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: Alfredo Gonzalez Texas State Veterans Home

Location: 301 East Yuma Avenue, McAllen, Texas 78503

Onsite / Virtual: Onsite

Dates of Survey: 3/19/24 – 3/22/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 160

Census on First Day of Survey: 147

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from March 19, 2024, through March 22, 2024, at the Alfredo Gonzalez 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.
§ 51.120 (i) Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. **Level of Harm** – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	Based on observation, clinical record review, interviews, and facility policy review, the facility failed to thoroughly investigate an incident that resulted in an injury of unknown origin for one (1) of six (6) residents sampled for falls. On [DATE], Resident #1 sustained an unwitnessed fall/incident requiring emergency intervention. The findings include: Review of the facility's Accidents & Incidents Reporting/Investigation policy, last revised 1/23, revealed: "all accidents or incidents involving residents, team members, visitors, vendors etc., occurring on our premises will be investigated and reported in the risk management of the EHR (electronic health record). Incidents involving team members, vendors or visitors will be reported to [Administrative Staff A]/designee to determine notifications within the [Company Name] organization and if meets regulatory reporting. These reports will also be utilized for bruises, skin tears, abrasions, along with medication errors, etc, identified.

	Reporting of Accidents/Incidents: An accident or incident will be reported to the department supervisor/administration/designee as soon as such accident/incident is discovered or when information of such accident/incident is learned. A Risk Management UDA will be completed in PCC for a reported accident or incidents involving unknown causes of bruises, abrasion, skin tears, lacerations, medication error, etc., and any other category listed within risk management. A team member witnessing an accident or incident involving a resident unless it is necessary to summon assistance; and the [Licensed Nurse] will be informed of accidents or incidents so that medical attention can be provided. An incident involving an allegation of abuse (verbal, physical, emotional) or exploitation should be reported as soon as possible to the community [Administrative Staff B/ Administrative Nurse A/ Licensed Nurse]/ Supervisor/designee. [Administrative Staff B] should follow state and federal requirements regarding what is state reportable and within the required timeframe" [sic]. Further review of the Accident & Incident policy indicating Investigation Action: "[Administrative Staff B (Administrative Staff A)/ Administrative Nurse A/ Licensed Nurse]/Supervisor/designee will investigate of the accident or incident. The following data, as it may apply, will be included in the Risk Management UDA: 1. Date and time the accident/ incident, took place. 2. The nature of the injury/illness or other risk management categories (e.g., bruise, fall skin tears, lacerations, medication error, etc.); 3. Where the accident or incident took place; 4. Ask the resident 'what happened' 5. The name(s) of witnesses (roommate, other residents, team members, visitors, vendor (i.e., [Consultant Staff A, Licensed Nurse A, Consultant Staff A, Dietary Staff A],, etc.) 6. Interviews and in addition preferably written statements of witnesses 7. The date/time the injured person's attended physician was notified; representative was notified. 9.The condition of the injured person, to include [their] vital signs; neuro checks, 02 sats as appropriate. 10. The disposition of the injured (i.e., transferred to hospital, put to bed, sent home, returned to work, etc.); 11. Corrective action taken. 12. Other pertinent data as necessary or required, and 13. The signature and title of the person completing the report. 14. The risk management generate a risk management progress note" [sic]. The policy noted it was important to follow state and federal requirements for reporting incidents. Review of the Texas Health and Human Services Long -Term Care Regulatory Provider Letter, dated 7/10/19, under the section "Injuries of unknown source," noted the following: "Note: an injury should be classified as an 'injury of unknown source' when both of the following conditions are met: • The source of the injury is not observed by any person,

