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: Kansas State Veterans Home

Location: Winfield, Kansas

Onsite / Virtual: Virtual

Dates of Survey: 3/14/22 - 3/17/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 97

Census on First Day of Survey: 67

Deficiency	Findings
	Initial Comments: A VA Annual survey was conducted from 3/14/22 through 3/17/22 at the Kansas State Veterans Home. The facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.43(b) Drugs and medicines for certain veterans VA will also furnish drugs and medicines to a State home for a veteran receiving nursing home, domiciliary, or adult day health care in a State home pursuant to 38 U.S.C. 1712(d), as implemented by § 17.96 of this chapter, subject to the limitation in § 51.41(c)(2). Rating: Not Met Scope and Severity – B Residents Affected – Some	The facility was unable to demonstrate that medications are only furnished subject to the limitations § 51.41(c)(2). Based on interviews and record reviews, it was identified that the facility does not have a process to ensure that medication costs for Veterans for which the facility receives the prevailing rate are covered in full by the facility. Review of records for September 2021 revealed that the facility's contracted pharmacy billed Medicare Part D and Tricare for three (3) prevailing rate Veterans, for which the facility is responsible for all medication costs. Administrative Staff A verified these findings with the Business Office and pharmacy.
§ 51.120(a)(4) Reporting of Sentinel Events	Based on record reviews, interviews, and review of the facility's policy, the facility failed to submit to Veteran Affairs (VA) medical center of jurisdiction a written report within 10 working

The facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility. Rating: Not Met Scope and Severity – F Residents Affected – All	days of analyzing the Sentinel Event of three (3) of three (3) reported Sentinel Events reviewed. Resident #13 expired from a subdural hematoma on [DATE]; the facility provided notice to the VA on [DATE]. Resident #14 was found dead in their room on [DATE]; the facility provided notice to the VA on [DATE]. Resident #15 fell and suffered a subdural hematoma on [DATE], was placed on hospice and died on [DATE]; the facility provided notice to the VA on [DATE]. The findings included: Review of the "Abuse, Neglect, and Exploitation of Residents: Prevention, Identification, and Reporting Procedure" policy revised 11/23/21, listed "… Investigation: … 5. The Clinical Director will provide a written report of the results of all abuse investigation and appropriate action taken to the state agency and certification agency, the local police department as required by state law, and to the VA or State Veterans Home Representative as required by CRF 51.120 Reporting of Sentinel Events…." 1. Resident #13 was a resident of the Kansas Veterans Home Assisted Living Facility (ALF) prior to their admission into the Kansas Veterans Home skilled nursing facility on [DATE]. The resident had been hospitalized for a Subdural Hematoma they sustained from an unwitnessed fall in the ALF on [DATE]. Review of the hospital's Discharge Summary dated [DATE], revealed "…Do not resume home ASA (Aspirin) … until Neurosurgery Dr. (name) follow in OP (outpatient) 6-8 weeks …" Review of the 2021 "Medication Administration Record" for Resident #13 revealed that Aspirin 81 milligrams (mg) one tablet by mouth was administered on [DATE] through [DATE] at 8:00 a.m. Interview with Licensed Nurse A on 3/16/22 at 1:00 p.m. revealed they were the nurse that admitted Resident #13 and did not note that the Aspirin was discontinued for Resident #13. Interview with the Family of Resident #13 on 3/16/22 at 3:00 p.m. revealed they reviewed Resident #13's medical records from the resident's hospital stay and realized the anticoagulant medications, Eliquis and Aspirin were discontinued when they were discharged from the hospital; however, the facility continued to administer Aspirin to the resident. They stated when Resident #13 complained of a headache (on [DATE]),

