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: Clifford Chester Sims State Veterans' Nursing Home

Location: 4419 Tram Road, Panama City, FL 32404

Onsite / Virtual: Onsite

Dates of Survey: 6/4/24 – 6/7/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 120

Census on First Day of Survey: 109

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from June 4, 2024, through June 7, 2024, at the Clifford Chester Sims State Veterans' Nursing Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.120 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. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	Based on interviews and record review, the facility failed to provide the necessary care and services to effectively manage hypoglycemic and/or hyperglycemic reactions for residents who received insulin. This deficient practice affected three (3) of three (3) residents who received insulin from a total of 27 residents sampled (Resident #2, Resident #3, and Resident #4). The findings include: According to the Mayo Clinic (https://www.mayoclinic.org/diseases-conditions/hypoglycemia/symptoms-causes/syc-20373685#:~:text=Hypoglycemia%20occurs%20when%20your%20blood%20sugar%20%28glucose%29%20level,side%20effect%20of%20medications%20used%20to%20treat%20diabetes): "Hypoglycemia is a condition in which your blood sugar (glucose) level is lower than the standard range. Glucose is your body's main energy source…Hypoglycemia needs immediate treatment…Treatment involves quickly getting your blood sugar back to within the standard range."

	According to the Mayo Clinic (https://www.mayoclinic.org/drugs-supplements/glucagon-injection-route/description/drg-20064089): "Glucagon injection is an emergency medicine used to treat severe hypoglycemia (low blood sugar) in diabetes patients treated with insulin who have passed out or cannot take some form of sugar by mouth." 1. A review of Resident #2's medical record revealed an initial admission date of [DATE]. Resident #2's medical history included a diagnosis of Type 2 Diabetes Mellitus. A Quarterly Minimum Data Set (MDS) assessment, dated [DATE], identified Resident #2 received insulin injections. A review of Resident #2's Physician Orders revealed an order for Novolog (short-acting) insulin, sliding scale, to be administered twice daily at 6:00 a.m., and 4:00 p.m. Further review of the Physician Orders revealed no orders for the treatment of hypo/hyperglycemic reactions. A review of Resident #2's Plan of Care revealed a focus area for Diabetes. An intervention, dated [DATE], directed staff to observe the resident for signs of hyperglycemia. A second intervention, dated [DATE], directed staff to observe the resident for signs of hypoglycemia. However, the Plan of Care did not include interventions to treat either condition. 2. A review of Resident #3's medical record revealed an initial admission date of [DATE]. Resident #3's medical history included a diagnosis of Type 2 Diabetes Mellitus. A Quarterly MDS assessment, dated [DATE], identified Resident #3 as receiving insulin injections. A review of Resident #3's Physician Orders revealed an order for Novolog insulin, sliding scale, to be administered twice daily at 6:00 a.m., and 5:00 p.m. The order directed staff to notify the Medical Provider for a blood sugar greater than 400 mg/dL (milligrams per deciliter). However, there were no orders for the treatment of hypoglycemic reactions. A review of Resident #3's Plan of Care revealed a focus area for complications related to Diabetes. Interventions directed staff to "observe for signs of hypoglycemia," and, "observe for signs of hyperglycemia," but did not include interventions to treat either condition. 3. Review of Resident #4's medical record revealed an initial admission date of [DATE]. Resident #4's medical history included a diagnosis of Type 2 Diabetes Mellitus. A Quarterly MDS, dated [DATE], identified Resident #4 as receiving insulin injections.