	or the source of the injury could not be explained by the resident. • The injury is suspicious because of the extent of the injury, the location of the injury, the number of injuries observed at one point in time or the incidence of injuries over time. Example of an injury of unknown source that must be report it: A resident has bruising on their left cheekbone area that was determined to be non-serious. No one witnessed the source of the injury. Although the injury was determined to be non-serious, the injury is suspicious because of the location of the injury." Resident #1 was admitted to the facility on [DATE], with the diagnoses: Cerebral Vascular Accident (CVA), Aphasia (Impairment of Language, Affecting the Production or Comprehension of Speech), Functional Quadriplegia (Complete Immobility Due to Severe Disability, Without Injury to the Brain or Spinal Cord), Chronic Respiratory Failure, Tracheostomy, Gastrostomy, Contracted Hips and Left Hand, and Dysfunctional Bladder. Review of Resident #1's most recent quarterly Minimum Data Set (MDS) assessment, dated [DATE], which was completed prior to the incident, revealed the facility was unable to complete a Brief Interview Mental Status (BIMS). However, after the facility assessed the BIMS and reviewed the medical record, the resident was assessed to have no acute mental status changes. The facility further assessed the resident to have continuous focusing difficulty, being easily distracted, and to have difficulty with keeping track of what was being said. The facility assessed the resident to require two (2) person physical assistance, due to the resident being totally dependent with bed mobility (movement to and from lying position) and transfers (movement between surfaces including bed). The MDS indicated that the resident had no falls since admission or reentry. Review of the resident's Annual MDS assessment, dated [DATE], revealed the facility was unable to assess the resident's BIMS. The facility did not assess the resident for disorganized thinking or altered level of consciousness. The facility assessed the resident to require physical assistance of two (2) with bed mobility and to be totally dependent on staff for transfers. The MDS was marked to indicate that the resident had no falls since admission or reentry. Review of a fall incident report, dated [DATE], at 3:45 a.m., revealed staff were called into the resident's room by Certified

	Nurse Aide A. The report stated: "the resident fell from bed and found on the floor. The resident was noted to have left eyebrow laceration, open area to their left toe, skin tear to right elbow and hematoma noted to left elbow. Tracheostomy is in place, gastrotomy tube and foley catheter in place. The resident was alert and oriented to self yet nonverbal. The resident was transferred by Emergency Medical System (EMS) to the emergency room. Notifications made appropriately. Immediate action taken includes assessment made by [Licensed Nurse B] who rendered first aid" [sic]. Review of the Texas State Veterans Home Issue Brief, dated [DATE], revealed: "the resident was observed in the room on the floor, on their right side, parallel to their bed by a [licensed nurse]" [sic]. The brief identified the injuries as a left eyebrow laceration, the left great toenail bleeding and missing, a skin tear to right elbow, and a hematoma to the left elbow. The brief indicated that the resident received first aid. The resident was transferred to the emergency room, where the resident required 10 sutures to the left side of the forehead. Review of the Physical Therapy Progress Report, service dates [DATE] – [DATE], revealed the resident's functional assessment identified Resident #1 as dependent in bed mobility. The resident's mobility score was zero (0) in a range from 0 -12, with 12 being the highest function. An interview, on 3/21/24, at 9:40 a.m., with Consultant Staff C, regarding the physical therapy notes, dated [DATE] – [DATE], revealed Resident #1 required physical therapy for range of motion and mobility to prevent further contractions. Consultant Staff C revealed the resident required total assistance with bed mobility, which indicated the resident was unable to turn on their own. Review of Administrative Nurse A's investigation notes (undated and untimed), regarding the [DATE], incident revealed they determined Resident #1 had landed on the floor from the left side and hit headfirst. This report indicated that the fall report was an error since it suggested the resident landed on the floor from the right side. Administrative Nurse A's investigation indicated that the resident was smiling, and their interpretation was (from the resident's nonverbal cues) that Resident #1 attempted to get up and fell on their left side. During an observation, on 3/19/24, at 10:50 a.m., Resident #1 was observed lying in a supine position with the head of bed (hob) up 45 degrees. The resident had an alternating mattress with parameter edges and grab bars. The resident was alert and unable to speak, but would nod head to yes or no, simple questions. The resident had a tracheotomy with oxygen