	they were sent back to the hospital for evaluation, which revealed the Subdural Hematoma had doubled in size. Resident #13 had surgery but never regained consciousness after the surgery and eventually passed away. The Family of Resident #13 stated the death certificate indicated the resident's cause of death was Multi-Organ Failure, Subdural Hematoma, Traumatic Head Injury, and slip and fall. Resident #13 was readmitted into the hospital on [DATE] where Computerized Tomography (CT) scan of their head indicated that the Subdural Hematoma was larger than it was when they were discharged from the hospital on [DATE]. During an interview with Consultant Staff B on 3/17/22 at 11:11 a.m., they stated that scenario could have happened even without Aspirin. Consultant Staff B stated a bleed could happen even without blood thinners. Interview with the Consultant Staff A of the facility on 3/17/22 at 12:05 p.m., revealed that they spoke to the doctors at the hospital, and the coroner. Resident #13 had co-morbidities and it was unlikely that the Aspirin caused their death. According to pre-survey documentation provided to the survey team, "On Monday, [DATE], Kansas Veterans' Home (KVH) in Winfield, Kansas notified the VA State Veterans' Home (SVH) Medical Representative of an event that occurred between [DATE] and [DATE]. The event was related to a medication error … The hospital discharge orders did indicate to discontinue … Aspirin 81 mg … On [DATE], Veteran (Resident #13) was sent to [LOCATION] due to decreased loss of consciousness and decrease fine motor skills functions. (They) were then transferred to [LOCATION]. Veteran passed away on [DATE]. (Family) requested the Veteran's medical records and noted that Aspirin 81mg was discontinued by the hospital on [DATE] and remained on the medication administration record at KVH … ." 2. Review of Resident #14's closed clinical record revealed an admission date of [DATE] with diagnoses to include Atrial Fibrillation, Heart Failure, and Congestive Heart Failure. Resident #14's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. Resident #14 required supervision of one staff person for bed mobility, transfers, dressing, toilet use and personal hygiene and independent with walk in room, locomotion on unit and eating. The resident had no impairment in their upper or lower bilateral extremities; and utilized a walker for mobility. The resident had no falls since admission.

	Review of Resident #14's Care Plan, updated [DATE], documented falls as a concern related to a decline in activities of daily living. The goal was for the resident to remain free from injury over the next review period. Interventions were listed as anticipate the resident's needs, assure call light is within reach, function ability of bed and chair alarm, keep bed in lowest position to prevent fall related injuries, and resident received skilled therapies for Physical and Occupational Therapy. Review of the facility's "Incident Report" dated [DATE], revealed Resident #14 was found on the floor of their room dead. It appeared Resident #14 fell forward out of their chair. The report indicated that the coroner thought the resident died before they fell out of the chair. The immediate cause of death as listed on the resident's death certificate was Congestive Heart Failure. During an interview on 3/16/22 at 11:15 a.m., the Administrative Staff B stated they reported the event to the VA on [DATE] and realized it was beyond the 10 days limit. The Administrative Staff B stated they realized they had to do better with reporting to the VA. The facility management failed to provide a written report to the VA medical center of jurisdiction within 10 working days following the Sentinel Event. 3. Review of Resident #15's closed clinical record revealed an admission date of [DATE] with diagnoses of history of a Cerebral Infarction, Essential Hypertension, and abnormalities of gait and mobility. Resident #15's Significant Change in Status Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) of 11, which indicated the resident was moderately impaired decision-making skills. Resident #15 required supervision for most activities of daily living: had no impairment to upper/lower bilateral extremities: and used a walker for mobility. The resident had one non injury fall, and one minor injury fall during the assessment period. Review of Resident #15's Care Plan, initiated [DATE] last reviewed [DATE], documented falls was a concern. The goal listed was for the resident to remain free from injury related to falls over the next review period. Interventions included appropriate footwear, non-skid socks, trash can within reach, assist resident into recliner, night light in home, resident to ask for assistance when unplugging cell phone, educate not to sit on