	A review of Resident #4's Physician Orders revealed an order, dated [DATE], for Lantus insulin to be given daily at 5:00 p.m. A second order, dated [DATE], was noted for Novolog insulin, sliding scale, to be given twice daily at 5:00 a.m., and 4:00 p.m. The order directed staff to call the Medical Provider for blood sugars over 400 mg/dL. However, there were no orders for the treatment of hypoglycemic reactions. A review of Resident #4's Plan of Care revealed a focus area for complication risk related to Diabetes. The goal indicated the resident would not experience any hypo/hyperglycemic crisis on the current medication regimen. Interventions directed staff to "observe for signs of hypoglycemia," and "observe for signs of hyperglycemia," but did not include interventions to treat either condition. On 6/5/24, at 3:50 p.m., an interview was conducted with Administrative Nurse A regarding the facility's practices for responding to hypo/hyperglycemic reactions in residents with Diabetes. Administrative Nurse A explained that the facility had a policy to address the reactions, and that a copy would be provided for review. The facility's policy titled, "Blood Glucose Monitoring: Clinical Guidelines," was reviewed. The policy contained a revision date of 9/26/19. The policy defined Hypoglycemia as "when the resident's blood glucose levels have fallen low enough that action needs to be take to bring them back to their target range." The policy also read: "Hypoglycemia can occur when oral or injected medications are given that directly lower blood glucose. Whenever a glucose test indicates hypoglycemia, treatment should be initiated immediately." The policy directed staff to "follow the facility's protocol and/or the physician's orders for treatment of hypoglycemia." A policy section titled, "Treatment for Severe Hypoglycemia," directed staff to use injectable glucagon medication. On 6/6/24, at 1:15 p.m., an interview was conducted with Licensed Nurse A regarding the facility's practices for responding to Hypoglycemia. When asked how severe Hypoglycemia would be treated in an unresponsive resident, Licensed Nurse A stated they would attempt to give some juice and recheck the blood sugar in about 10 minutes. When asked again how severe Hypoglycemia would be treated in an unresponsive resident that would be unable to swallow, Licensed Nurse A stated they would call the doctor and "try to get an order" to send the resident to the hospital. Licensed Nurse A stated they were unfamiliar with glucagon injectable medication.

§ 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** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on interviews and record review, the facility failed to: 1) Investigate the circumstances of, and determine the root cause for, falls occurring off facility premises; 2) Implement safety interventions for falls that occur off facility premises; and 3) Conduct neurological checks according to the facility's policy for residents who sustained falls off facility premises. This deficient practice affected one (1) of four (4) residents reviewed for falls from a total of 27 residents sampled. The findings include: The facility's policy for fall prevention and management was reviewed. The policy was titled, "Fall and Fall Risk Management," and contained an effective date of 5/15/17. The policy's standard read: "The facility will ensure that the resident's environment remains as free from accident hazards as possible, and each resident receive adequate supervision and assistance devices to prevent accidents." The policy defined a fall as: "an unintentional coming to rest on the ground, floor, or other lower level that is not the result of external force." The policy also read: "Based on that definition, a fall includes, but is not limited to: a fall reported by the resident, family, or other personnel." Review of Resident #4's medical record revealed an initial admission date of [DATE]. Resident #4's medical history included Depression, Chronic Pain, and Diabetes Mellitus. A Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11 from a total of 15 possible points, which indicated moderately impaired cognition. Resident #4's fall history was reviewed. The last recorded fall was on [DATE], where the resident was found on the floor of their room. There were no other recorded falls recorded since this event. Continued review of Resident #4's medical record revealed a Progress Note, dated [DATE], at 1:32 p.m., which indicated the resident fell while out with their family member. The note indicated that the family member reported the resident fell out of their wheelchair while coming out of a restaurant. The note indicated there was a "scrape" on the outside of the resident's left eye. Continued review of Resident #4's fall history revealed no evidence of an incident report or investigation related to this fall. A review of Resident #4's Plan of Care revealed a focus area for falls. There were no revisions to the resident's Plan of Care for the fall on [DATE].

	Continued review of Resident #4's medical record revealed no evidence that neurological checks were conducted after the resident returned from the outing, despite evidence of Resident #4 potentially hitting their head. On 6/6/24, at 12:32 p.m., an interview was conducted with Administrative Nurse A. The facility's investigation of the resident's fall on 5/20/24 was requested. Administrative Nurse A stated: "Oh, they [the facility] don't do reports for falls that occur outside of the facility." On 6/7/24, at 9:50 a.m., an interview was conducted with Administrative Staff A regarding the facility's practices for the investigation of falls. Administrative Staff A confirmed that the facility: "generally doesn't investigate falls that happen off campus." Administrative Staff A also confirmed that Resident #4's record was reviewed by facility staff, and that neurological checks were not completed after the fall was reported.