	humidifier. The resident's spouse was at the bedside (see family comments). A tube-feeding infusing with Nurten @ 45 milliliters (ml) was observed. The resident's left hand was contracted, and they were wearing a left arm splint. During the initial tour, on 3/19/24, at 10:50 a.m., an interview was conducted with Resident #1's spouse. The spouse revealed that the resident was admitted to the facility after suffering a severe stroke. The spouse stated they had been married over 58 years, and they visited the facility at least four (4) days a week. They stated that the resident was unable to move without staff total assistance. The spouse revealed concern over how the resident fell out of bed and sustained left side injuries. They also revealed that the facility stated the resident fell out of bed on the right side. The spouse voiced concern regarding the fall by inquiring if the resident fell on the right side of bed, why were the resident's injuries predominately sustained on the left side? An observation was conducted, on 3/21/23, at 11:35 a.m., with two (2) Certified Nursing Aides providing incontinent care, which included catheter care. No concerns were noted with catheter, or incontinent care. The resident's skin was observed to be intact. After the completion of care, the resident was turned and positioned on their right side. During the observation, the resident provided no physical assistance. An interview was immediately conducted with Certified Nurse Aide B after the incontinent care. Certified Nurse Aide B noted that they cared for Resident #1 on a consistent basis. Certified Nurse Aide B revealed that the resident required total care of two (2) staff members due to the resident's inability to assist with bed mobility. An interview was conducted, on 3/20/24, at 12:50 p.m., with Licensed Nurse C, who was the nurse caring for Resident #1 on [DATE], the date of the incident. Licensed Nurse C recalled monitoring Resident #1 often, due to their unfamiliarity with tracheotomy caring. They recalled being called into the resident's room due to the resident being found on the floor. Licensed Nurse C indicated being surprised, because the resident was totally dependent on staff for positioning. Licensed Nurse C expressed that they, "never knew the resident to be able to move." Licensed Nurse C revealed that no interview or written statement was requested regarding Resident #1's incident. In a phone interview, on 3/21/24, at 4:09 a.m., with Licensed Nurse D, they revealed being employed one (1) year as a Pro Re Nata (PRN- as needed) employee. They revealed working the night of Resident #1's incident ([DATE]). Licensed Nurse D

	described the resident as nonverbal, but able to make needs known, and added that the resident was contracted. Licensed Nurse D recalled wondering how the resident fell, noting that the resident was unable to move their legs and was contracted on the left side. Licensed Nurse D revealed that the resident did not move without staff assistance. Licensed Nurse D stated that the facility did not request an interview regarding the incident, or request them to provide a written statement of the incident. During a phone interview, on 3/21/24, at 4:10 a.m., with Licensed Nurse E, they revealed being employed for three (3) years and caring for Resident #1 consistently. Licensed Nurse E identified Resident #1's care to include tracheostomy care, suctioning, no skin breakdown, and continuous tube-feeding. Licensed Nurse E stated that the resident did not move, and required staff for turning and repositioning. They further revealed working the night of [DATE]. Licensed Nurse E recalled that Resident #1 was assigned to Licensed Nurse C. Nevertheless, they assisted with the resident care once the incident occurred. Licensed Nurse C recalled that the incident was unwitnessed, and the resident was found on the right side, face down. Licensed Nurse C revealed the facility did not request their interview, or request them to provide a written statement regarding Resident #1's incident. In a phone interview with Certified Nurse Aide C, on 3/21/24, at 4:10 p.m., they revealed being assigned to Resident #1 on [DATE]. Certified Nurse Aide C recalled last being in the resident's room, on [DATE], around 2:30 a.m. However, they were unsure as to what care was provided to the resident. Nevertheless, Certified Nurse Aide C recalled that the next time they entered the room (unsure of the time) was when the resident was on the floor. Certified Nurse Aide C indicated that the resident was totally dependent on staff for bed mobility and had never fallen before. Certified Nurse Aide C revealed that the facility did not interview them or request a written statement regarding Resident #1's incident. An interview was conducted in Administrative Staff A's office with Administrative Nurse A, Administrative Staff A, and Administrative Staff C on 3/22/24, at 9:15 a.m. Administrative Nurse A revealed that an injury of unknown source was ruled out because Resident #1 explained by nodding their head to indicate "yes" or "no" as to how the incident happened. At the conclusion of the interview, Administrative Nurse A stated the resident's nonverbal gestures lead them to the conclusion that the resident was attempting to get up. During the interview, the surveyor discussed the discrepancy in the investigation regarding the location, on which side of bed, the resident was on (right or left side), and why no staff were interviewed, or written witness statements obtained. The surveyor directed

