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: Long Island State Veterans Home

Location: 100 Patriots Road, Stony Brook, NY 11790-3300

Onsite / Virtual: Onsite

Dates of Survey: 11/28/22 – 12/1/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 350

Census on First Day of Survey: 301

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from November 28, 2022 through December 1, 2022 at the Long Island State Veterans Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.90 (c) (2) Staff treatment of residents. The facility management must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on record reviews and interviews with staff and residents, the facility failed to ensure that potential misappropriation of property was immediately reported to the Administrator and other officials in accordance with state law through established procedures for one (1) of 22 residents sampled. The findings include: The facility's policy and procedure titled, "Freedom from Abuse Mistreatment, Neglect, and Exploitation," revised 10/22, stated under the policy section, "9. Immediately report to the New York State Department of Health and appropriate required regulatory agencies, in accordance to law, alleged violations involving…misappropriation." Under the Investigation section of the same policy and procedure, it stated that, "Stony Brook University Police must be notified for complaints of misappropriation of resident /registrant property."

	A review of the facility grievance/concern form, dated [DATE], revealed that on [DATE], Resident #22 reported missing $200. The report stated that Resident #22 kept their money in a zipped, blue pouch on their bed with other personal items and went to take a shower. Upon returning from the shower, Resident #22 stated that the blue pouch and money were missing. During an interview, on 11/30/22, at 4:50 p.m., Resident #22 stated that they were not exactly sure when the money went missing. They stated that the amount was $250. The resident stated that they went to sleep and when they woke up the next morning, the pouch was not in the same position as when they went to bed. This prompted the resident to look in the pouch, and that was when they discovered that the money was missing. Upon a review of facility and resident records, there was no documentation that a report was filed with the New York State Department of Health or other officials in accordance with state law. The facility's policy and procedure stated incidents regarding misappropriations must be reported within 24 hours to the appropriate entities. During an interview, on 12/1/22, at 11:00 a.m., Consultant Staff A stated that since Resident #22 declined to file a grievance, they did not think they needed to report the missing money to the authorities. Consultant Staff A also stated that since Resident #22 had lost money repeatedly in the past and had had it returned to them, staff did not think the money was stolen. During an interview, on 11/30/22, at 4:50 p.m., Resident #22 stated that they reported the missing money some time the next day, on [DATE], but the report was not generated until Resident #22's Care Plan meeting on [DATE].
§ 51.90 (c) (3) Staff treatment of residents. The facility management must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on record reviews and interviews with staff and residents, the facility failed to thoroughly investigate potential misappropriation of funds for one (1) resident of 22 sampled residents. The findings include: The facility's policy and procedure titled, "Freedom from Abuse Mistreatment, Neglect, and Exploitation," revised 10/22, stated, under the Investigation section, that staff must identify all staff who were in the area when the allegation or event occurred. Under the section titled "Investigation Findings," it stated the investigation would consist of interviews with staff members having contact with the resident during the relevant periods or shifts of the alleged incident, and a root-cause analysis of all circumstances surrounding the incident.

