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: Baldomero Lopez Veterans Nursing Home

Location: 6919 Parkway Blvd., Land O'Lakes, FL 34639

Onsite / Virtual: Onsite

Dates of Survey: 9/24/24 – 9/26/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 120

Census on First Day of Survey: 115

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from September 24, 2024, through September 26, 2024, at the Baldomero Lopez 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 (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, interview, record review, and policy review, the facility failed to ensure one (1) of eight (8) residents with enteral feedings received proper care and treatment when administration of medications via a gastrostomy tube (G-tube) occurred. Staff failed to verify placement of Resident #16's G-tube prior to administering medications. The findings include: Review of the facility's Policy and Procedure titled, "Enteral Feedings," effective 3/19/18, revealed the following: **"Preventing Aspiration** 1. Check feeding tube residual volume prior to each feeding and administration of medication if appropriate. (See confirmation of placement of feeding tube.) … **Confirming Placement of Feeding Tube** Check gastric residual volume…

	Medication Administration via Feeding Tube… 3. Check residual volume prior to administration of medication as appropriate or if resident receiving continuous feed, pause tube feeding during process." Record review of Resident #16's face sheet revealed the resident was re-admitted to the facility on [DATE], with diagnoses which included: Pulmonary Fibrosis, Gastrostomy, Type 2 Diabetes, Cerebral Infarction, and Sarcopenia. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], revealed the resident's cognitive status was cognitively intact, with a Brief Interview for Mental Status (BIMS) score of 13. Review of Resident #16's Physician Orders revealed Resident #16 was to have their G-Tube checked for gastric residual every shift: "If greater than 100 milliliters (ml), hold tube feed for four (4) hours. Recheck, and if residual is under 100 ml, resume feed as ordered. If residual recheck is greater than 100 ml, call the physician." Observation of Resident #16 during medication administration, on 9/25/24, at 12:20 p.m., revealed Licensed Nurse A paused the continuous tube feeding, capped the tube, and, with a piston syringe, flushed the tubing with 50 ml of water. Licensed Nurse A then administered crushed medications of Tylenol 500 mg two (2) tabs in five (5) ml of water and Simethicone 80 mg in five (5) ml of water into the G-tube and flushed with 50 ml of water. Licensed Nurse A failed to verify placement of Resident #16's G-tube prior to administering medications. In an interview, on 9/25/24, at 12:40 p.m., with Licensed Nurse A, they confirmed that they had not checked for residual to verify the placement of the G-tube prior to administering Resident #16's medications. They stated: "I was nervous and should have known better." In an interview with Administrative Nurse A, on 9/25/24, at 1:55 p.m., they were asked to provide the facility's policy and procedure for administering nutrition and medications via G-tube. During an interview, at 1:55 p.m., on 9/25/24, Administrative Nurse A verified that Licensed Nurse A should have checked the placement of Resident #16's G-tube prior to administering medications via their G-tube.