	Administrative Nurse A to Resident #1's medical record, which detailed the resident to be easily distracted, having difficulty keeping track of what was being said, and having difficulty focusing. The record also revealed that the resident was totally dependent and required the assistance of two (2) staff with bed mobility and transfers. Administrative Nurse A was unable to verbalize how all the above factors did not constitute or define a "injury of unknown source," or if the incident was thoroughly investigated. During the interview with Administrative Nurse A, on 3/22/24, at 9:15 a.m., Administrative Staff A verbalized being the Administrative Staff B. They recalled that Resident #1's incident was reviewed in the morning meeting. Administrative Staff A stated they questioned how the incident occurred; nevertheless, Administrative Nurse A's findings were accepted. They revealed the facility utilized the Texas Health and Human Services definition to determine an "injury of unknown source." They queried as to if Resident #1's incident met the criteria of an injury of unknown source. During the interview with Administrative Nurse A, on 3/22/24, at 9:15 a.m., Administrative Staff A and Consultant Staff C referred to the Texas Health and Human Services as the criteria to define an "injury of unknown source." Administrative Staff C validated Administrative Nurse A's finding as to why the incident should not be considered an "injury of unknown source."
§ 51.120 (m) (1) Unnecessary drugs (1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose (including duplicate drug therapy); or (ii) For excessive duration; or (iii) Without adequate monitoring; or (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) Any combinations of the reasons above. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, and record review, the facility failed to ensure two (2) of three (3) sampled residents, who were administered psychotropic medications, had behavior monitoring in place to assess the effectiveness of the medications (Resident #12 and Resident #14). The findings include: The facility policy "Psychotropic Medications & Gradual Dose Reduction," dated January, 2023, indicated the following: <u>"Standards</u> The community is expected to make every effort to comply with state and federal regulations related to the use of psychotropic medication in the community to include diagnosis, targeted behavior, or clinical indications for use, prescriber's specified dosage frequency and duration of therapy, consent must be received and noted in the medical record for any use of psychotropic medications." 1. According to record review, Resident #12 was admitted to the facility on [DATE], with multiple medical diagnoses including

	Dementia and Parkinsons disease. The initial MDS assessment, dated [DATE], documented the resident needed extensive assistance with transfers, walking, toileting, dressing, grooming, and eating), including mobility and used a wheelchair for with staff assistance for locomotion. The assessment indicated a Brief Interview for Mental (BIMS) score of 00/15, indicating that the resident had severely impaired cognition, and displayed no behaviors and was not administered psychotropic medications. The subsequent, quarterly MDS assessments, dated [DATE], and [DATE], also documented the resident had no behaviors, and documented the resident was administered antipsychotic (AP) and antidepressant (AD) medication. On [DATE], a Mental Health (MH) consult was obtained which reported symptoms of psychosis, which were a new onset. The resident reported: "I see little people." The consult documented: "Resident reports that has been seeing people sometime since after Covid." The consult noted: "(named resident's) psychotic symptoms are reported by others. Visual hallucinations have been described" [sic]. Review of the clinical record revealed that the AP medication was increased during the month of [DATE], on two (2) occasions, [DATE], and [DATE]. The [DATE] Medication Administration Record and Treatment Administration Record (MAR/TAR) did not document that any behaviors were observed by the facility staff, even though changes in medications occurred with the Seroquel and other psychotropic medications. The MAR/TAR documented that no behaviors were observed. The MAR/TAR's and Behavior Monitoring (BM), for [Dates], found no documentation that the resident ever displayed any behaviors, including hallucinations. 2. Record review revealed Resident #14 was admitted to the facility on [DATE], with diagnoses including Dementia, Depression, Anxiety, and a sleep disorder Insomnia. The last annual Minimum Data Set (MDS) assessment, dated [DATE], documented that the resident was independent with most Activities of Daily Living (ADL I.e., transfers, walking, using the toilet, and eating), and needed supervision and/or assistance with dressing, bathing, and hygiene activities. The annual MDS, dated [DATE], documented the resident had not displayed any behaviors. The Care Area Assessment (CAA) for psychotropic medications, completed with the annual MDS, dated [DATE], noted that Anti-Anxiety (AA) and Anti-Depressant (AD) medications were administered. There was no additional

	information about the use of the medications, and target behaviors were described for the resident in the CAA. The only other information identified the resident was at risk for Adverse Side Effects (ASE) related to the use of the medications. The CAA did not identify that Melatonin (for insomnia) was prescribed, which could also have ASEs associated with its use. Two (2) quarterly MDS assessments, dated [DATE], and [DATE], also documented the resident had no behaviors identified. The current Physician Orders, dated [DATE], documented the resident was administered an AA medication (clorazepate - also a benzodiazepine), initiated on [DATE], two (2) different AD medications (Trazadone and Duloxetine), and Melatonin (a dietary supplement / hormone) commonly used for treatment of insomnia. The orders also identified the Target Behaviors and Adverse Side Effects associated with the AA medication. Review of the Medication and Treatment Administration Record (MAR/TAR), and Behavior Monitoring (BM), dated [DATE], through [DATE], found that the target behaviors the AA medication was prescribed for and /or a behavior monitor was not identified. In addition, although the resident was administered Melatonin for insomnia, there was no sleep monitor in place. On 3/21/24, at 2:00 p.m., Administrative Nurse A was interviewed. When asked where behavior monitors could be found, Administrative Nurse A stated they should be found under the BM or the Licensed Nurse's portion of the MAR. When asked if the facility practice was to monitor sleep for residents who were being treated for insomnia, Administrative Nurse A responded "yes." The concerns about the lack of behavior monitoring for Resident #12 and Resident #14 were discussed. Administrative Nurse A was asked to provide additional information to clarify, and a follow up meeting to review the issue was arranged for the following day. On 3/22/24, at 9:15 a.m., Administrative Nurse A and Consultant Staff C participated in a joint interview. Administrative Nurse A stated no additional information was provided. Consultant Staff C stated the facility practice was to document exceptions, and if no behaviors occurred, then no documentation on the MAR/TAR or BM would be expected. On 3/22/24, at 9:15 a.m., during the joint interview, after reviewing the Physician Orders, Administrative Nurse A and Consultant Staff C agreed the orders identified target behaviors for each classification, and directed staff to monitor behaviors each shift.

