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: Central Nebraska Veterans Home

Facility Location: 4510 E. 56th Street, Kearney, NE, 68847

Onsite / Virtual: Virtual

Dates of Survey: 3/14/22 – 3/18/22

Nursing Home (NH) / Domiciliary (DOM) / Adult Day Health Care (ADHC): NH

Survey Class: Annual

Total Available Beds: 225

Census on First Day of Survey: 147

Deficiency	Findings
	Initial Comments: A VA Annual survey was conducted from 3/14/22 through 3/18/22 at the Central Nebraska Veterans Home. The facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes. On 3/16/22, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrative Staff A was informed of the immediate jeopardy on 3/16/22 at 12:00 p.m. The noncompliance related to the immediate jeopardy was identified to have existed on [DATE]. The immediate jeopardy continued through 3/17/22 and was removed on 3/17/22. The facility implemented a Plan of Removal related to the immediate jeopardy on 3/16/22.
§51.43(e) Drugs and medicines for certain veterans As a condition for receiving drugs or medicine under this section or under § 17.96 of this chapter, the State must submit to the VA medical center of jurisdiction a completed VA Form 10-	The facility failed to complete and submit VA Form 10-0460 for Veterans who may be eligible to have medications provided by the VA of jurisdiction. Based on interviews and record reviews, the facility obtained medications from the VA of jurisdiction for Veterans who meet eligibility under 38 CFR §51.43. During interview with the facility

0460 with the corresponding prescription(s) for each eligible veteran. Rating: Not Met Scope and Severity: C Residents Affected: All	Consultant Staff B on 3/11/2022, it was reported the SVH is utilizing VA Form 10-0460 for eligible Veterans whose medications are reimbursed by the VA of jurisdiction. However, subsequent record review identified that the facility failed to complete VA Form 10-0460 as required. The facility identified 22 Veterans as being eligible to receive medications from the VA of jurisdiction. The facility failed to provide copies of VA Form 10-0460 for two (2) of 22 Veterans. A review of VA form 10-0460 for eight (8) of 22 Veterans revealed they were completed the day of survey interviews on 3/11/22. A review VA form 10-0460 for four (4) of 22 Veterans revealed they were completed incorrectly. The facility staff verified missing and discrepant information.
§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. Rating: Not Met Scope and Severity - J Residents Affected – Few	Based on interviews, record review, and facility policy review it was determined that for one (1) of 14 residents sampled, the facility failed to ensure the resident received clinical intervention services in accordance with the physician's orders, plan of care and the resident's rights. Resident #41 was deemed capable of making his/her own decisions and on [DATE] signed a "Resuscitation and Treatment Request" form, which indicated [THEY] wanted to receive Cardiopulmonary Resuscitation (CPR) in the absence of a pulse or respirations. Resident #41 was found on [DATE] by a nurse to be in bed with no pulse or respirations. Facility staff did not know the resident's desired code status or how to access documentation pertaining to the resident's code status, and CPR was not initiated. Resident #41 expired in the facility on [DATE] without CPR being provided. The facility's non-compliance created an immediate jeopardy to Resident #41 and other residents' health that could cause serious physical effects resulting in impairment, harm, or death. The facility was informed on 3/16/22 at 12:07 p.m. that immediate jeopardy existed in the facility, effective on [DATE] through [DATE]. The findings included: Review of a facility policy titled, "Advance Medical Directives" reviewed November 2018 revealed "members will make informed decisions regarding his/her medical care and will be encouraged to develop an Advance Medical Directive." The policy stated if an Advance Medical Directive existed, it would become a part of the member's comprehensive Plan of Care to assure all disciplines were aware of the member's wishes regarding their care. The member's Care Plan team would review quarterly and upon change of condition with the member and/or legal representative their Advance Directive wishes. Resident #41 was admitted to the facility on [DATE]. Admitting diagnoses included Atrial Fibrillation, Coronary Artery Disease,

	Heart Failure, Hypertension, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. A review of the Admission Minimum Data Set (MDS) Assessment dated [DATE] revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated independence in cognitive skills for daily decision making. Review of Resident #41's Physician's Orders revealed on [DATE] an order was given for CPR "Full Code". Review of a form titled, "Resuscitation and Treatment Request", revealed under a category titled "Initial Selection", Resident #41's initials had been written under "Status", "Cardiopulmonary Resuscitation" (CPR) was selected to indicate the resident wanted to have CPR. Further description of this selection was documented as "I DO want to be resuscitated and choose to have CPR or Cardiopulmonary Resuscitation for my resuscitation status." Continued description was documented as "In the absence of pulse and respirations, Cardiopulmonary Resuscitation (CPR) will be initiated. With a Resuscitation status, CPR will be started by trained staff until the rescue squad arrives and I am then transported to the hospital." The form indicated Resident #41 had no Power of Attorney for Health Care activated. Resident #41 had signed the form on [DATE] and the form was signed by a Notary Public on the same date. Review of Resident #41's Care Plan dated [DATE] revealed a problem deficit that stated, "Potential interruption with psychosocial well-being due to skilled placement." The established goal stated, in part "(Resident) and family wish to have [THEIR] psychosocial needs met at (facility) on a daily basis". Planned interventions included "FULL CODE" has been selected as (resident's) code status per Resuscitation and Treatment request form. (Family of Resident #41) serves as [THEIR] attorney in fact for health care and finances. POAHC (Power of Attorney Health Care) has not been activated". Review of a document titled "Interdisciplinary Care Plan Notes" dated [DATE] revealed the documentation was regarding a quarterly review of the resident's Care Plan. The Care Plan review documentation revealed "Advance Directives" was reviewed with a notation made "Full Code has been selected as member's code status per Resuscitation and Treatment request form." Resident #41's signature was on the document indicating the resident's attendance and participation in the quarterly Care Plan review. Review of an "State Veterans Home Issue Brief Cover Page" report dated [DATE] revealed an event was documented as having occurred on [DATE] involving Resident #41. The