	the arm of the recliner, dycem in recliner, concave mattress, and Occupational Therapy to evaluate. Review of the facility's "Incident Report" completed [DATE], revealed that on [DATE], Resident #15 was ambulating with their walker from their room down the hall toward the nurse's station. Resident #15 began to lose their balance, leaned towards the left side, fell backwards, and hit their head on the floor and sustained an injury on the left side of their head. Resident #15 was sent to the emergency room where it was determined they had a Subdural Hematoma. Resident #15 was then transferred from the hospital to hospice where they passed away on [DATE]. According to the "SVH Pre-Survey Information", the facility didn't report the Sentinel Event until [DATE], which was 20 days later from when the Sentinel Event took place. During an interview on 3/16/22 at 11:15 a.m., the Administrative Staff B stated they realized the reporting was beyond the 10-day limit. The Administrative Staff B stated they would pay attention to the time frame the next time they have a sentinel event. The Administrative Staff B acknowledged they had to be timelier when reporting sentinel events. The facility management failed to provide a written report to the VA medical center of jurisdiction within 10 working days following the Sentinel Event.
§ 51.200(a) Life safety from Fire The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. (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. Rating: Not Met Scope and Severity – E Residents Affected – Few	The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. (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. 1. Based on observation and interview, the facility failed to maintain the smoke barriers. The deficient practice affected one (1) of four (4) smoke compartments, staff, and 26 residents. The facility has the capacity for 97 beds with a census of 67 on the first day of survey. The findings included: Observation during the virtual building inspection tour on 3/16/22 at 11:30 a.m. of the smoke barrier wall above the lay-in ceiling tile at the double-doors leading into the [Location] revealed a penetration where several blue and white communication cables enter the Nursing Unit were not sealed or

	fire stopped, as required by section 8.5.6 of NFPA 101, Life Safety Code. Interview at that time with the Maintenance Staff A revealed the facility was not aware of the unsealed penetration. The census of 97 was verified by the Administrative Staff A on 3/14/22. The finding was acknowledged by the Administrative Staff A and verified by the Maintenance Staff A during the exit interview on 3/17/22 at 1:30 p.m. **Actual NFPA Standard: NFPA 101 (2012) Life Safety Code** **19.3.7.3** Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1⁄2-hour fire resistance rating, unless otherwise permitted by one of the following: **(1)** This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: **(a)** Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). **(b)** Not less than two separate smoke compartments shall be provided on each floor. **(2)***Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. **8.5 Smoke Barriers.** **8.5.6 Penetrations.** **8.5.6.1** The provisions of 8.5.6 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations of smoke barriers. **8.5.6.2** Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. 2. Based on records review and interview, the facility failed to document the inspection and testing of Patient Care Related Electrical Equipment (PCREE). The deficient practice affected four (4) of four (4) smoke compartments, staff, and all residents. The facility has the capacity for 97 beds with a census of 67 on the first day of survey. The findings included:

	Records review on 3/15/22 at 10:50 a.m. revealed there was not documentation for the testing the physical integrity, resistance, leakage current, and touch current tests for the electric, resident beds throughout the facility, as required by section 10.3 of NFPA 99, Health Care Facilities Code. Interview at that time with the Maintenance Staff A revealed the facility was not aware that physical integrity, resistance, leakage current, and touch current tests for the electric, resident beds throughout the facility was required to be conducted when the beds were placed into service, after a repair, and at intervals determined by the facility. The census of 97 was verified by the Administrative Staff A on 3/14/22. The finding was acknowledged by the Administrative Staff A and verified by the Maintenance Staff A during the exit interview on 3/17/22 at 1:30 p.m. **Actual NFPA Standard: NFPA 99 Health Care Facilities Code (2012)** **10.3 Testing Requirements — Fixed and Portable.** **10.3.1* Physical Integrity.** The physical integrity of the power cord assembly composed of the power cord, attachment plug, and cord-strain relief shall be confirmed by visual inspection. **10.3.2* Resistance.** **10.3.2.1** For appliances that are used in the patient care vicinity, the resistance between the appliance chassis, or any exposed conductive surface of the appliance, and the ground pin of the attachment plug shall be less than 0.50 ohm under the following conditions: (1) The cord shall be flexed at its connection to the attachment plug or connector. (2) The cord shall be flexed at its connection to the strain relief on the chassis. **10.3.2.2** The requirement of 10.3.2.1 shall not apply to accessible metal parts that achieve separation from main parts by double insulation or metallic screening or that are unlikely to become energized (e.g., escutcheons or nameplates, small screws). **10.3.3* Leakage Current Tests.** **10.3.3.1 General.** **10.3.3.1.1** The requirements in 10.3.3.2 through 10.3.3.4 shall apply to all tests. **10.3.3.1.2** Tests shall be performed with the power switch ON and OFF. **10.3.3.2 Resistance Test.** The resistance tests of 10.3.3.3 shall be conducted before undertaking any leakage current measurements. **10.3.3.3* Techniques of Measurement.** The test shall not be made on the load side of an isolated power system or separable isolation transformer.