§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on observation, interview, and record review, the facility failed to ensure that foods were stored, prepared, and distributed under sanitary conditions as evidenced by 1.) failure to ensure dishes were stored in a manner that would allow them to effectively dry, and 2.) failure to ensure food preparation equipment and storage areas were cleaned after use and dried after cleaning. The findings include: On 3/19/24, during a joint tour of the [LOCATION] with Dietary Staff B between 9:40 a.m., and 10:00 a.m., the following observations were noted: Seven (7) trays of glasses were found stacked in the clean dish area. The cups had visible condensation and water droplets on the inside. When asked how the drinking glasses should be stored, Dietary Staff B stated the staff should be using a mesh mat on the tray surfaces. Dietary Staff B then placed them on a counter and commented that the staff should be placing them on trays before stacking. A beverage service station, located next to the dining room, was observed with a juice gun, which had different colored juices and a build-up of visible pulp. A Robo coup was observed set on its base, and it had standing water in it. Dietary Staff B asked a preparation staff member about the unit, and they said it was clean and ready for use. In another food preparation area, a small blender was observed to be soiled on the base and buttons. Dry goods stored in bins under a food preparation counter were observed with crumbs and particulate matter scattered on the tops. A can opener mounted on a preparation table had visible metal shavings on the blade, and the base had dried spills and food matter on the surfaces. On 3/21/24, at 1:15 p.m., during an interview with Dietary Staff B and Dietary Staff A, staff verified that equipment should be cleaned and dried after being used.
§ 51.200 (a) Life safety from fire. (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.	**<u>Smoke Barriers and Sprinklers</u>** 1. Based on observations and interviews, the facility failed to maintain proper storage ceiling clearance as required by the code. The deficient practice affected one (1) of nine (9) smoke compartments, staff, and residents. The

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	facility had the capacity for 160 beds with a census of 147 on the first day of survey. The findings include: Observation during the facility tour, on 3/19/24, at 12:15 p.m., of [LOCATION] located in the [LOCATION]of the facility, was observed with materials, to include boxes of spare parts, electrical wiring, paper manuals, and plastic piping stacked within eighteen inches of the room's ceiling which contained sprinkler heads. The 18 inch measurement was indicated by a red fire line painted on the room's wall above the shelving, and was confirmed by the Maintenance Staff A. An interview, on 3/19/24, at 12:30 p.m., with Maintenance Staff A, revealed the facility was aware that items were not to be stored above the red painted line. The census of 147 was verified by Administrative Staff A on 3/19/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A, during the LSC exit interview on 3/21/24, at 3:30 p.m. **Actual NFPA Standard: NFPA 13, Standard For the Installation Of Sprinkler Systems.** **8.6.6 Clearance to Storage** (Standard Pendent and Upright Spray Sprinklers) **8.6.6.1** The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. **8.6.6.2** The 18 in. (457 mm) dimension shall not limit the height of shelving on a wall or shelving against a wall in accordance with 8.6.6, 8.7.6, 8.8.6, and Section 8.9. **8.6.6.2.**1 Where shelving is installed on a wall and is not directly below sprinklers, the shelves, including storage thereon, shall extend above the level of a plane located 18 in. (457 mm) below ceiling sprinkler deflectors. **8.6.6.2**.2 Shelving, and any storage thereon, directly below the sprinklers shall not extend above a plane located 18 in. (457 mm) below the ceiling sprinkler deflectors.