post fall huddle immediately following the fall and spoke to staff that were present on the unit. Administrative Nurse A acknowledged the facility didn't in-service the whole staff as mentioned in the report as the plan of correction. In an interview on 2/25/22 at 11:40 a.m., the Administrative Staff A stated they did a post fall huddle with all the staff involved and addressed staff education regarding explaining to staff what they are doing before they do it. Administrative Staff A also acknowledged they didn't in-service the whole staff as was identified as the plan of correction in the report.

Standard 51.120 (e) 1-2 Quality of Care (e) Urinary and Fecal Incontinence. Based on the resident's comprehensive assessment, the facility management must ensure that— (1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (2) A resident who is incontinent of urine receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible; and Scope and Severity – No Actual Harm, with potential for more than minimal harm Residents Affected - Few	Based on observation, interviews, and record review, the facility failed to ensure Resident #7's Foley Catheter was secured and anchored with a leg strap. This deficient practice affected Resident #7; one of two sampled residents reviewed with a catheter. The findings included: Record review revealed Resident #7 was admitted to the facility in 2019. Resident #7 has a medical history to include diagnoses of Chronic Kidney Disease, Benign Prostatic Hyperplasia with lower urinary tract symptoms, and personal history of Urinary Tract Infections. Review of Resident #7's Clinical Physician Orders revealed an order for a Foley Catheter with a start date of [DATE]. During an observation on 2/22/22 at 12:50 p.m. in the presence of the Administrative Nurse D, Resident #7 was observed not having a catheter leg strap to secure and anchor the catheter tubing. Administrative Nurse D reported the facility's policy was that a leg strap is put in place to secure the catheter. In an interview on 2/22/22 at 1:50 p.m., Certified Nursing Aide CC verified and confirmed Resident #7's catheter leg strap was not placed on the resident today when they arrived. Certified Nursing Aide CC stated they placed the leg strap on the resident after they gave resident a bath. During a follow-up interview on 2/24/22 at 1:33 p.m., Certified Nursing Aide CC stated they provided baths and incontinent care to Resident #7 two times a week. Certified Nursing Aide reported they normally arrived at the facility around 1:00 p.m. Certified Nursing Aide CC reported similar incidents of having to ensure Resident #7's leg strap was in place due to the facility CNA staff forgetting to apply the resident's leg strap. In an interview on 2/24/22 at 11:08 p.m., Certified Nursing Aide DD verified and confirmed that they provided incontinent and peri-care to Resident #7 around [DATE] and forgot to place the leg strap on the resident. Certified Nursing Aide DD reported that Resident #7 had a bowel movement, and they removed the leg strap and forgot to apply a clean one. Certified Nursing Aide DD confirmed receiving in-services about the importance of the placement of a leg strap.

Standard 51.140 (c) Menus and nutritional adequacy. Menus must— (1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; (2) Be prepared in advance; and (3) Be followed. Scope and Severity – Potential for more than minimal harm Residents Affected - Few	Based on observation, policy review, and interviews, the facility failed to follow the menu as written for the lunch meal service on 2/23/22. The correct portions were not served to four out of 10 residents who ordered a pureed diet. The findings included: Review of the facility's undated policy, "Portion Control", documented, "Policy: The facility will use standard portion control procedures and utensils to ensure that adequate portions are served to residents. Procedure: … 3. Portions for each food item should follow the specific portion sizes listed on the menu …." During an observation of the lunch tray line meal on 2/23/22 at 11:50 a.m., revealed residents with physician's orders for pureed diets were receiving ham, sweet potatoes, and beans. The Dietary Staff B used a four-ounce ladle for all the food items portioned for the pureed diets. In an interview on 2/23/22 at 12:00 p.m., the Dietary Staff B stated that the pureed diets were to receive four ounces of all the food listed on the menu for the lunch meal. The Dietary Staff A confirmed that they were serving all the pureed food with a four-ounce ladle. Review of the menu, titled Fall/Winter 2021, and dated, week 5 day 32, documented for the noon meal that the pureed diets were to receive a #6 scoop for pureed ham which equates to 6 ounces instead of four ounces that was actually served. In an interview on 2/23/22 at 12:10 p.m., the Dietary Staff A acknowledged that the correct portion for the pureed ham was six ounces as documented on the menu. Dietary Staff A acknowledged the pureed meal trays were given the wrong portion and stated they would correct it. Dietary Staff A stated the menu was very small print and difficult to read, which was probably why the menu was misread. The first food cart had already left the kitchen and contained four pureed diet meal trays.
51.200 (a) Physical Environment The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. (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.	1. Based on observations and interview, the facility failed to provide the required separation of hazardous areas from other areas of the facility. The deficient practice affected one (1) of 11 smoke compartments, staff, and 10 residents. The facility has a capacity for 160 beds with a census of 128 on the day of the survey. The findings include: a. Observation during the virtual building inspection tour on 02/23/22 at 11:05 am of the [LOCATION] revealed the storage closet for the room was over 50 square feet

Scope and Severity – No Actual Harm, with potential for more than minimal harm Residents Affected - Many	and filled with cardboard, plastics, mats, clean linens, and other combustibles. The door leading into the storage closet was not equipped with a self-closing or automatic closing device, as required by section 19.3.2.1.3 of NFPA 101 Life Safety Code. Interview at this time with the Maintenance Staff A revealed the facility was not aware that a self-closing or auto-closing device was required for the closet door. b. Observation during the virtual building inspection tour on 02/24/22 at 1:00 pm of the storage closet marked as [LOCATION] revealed the room was over 50 square feet and filled with cardboard boxes and other combustibles. The door leading into the storage closet was not equipped with a self-closing or automatic closing device, as required by section 19.3.2.1.3 of NFPA 101 Life Safety Code. Interview at this time with the Maintenance Staff A revealed the facility was not aware that a self-closing or auto-closing device was required for the closet door. The census of 128 was verified by the Administrative Staff A on 02/22/22. The finding was acknowledged by the Administrative Staff A and verified with the Maintenance Staff A during the exit interview on 02/25/22 at 4:00 pm. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.3.2 Protection from Hazards.** **19.3.2.1 Hazardous Areas**. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. **19.3.2.1.1** An automatic extinguishing system, where used in hazardous areas, shall be permitted to be in accordance with 19.3.5.9. **19.3.2.1.2*** Where the sprinkler option of 19.3.2.1 is used, the areas shall be separated from other spaces by smoke partitions in accordance with Section 8.4. **19.3.2.1.3** The doors shall be self-closing or automatic-closing. **19.3.2.1.4** Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (1220 mm) above the bottom of the door. 2. Based on records review, observation, and interview, the facility failed to properly inspect and test all components of the emergency generator. The deficient practice affected 11 of 11 smoke compartments, staff, and all residents. The facility has a capacity for 160 beds with a census of 128 on the day of the survey.

	The findings include: a. Records review on 02/23/22 at 9:50 am of the monthly emergency generator inspection and testing records dating back 12 months prior to the survey revealed there was no documentation of monthly testing of the electrolyte specific gravity or conductance testing for the lead acid batteries, as required by section 8.3.7.1 of NFPA 110, Standard for Emergency and Standby Power Systems. Interview at that time with the Maintenance Staff A revealed the facility generator battery (s) were sealed and that the facility was not aware of the monthly generator battery testing requirements and that they were not being done. b. Records review on 02/23/22 at 9:48 am of the monthly emergency generator inspection and testing records dating back 12 months prior to the survey revealed there was no documentation that the generator had been inspected weekly or tested on load monthly, as required by section 8.3.4 and 8.4.1 of NFPA 110, Standard for Emergency and Standby Power Systems. Interview at that time with the Maintenance Staff A revealed the facility was conducting weekly inspections and monthly load testing of the generator but not properly documenting it. The census of 128 was verified by the Administrative Staff A on 02/22/22. The finding was acknowledged by the Administrative Staff A and verified with the Maintenance Staff A during the exit interview on 02/25/22 at 4:00 pm. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.5 Building Services.** **19.5.1 Utilities.** **19.5.1.1** Utilities shall comply with the provisions of Section 9.1. **9.1.3 Emergency Generators and Standby Power Systems.** Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. **9.1.3.1** Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. **Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems** **(2010)** **8.3.7.1** Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the

testing.
8.3.4 A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available.
8.3.4.1 The permanent record shall include the following:
(1) The date of the maintenance report.
(2) Identification of the servicing personnel.
(3) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced.
(4) Testing of any repair for the time as recommended by the manufacturer.
8.4 Operational Inspection and Testing.
8.4.1 * EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly.
8.4.1.1 If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, providing the same record as required by 8.3.4.
8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:
(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.
(2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating.
8.4.2.1 The date and time of day for required testing shall be decided by the owner, based on facility operations.
8.4.2.2 Equivalent loads used for testing shall be automatically replaced with the emergency loads in case of failure of the primary source.
8.4.2.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate KW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours.

3. Based on records review and interview, the facility failed to document the inspection and testing of Patient Care Related Electrical Equipment (PCREE). The deficient practice affected 10 of 11 smoke compartments, staff, and all residents. The facility has a capacity for 160 beds with a census of 128 on the day of the survey.