	10.3.3.4* Leakage Current Limits. The leakage current limits in 10.3.4 and 10.3.5 shall be followed. **10.3.4 Leakage Current — Fixed Equipment.** **10.3.4.1** Permanently wired appliances in the patient care vicinity shall be tested prior to installation while the equipment is temporarily insulated from ground. **10.3.4.2** The leakage current flowing through the ground conductor of the power supply connection to ground of permanently wired appliances installed in general or critical care areas shall not exceed 10.0 mA (ac or dc) with all grounds lifted. **10.3.5 Touch Current — Portable Equipment.** **10.3.5.1* Touch Current Limits.** The touch current for cord connected equipment shall not exceed 100 µA with the ground wire intact (if a ground wire is provided) with normal polarity and shall not exceed 500 µA with the ground wire disconnected. **10.3.5.2** If multiple devices are connected together and one power cord supplies power, the leakage current shall be measured as an assembly. **10.3.5.3** When multiple devices are connected together and more than one power cord supplies power, the devices shall be separated into groups according to their power supply cord, and the leakage current shall be measured independently for each group as an assembly. **10.3.5.4 Touch Leakage Test Procedure.** Measurements shall be made using the circuit, as illustrated in Figure 10.3.5.4, with the appliance ground broken in two modes of appliance operation as follows: **(1)** Power plug connected normally with the appliance on **(2)** Power plug connected normally with the appliance off (if equipped with an on/off switch) **10.3.5.4.1** If the appliance has fixed redundant grounding (e.g., permanently fastened to the grounding system), the touch leakage current test shall be conducted with the redundant grounding intact. **10.3.5.4.2** Test shall be made with Switch A in Figure 10.3.5.4 closed. **10.3.6* Lead Leakage Current Tests and Limits — Portable Equipment.** **10.3.6.1** The leakage current between all patient leads connected together and ground shall be measured with the power plug connected normally and the device on. **10.3.6.2** An acceptable test configuration shall be as illustrated in Figure 10.3.5.4. **10.3.6.3** The leakage current shall not exceed 100 µA for ground wire closed and 500 µA ac for ground wire open. **10.5.2.1 Testing Intervals.** **10.5.2.1.1** The facility shall establish policies and protocols for the type of test and intervals of testing for patient care–related electrical equipment.