	A review of the facility grievance/concern form, dated [DATE], revealed that on [DATE], Resident #22 reported missing $200. The report stated that Resident #22 kept their money in a zipped blue pouch on their bed with other personal items and went to take a shower. Upon returning from the shower, Resident #22 stated that the blue zippered pouch and money were missing. During an interview, on 11/30/22, at 4:50 p.m., Resident #22 stated that they were not exactly sure when the money went missing. They stated that the amount was $250. The resident stated that they went to sleep, and when they woke up the next morning, the pouch was not in the same position as when they went to bed. This prompted the resident to look in the pouch and that was when they discovered that the money was missing. During an interview, on 11/30/22, at approximately 4:10 p.m., Consultant Staff B stated that since Resident #22 had lost money repeatedly in the past and had had it returned to them, staff did not think the money was stolen, therefore an investigation was not warranted.
§ 51.120 (b) (3) Activities of daily living. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to provide residents with the appropriate services to promote good nutrition. This deficient practice affected one (1) resident (Resident #19) of one (1) resident reviewed for activities of daily living from a total sample of 22 residents. The findings include: Review of Resident #19's medical record revealed an admission date of [DATE]. Resident #19's medical diagnoses included Vascular Dementia. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed a BIMS score of 99, indicating Resident #19 was unable to answer the associated assessment questions. Resident #19's cognitive skills for daily decision making were severely impaired. The assessment indicated Resident #19 required extensive assistance of two (2) or more staff members for bed mobility and limited physical assistance of one (1) staff member for eating. On 11/29/22, at 9:20 a.m., Resident #19 was observed lying in their bed with their eyes open. They were positioned low in the bed. The head of the bed was elevated to approximately 45 degrees. Resident #19's over-bed table and breakfast tray were positioned over them. Resident #19 was holding a bowl of dry, bran cereal with raisins in their left hand and was peering over the tray and attempting to use a spoon to scoop tea from a cup into the cereal bowl. The breakfast tray consisted of pancakes, which were cut into large pieces, bacon that was broken apart and scattered among the tray, a bowl of oatmeal, a cup of tea, an unopened

	container of whole milk, and a container of yogurt which had pieces of pancake and bacon in it. There was also a peeled, whole banana resting on the plate. On 11/29/22, at approximately 9:35 a.m., an interview was attempted with Resident #19. The call light was noted to be draped over the right bed rail and was dangling to the floor. Immediately upon entering the room, Resident #19 frowned and stated, “I hate it.” When asked what was wrong, Resident #19 looked at the bowl of cereal. When asked whether they would like milk added to the cereal, Resident #19 opened their eyes widely and smiled and stated, “Yes!” On 11/29/22, at 9:43 a.m., a staff member entered Resident #19’s room and asked the resident if they were finished with breakfast. Resident #19 stated, “No,” and the employee stated, “Ok. I’ll be back later.” The employee did not offer to reposition Resident #19 higher in the bed or to assist the resident with breakfast. On 11/29/22, at 9:48 p.m., Licensed Nurse A entered Resident #19’s room and asked Resident #19, “Do you want me to feed you?” Resident #19 did not answer. Licensed Nurse A proceeded to assist Resident #19 with the breakfast. At approximately 10:00 a.m., Licensed Nurse A exited the room with Resident #19’s breakfast tray and stated, “I tried to feed [them], but [they] didn’t want to eat most of it. I left [their] bowl of cereal because [they are] eating it. [They] also ate the banana. I also left the tea and milk.” Review of Resident #19’s Physician Orders revealed an order for a regular diet with thin liquids. A second order was noted for Ensure Plus 240 milliliters (ml) by mouth daily at 10:00 a.m. Review of Resident #19’s comprehensive Care Plan revealed a focus area for activities of daily living. The Care Plan directed nursing staff to provide “extensive 1 [one] to 2 [two] person assist” with bed mobility and “supervision with set up. Encourage to feed [themselves] but limited assist of 1 [one] person as needed” with eating. On 12/1/22, at 9:20 a.m., Resident #19 was observed lying in their bed with their eyes open. The room lights were off. The call light was draped across the bedside table to Resident #19’s left side and was out of their reach. Resident #19 was positioned low in the bed with the head of the bed elevated. The over-bed table with a breakfast tray was positioned across the resident. The food items had not been opened or set up. The utensils were wrapped neatly in a napkin and Resident #19 was not eating. On 12/1/22, at 9:25 a.m. an interview was conducted with Licensed Nurse A. They entered Resident #19’s room and stated they were going to assist the resident with breakfast. When asked whether

	staff had set up Resident #19's breakfast tray, Licensed Nurse A looked at the tray and stated, "It doesn't look like it." When asked whether the facility had tried assisting Resident #19 out of the bed for breakfast, to promote a proper position for eating, Licensed Nurse A stated, "[They eat] a lot better when [they are] out of the bed. [They] will take drinks and food much better. We will try that."
§ 51.120 (n) Medication Errors. The facility management must ensure that— (1) Medication errors are identified and reviewed on a timely basis; and (2) strategies for preventing medication errors and adverse reactions are implemented. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to prevent medication errors for one (1) resident (Resident #20) of four (4) residents observed for medication administration from a total sample of 22 residents. There were two (2) identified medication errors and a total of 27 opportunities for error. The findings include: According to the Cleveland Clinic (https://my.clevelandclinic.org/health/drugs/19899-aztreonam-injection Accessed 11/30/22), Aztreonam is an antibiotic medication used to treat infections caused by bacteria. According to the drug insert for Aztreonam, the contents of the medication vial should be, "reconstituted with at least 3 milliliters (ml) of an appropriate diluent," and, "should be given into a large muscle mass such as the upper outer quadrant of the gluteus maximus or lateral part of the thigh." A publication by Elsevier (an academic publishing company specializing in scientific, technical, and medical content), dated November 22, 2022 read, "Although the deltoid site is easily accessible, the muscle is not well developed in many adults. This site is used for small medication volumes (2 ml or less)." On 11/30/22, at 10:20 a.m., an observation of medication administration was observed for Resident #20 with Licensed Nurse B. Licensed Nurse B prepared the following medications for administration: 1. Acidophilus capsule 2. Acetaminophen 325 milligram (mg) tablet 3. Acetaminophen 325 mg tablet 4. Aztreonam 1 gram (gm) injectable 5. Eliquis 5 mg tablet 6. Furosemide 40 mg tablet 7. Gabapentin 300 mg capsule 8. Lisinopril 5 mg tablet 9. PreserVision tablet 10. Lidocaine patch left elbow 11. Lidocaine patch right elbow 12. Lidocaine patch left knee 13. Lidocaine patch lower back 14. Breo Ellipta 200-25 microgram (mcg) inhaler 15. Pro-Air Inhaler

	Licensed Nurse B prepared a one (1) gram (gm) vial of injectable Aztreonam by reconstituting the vial with three (3) ml of bacteriostatic water. Licensed Nurse B then withdrew three (3) ml of the Aztreonam into a syringe. They brought the syringe, the Pro-Air Inhaler, Lidocaine patches, and a medicine cup containing oral medications to Resident #20's bedside. Licensed Nurse B left the Breo Ellipta inhaler sitting on the medication cart. They prepared Resident #20's right deltoid (upper arm) muscle for injection and injected three (3) ml of the Aztreonam into the right deltoid. Licensed Nurse B then administered the oral medications and offered Resident #20 the Pro Air inhaler (which they refused). Licensed Nurse B applied the lidocaine patches to the ordered sites, then disposed of the syringe, gathered the Pro Air inhaler, and returned to the medication cart where they placed both inhalers back into the medication cart. Licensed Nurse B then proceeded to prepare medications for the next resident. On 11/30/22, at 1:44 p.m., an interview was conducted with Licensed Nurse B regarding Resident #20's medications. Licensed Nurse B confirmed that the Breo Elipta inhaler had not been administered. They added, "[Resident #20] didn't want the Pro Air inhaler so I figured [Resident #20] wouldn't want that one either." Licensed Nurse B also confirmed that 3ml of the injectable antibiotic had been injected into Resident #20's right deltoid. When asked whether the deltoid muscle was an appropriate site selection for a three (3) ml injection, Licensed Nurse B stated, "I don't see why not. That's where we usually do it because it's easier to get to." On 12/1/22, the facility produced a copy of the policy and procedure governing medication administration. The policy was titled, "Medication Administration," and was dated 6/22. Step five (5) of the policy read, "It is the responsibility of each licensed nurse to be aware of drug classifications, actions/interactions, standard dosages, side effects and the reason the drug is being given to a particular resident." The policy did not address site selection for intramuscular injections.