	document detailed a "Description of the Event" and stated at approximately 5:02 p.m., [Licensed Nurse B] entered Resident #41's room to administer medications and found the resident unresponsive with no pulse. At approximately 5:04 p.m., [Licensed Nurse B] called the [Administrative Nurse C] to verify code status and inform [Administrative Nurse C] of the situation. According to the facility's report, [Administrative Nurse C] stated that they located the "Code List" on the crash cart and determined not to initiate CPR. [Licensed Nurse B] stated at approximately 5:10 p.m. [Administrative Nurse C] called and informed [Administrative Nurse A] of member's passing. At approximately 5:15 p.m., 911 was called to have a Deputy Sheriff come to the facility per policy. The report went on to state, "[Administrative Nurse C] called (Family of Resident #41), regarding passing of member. (Family of Resident #41) confirms to [Administrative Nurse C] that member is a DNR". The "Description of the Event" was concluded with, "Advance Directive and Physician order stated that (Resident #41) was a Resuscitate. [Administrative Nurse C] believed that code list stated DNR". An interview was conducted on 3/16/22 at 9:28 a.m., with the Social Services Staff A. The Social Services Staff A stated Resident #41 had a Physician's Order, dated [DATE] that specified the resident had made the decision to be a full code. The Social Services Staff A stated during each quarterly review by the Interdisciplinary Team (IDT) of the Care Plan, the resident being reviewed (or their POAHC) was consulted regarding code status to ensure they wished to continue with the current selected status. An interview was conducted on 3/15/22 at 3:15 p.m. with [Licensed Nurse B], who was the nurse assigned to care for Resident #41 on [DATE]. [Licensed Nurse B] stated on [DATE] they entered Resident #41's room to administer medications. The resident was lying in bed and appeared to be asleep. [Licensed Nurse B] stated they touched the resident's arm to wake them up and noted their skin was cool. They checked the resident's right side neck carotid artery and noted no pulse. [Licensed Nurse B] stated they did not know how to find the resident's code status and called the [Administrative Nurse C] to ask what it was. [Licensed Nurse B] stated the [Administrative Nurse C] "checked something" and reported Resident #41 had a "Do Not Resuscitate (DNR)" status. The [Administrative Nurse C] told [Licensed Nurse B] to come to the nurses' station, so the [Licensed Nurse B] left the resident's room. [Licensed Nurse B] stated at the time of the incident they did not know where to look and did not want to take the extra time to run and try to look to find the resident's Advance Directives status.

	An interview was conducted on 3/15/22 at 4:59 p.m. with the [Administrative Nurse C] who was working on [DATE]. [Administrative Nurse C] stated they were working the 2:00 p.m. to 10:30 p.m. shift on [DATE]. [Administrative Nurse C] stated at around supper time, while making their rounds, they received a call from [Licensed Nurse B] who reported Resident #41 was unconscious and needed to know the resident's code status. [Administrative Nurse C] stated they went to the unit where the resident resided and started looking at paperwork to find the resident's code status. [Administrative Nurse C] stated in other facilities they had worked at usually had something quick to look at for code status kept at the nurses' station. [Administrative Nurse C] looked around and could not find anything. [Administrative Nurse C] stated they knew they could look in the Electronic Medical Record (EMR) and could log onto the computer system, but they were trying to find something quickly. [Administrative Nurse C] stated because they were the [Administrative Nurse], they had a list of all residents and their responsible party (RP) information, so they called the Family of Resident #41. [Administrative Nurse C] stated by this time so much time had elapsed, and they stated "of geez. I need this now". [Administrative Nurse C] stated Resident #41's Family answered the phone and stated they thought the resident had a DNR in place, so don't do CPR. [Administrative Nurse C] stated they had started employment at the facility in 2021. [Administrative Nurse C] further stated they had not been trained by the facility regarding where to look for a resident's code status prior to the incident with Resident #41. Although the facility's "State Veterans Home Issue Brief Cover Page" dated [DATE] specified [Administrative Nurse C] reviewed a list on the crash cart to identify Resident #41 as having a DNR status, [Administrative Nurse C] stated they had not been able to find a code status for the resident and so had called Resident #41's Family to obtain the information. On 3/16/22 it was determined the facility failed to provide Resident #41 CPR on [DATE] when the resident was found to be unresponsive. Staff's lack of training and knowledge regarding the facility's system for identifying and implementing the resident's selected "full code" status placed the resident in immediate jeopardy. The survey conducted on 3/14/22 – 3/17/22 revealed nursing staff responsible for ensuring each resident's Advance Directive, had not been trained regarding the facility's system for identifying and implementing code status. Administrative Staff A was made aware of the on-going immediate jeopardy on 3/16/22 at 12:00 p.m. The facility implemented a Plan of Removal and the immediate jeopardy was determined to be removed on 3/17/22.