The findings include:

Records review on 02/24/22 at 11:40 am revealed there was not documentation for testing of resistance, leakage current, and touch current for any of the electrical, resident beds, as required by section 10.5.2.1 of NFPA 99, Health Care Facilities Code.

	Interview with the Maintenance Staff A at this time revealed the facility does not have a program for electrical safety tests for patient care appliances and finds it feasible to replace some appliances rather than test them. The census of 128 was verified by the Administrative Staff A on 02/22/22. The finding was acknowledged by the Administrative Staff A and verified with the Maintenance Staff A during the exit interview on 02/25/22 at 4:00 pm. **Actual NFPA Standard: NFPA 99, Health Care Facilities Code (2012)** **10.3 Testing Requirements — Fixed and Portable.** **10.3.2* Resistance.** **10.3.2.1** For appliances that are used in the patient care vicinity, the resistance between the appliance chassis, or any exposed conductive surface of the appliance, and the ground pin of the attachment plug shall be less than 0.50 ohm under the following conditions: (1) The cord shall be flexed at its connection to the attachment plug or connector. (2) The cord shall be flexed at its connection to the strain relief on the chassis. **10.3.2.2** The requirement of 10.3.2.1 shall not apply to accessible metal parts that achieve separation from main parts by double insulation or metallic screening or that are unlikely to become energized (e.g., escutcheons or nameplates, small screws). **10.3.3 * Leakage Current Tests.** **10.3.3.1 General.** **10.3.3.1.1** The requirements in 10.3.3.2 through 10.3.3.4 shall apply to all tests. **10.3.3.1.2** Tests shall be performed with the power switch ON and OFF. **10.3.3.2 Resistance Test.** The resistance tests of 10.3.3.3 shall be conducted before undertaking any leakage current measurements. **10.3.3.3* Techniques of Measurement.** The test shall not be made on the load side of an isolated power system or separable isolation transformer. **10.3.3.4* Leakage Current Limits**. The leakage current limits in 10.3.4 and 10.3.5 shall be followed. **10.3.5 Touch Current — Portable Equipment.** **10.3.5.1 * Touch Current Limits.** The touch current for cord connected equipment shall not exceed 100 µA with the ground wire intact (if a ground wire is provided) with normal polarity and shall not exceed 500 µA with the ground wire disconnected. **10.3.5.2** If multiple devices are connected together and one power cord supplies power, the leakage current shall be measured as an assembly.

	10.3.5.3 When multiple devices are connected together and more than one power cord supplies power, the devices shall be separated into groups according to their power supply cord, and the leakage current shall be measured independently for each group as an assembly. **10.3.5.4 Touch Leakage Test Procedure.** Measurements shall be made using the circuit, as illustrated in Figure 10.3.5.4, with the appliance ground broken in two modes of appliance operation as follows: **(1)** Power plug connected normally with the appliance on. **(2)** Power plug connected normally with the appliance off (if equipped with an on/off switch). **10.3.5.4.1** If the appliance has fixed redundant grounding (e.g., permanently fastened to the grounding system), the touch leakage current test shall be conducted with the redundant grounding intact. **10.3.5.4.2** Test shall be made with Switch A in Figure 10.3.5.4 closed. **10.3.6 * Lead Leakage Current Tests and Limits — Portable Equipment.** **10.3.6.1** The leakage current between all patient leads connected together and ground shall be measured with the power plug connected normally and the device on. **10.3.6.2** An acceptable test configuration shall be as illustrated in Figure 10.3.5.4. **10.3.6.3** The leakage current shall not exceed 100 µA for ground wire closed and 500 µA ac for ground wire open. **10.5.2.1 Testing Intervals.** **10.5.2.1.1** The facility shall establish policies and protocols for the type of test and intervals of testing for patient care–related electrical equipment. **10.5.2.1.2** All patient care–related electrical equipment used in patient care rooms shall be tested in accordance with 10.3.5.4 or 10.3.6 before being put into service for the first time and after any repair or modification that might have compromised electrical safety. **10.5.2.5*** System Demonstration. Any system consisting of several electric appliances shall be demonstrated to comply with this code as a complete system. **10.5.6 Record Keeping — Patient Care Appliances.** **10.5.6.2* Documentation.** **10.5.6.2.1** A record shall be maintained of the tests required by this chapter and associated repairs or modifications. **10.5.6.2.2** At a minimum, the record shall contain all of the following: **(1)** Date. **(2)** Unique identification of the equipment tested. **(3)** Indication of which items have met or have failed to meet the performance requirements of 10.5.6.2.

	10.5.6.3 Test Logs. A log of test results and repairs shall be maintained and kept for a period of time in accordance with a health care facility's record retention policy.