	10.5.2.1.2 All patient care–related electrical equipment used in patient care rooms shall be tested in accordance with 10.3.5.4 or 10.3.6 before being put into service for the first time and after any repair or modification that might have compromised electrical safety. **10.5.2.5*** System Demonstration. Any system consisting of several electric appliances shall be demonstrated to comply with this code as a complete system. **10.5.3 Servicing and Maintenance of Equipment.** **10.5.3.1** The manufacturer of the appliance shall furnish documents containing at least a technical description, instructions for use, and a means of contacting the manufacturer. **10.5.3.1.1** The documents specified in 10.5.3.1 shall include the following, where applicable: **(1)** Illustrations that show the location of controls **(2)** Explanation of the function of each control **(3)** Illustrations of proper connection to the patient or other equipment, or both **(4)** Step-by-step procedures for testing and proper use of the appliance **(5)** Safety considerations in use and servicing of the appliance **(6)** Precautions to be taken if the appliance is used on a patient simultaneously with other electric appliances **(7)** Schematics, wiring diagrams, mechanical layouts, parts lists, and other pertinent data for the appliance **(8)** Instructions for cleaning, disinfection, or sterilization **(9)** Utility supply requirements (electrical, gas, ventilation, heating, cooling, and so forth) **(10)** Explanation of figures, symbols, and abbreviations on the appliance **(11)** Technical performance specifications **(12)** Instructions for unpacking, inspection, installation, adjustment, and alignment **(13)** Preventive and corrective maintenance and repair procedures **10.5.3.1.2** Service manuals, instructions, and procedures provided by the manufacturer shall be considered in the development of a program for maintenance of equipment. **10.5.6 Record Keeping — Patient Care Appliances.** **10.5.6.1 Instruction Manuals.** **10.5.6.1.1** A permanent file of instruction and maintenance manuals shall be maintained and be accessible. **10.5.6.1.2** The file of manuals shall be in the custody of the engineering group responsible for the maintenance of the appliance. **10.5.6.1.3** Duplicate instruction and maintenance manuals shall be available to the user.

	10.5.6.1.4 Any safety labels and condensed operating instructions on an appliance shall be maintained in legible condition. **10.5.6.2* Documentation.** **10.5.6.2.1** A record shall be maintained of the tests required by this chapter and associated repairs or modifications. **10.5.6.2.2** At a minimum, the record shall contain all of the following: **(1)** Date **(2)** Unique identification of the equipment tested **(3)** Indication of which items have met or have failed to meet the performance requirements of 10.5.6.2 **10.5.6.3 Test Logs**. A log of test results and repairs shall be maintained and kept for a period of time in accordance with a health care facility's record retention policy. **10.5.8 Qualification and Training of Personnel.** **10.5.8.1*** Personnel concerned for the application or maintenance of electric appliances shall be trained on the risks associated with their use. **10.5.8.1.1** The health care facilities shall provide programs of continuing education for its personnel. **10.5.8.1.2** Continuing education programs shall include periodic review of manufacturers' safety guidelines and usage requirements for electrosurgical units and similar appliances. **10.5.8.2** Personnel involved in the use of energy-delivering devices including, but not limited to, electrosurgical, surgical laser, and fiberoptic devices shall receive periodic training in fire suppression. **10.5.8.3** Equipment shall be serviced by qualified personnel only.
§ 51.200(b) Emergency power (1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination. (2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. (3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99,	An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. Based on records review, observation, and interview, the facility failed to properly inspect and test all components of the emergency generator. The deficient practice affected four (4) of four (4) smoke compartments, staff, and all residents. The facility has the capacity for 97 beds with a census of 67 on the first day of survey. The findings included: Records review on 3/14/22 at 11:05 a.m. of the monthly emergency generators inspection and testing records dating

Health Care Facilities Code. (4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. Rating: Not Met Scope and Severity – F Residents Affected – All	back 12 months prior to the survey revealed there was no documentation of monthly electrolyte specific gravity testing or conductance testing for the lead-acid batteries, as required by section 8.3.7.1 of NFPA 110, Standard for Emergency and Standby Power Systems. Interview at that time with the Maintenance Staff A revealed the facility was not aware of the monthly generator battery testing requirements and that they were not being done. The census of 97 was verified by the Administrative Staff A on 3/14/22. The finding was acknowledged by the Administrative Staff A and verified by the Maintenance Staff A during the exit interview on 3/17/22 at 1:30 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.5 Building Services.** **19.5.1 Utilities.** **19.5.1.1** Utilities shall comply with the provisions of Section 9.1. **9.1.3 Emergency Generators and Standby Power Systems.** Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. **9.1.3.1** Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. **Actual NFPA Standard: NFPA 110 (2010), Standard for Emergency and Standby Power Systems** **8.3.7.1** Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted.