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: Grand Rapids Homes for Veterans

Location: 3000 Monroe N.W. Grand Rapids, MI 49505

Onsite / Virtual: Onsite

Dates of Survey: 1/23/24 through 1/26/24

NH / DOM / ADHC: NH

Survey Class: 2023 Annual

Total Available Beds: 128

Census on First Day of Survey: 115

Surveyed By: Stephanie Barch, RN; Mark Bennett, RN; Tonya Green, RN; Nomie Wallace, MS; Allen Beebe, (LSC); Cicely Robinson, VACO.

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from January 23, 2024, through January 26, 2024, at the Grand Rapids Home for Veterans. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.43 (d) Drugs and medicines for certain veterans VA may furnish a drug or medicine under this section and under §17.96 of this chapter by having the drug or medicine delivered to the State home in which the veteran resides by mail or other means and packaged in a form that is mutually acceptable to the State home and to VA set forth in a written agreement. **Rating** – Not Met **Scope and Severity** - C **Residents Affected** - Many	The facility was unable to demonstrate that the VA only furnishes drugs or medicines as set forth in a written agreement. Based on interviews and record reviews, it was identified that the facility does not have a written agreement with the VA Medical Center (VAMC) of jurisdiction for drugs and medicines being furnished by the VA's Pharmaceutical Prime Vendor (PPV) using VA's Federal Supply Schedule (FSS) contracts. During an interview on 1/24/24 with the facility Administrator and Pharmacy Manager, it was identified that the facility orders the majority of needed drugs and medications for all residents through the VA's PPV using the VA's FSS contracts. Those present described that the facility had previously had a written agreement with the VAMC allowing the facility access to the VA's PPV for ordering of drugs and medicines, however this written agreement started in 2005 and expired after an initial

	base year and four (4) option years. The facility confirmed that the VAMC is currently working to create a new written agreement. Facility leadership confirmed understanding that a written agreement with the VAMC is necessary in order for the facility to order drugs and medicines from the VA's PPV using VA's FSS contracts.
§ 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. **Rating** – Not Met **Scope and Severity** – G **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to provide services that meet professional standards of quality by failing to 1) Implement interventions to prevent falls in accordance with the Comprehensive Assessment and Care Plan for one (1) of three (3) residents reviewed for falls (Resident #6) and 2) Maintain acceptable parameters of nutritional status by failing to assist residents with meals as indicated by the comprehensive assessment and Care Plan for one (1) of one (1) residents reviewed for nutrition from a total of 21 sampled residents (Resident #6). The findings include: Cross Reference to § 51.120 (i) Accidents and § 51.120 (j) Nutrition. 1. A review of Resident #6's medical record revealed an initial admission date of 7/29/21. His/her medical history included Disorganized Schizophrenia and Abnormal Weight Loss. A significant change in the Minimum Data Set (MDS) assessment, dated 11/21/23, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of a possible 15 points, suggesting moderate cognitive impairment. The assessment further indicated Resident #6 required substantial to maximal assistance with toileting and identified Resident #6 as having one (1) fall with injury. A review of Resident #6's comprehensive Care Plan revealed a focus area for falls. An intervention, dated 10/30/23, directed staff to not leave Resident #6 in the restroom unattended due to his/her risk for falls. A second intervention, dated 10/30/23, read: "[Resident #6] has recently had multiple falls while in the bathroom, [he/she] needs 1 [one] person assistance at this time while using the toilet for [his/her] safety." On 1/25/24, at 12:27 p.m., an interview was attempted with Resident #6 in his/her room. Resident #6 was not observed in his/her room. A brief interview was conducted with Certified Nursing Aide (CNA) D at that time. He/she stated, "[Resident #6] might be in the restroom." CNA D then walked down to Resident #6's room, opened the restroom door, and confirmed that Resident #6 was in the restroom (unattended). CNA D stated to Resident #6, "Just checking on you," and then

	immediately left Resident #6 unattended in the restroom and exited the room. 2. A review of Resident #6's comprehensive Care Plan revealed a focus area for Nutrition Risk related to a disordered eating pattern. A related intervention directed staff to provide Resident #6 with one-to-one assistance with meals. The intervention also read: "Assist feeding [Resident #6] side by side assistance." A second intervention, dated 11/9/23, directed staff to obtain Resident #6's weight daily and observe for significant weight changes. On 1/24/24, at 12:02 p.m., CNA A rolled a cart to the entrance of Resident #6's room containing his/her lunch tray. CNA B approached CNA A and stated to CNA A, "Just set everything up and let [Resident #6] know it's there. Oh and don't take the tray out until [Resident #6] is for sure done." CNA A set the tray up on the overbed table in Resident #6's room and stated, "You've got your lunch right here." CNA A then immediately left the room. Staff failed to provide Resident #6 with meal assistance. On 1/25/24, at 2:42 p.m., an interview was conducted with the Dietitian regarding Resident #6. When asked about the level of assistance Resident #6 required with meals, the Dietitian stated: “I think [he/she] is able to physically feed [him/herself] but needs a lot of encouragement. Staff should definitely be with [him/her] during meals.” When asked whether weights were being obtained and recorded daily as recommended by the Dietitian, he/she stated, “No. Actually thank you for reminding me because I think we need to move [him/her] to weekly weights because the daily ones haven’t necessarily been done.”
§ 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. **Rating** – Not Met **Scope and Severity** – D **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to implement interventions to prevent falls in accordance with the Comprehensive Assessment and Care Plan for one (1) of three (3) residents reviewed for falls from a total of 21 residents sampled (Resident #6). The findings include: A review of Resident #6's medical record revealed an initial admission date of 7/29/21. His/her medical history included Disorganized Schizophrenia and Abnormal Weight Loss. A significant change in the Minimum Data Set (MDS) assessment, dated 11/21/23, revealed a BIMS score of 12 out of a possible 15 points, suggesting moderate cognitive impairment. The assessment further indicated Resident #6 required substantial to maximal assistance with toileting and identified Resident #6 as having one (1) fall with injury.

	A review of Resident #6's comprehensive Care Plan revealed a focus area for falls. An intervention, dated 10/30/23, directed staff to not leave Resident #6 in the restroom unattended due to his/her risk for falls. A second intervention, dated 10/30/23, read: "[Resident #6] has recently had multiple falls while in the bathroom, [he/she] needs 1 [one] person assistance at this time while using the toilet for [his/her] safety." Continued review of Resident #6's medical record revealed a fall on 10/30/23, at 1:00 a.m., where Resident #6 was observed laying on the floor in his/her bathroom with the call light on. Staff observed urine on the floor next to the resident. The correlating incident report indicated that Resident #6's Care Plan would be revised, to direct staff to provide assistance with toileting. On 1/24/24, at 12:12 p.m., Resident #6 was observed moving the overbed table with his/her lunch tray on it, against the wall and away from him/herself, and ambulating to the restroom with a shuffling gate and forward-leaning posture. On 1/24/24, at 12:14 p.m., CNA B entered a room directly adjacent to Resident #6's room and picked up a meal tray. CNA B did not offer Resident #6 assistance in the restroom. On 1/24/24, at 12:16 p.m., CNA B entered another room directly adjacent to Resident #6's room and picked up a meal tray. CNA B did not offer Resident #6 assistance in the restroom. On 1/24/24, at 12:20 p.m., Licensed Practical Nurse (LPN) C entered a room directly adjacent to Resident #6's room and began holding a conversation with the resident in that room. LPN C did not offer Resident #6 assistance in the restroom. On 1/25/24, at 12:27 p.m., an interview was attempted with Resident #6 in his/her room. Resident #6 was not observed in his/her room. A brief interview was conducted with CNA D at that time. He/she stated, "[Resident #6] might be in the restroom." CNA D then walked down to Resident #6's room, opened the restroom door, and confirmed that Resident #6 was in the restroom (unattended). CNA D stated to Resident #6, "Just checking on you," and then immediately left Resident #6 unattended in the restroom and exited the room.
§ 51.120 (j) Nutrition. Based on a resident's comprehensive assessment, the facility management must ensure that a resident— (1) Maintains acceptable parameters of nutritional status, such as body weight	Based on observations, interviews, and record review, the facility failed to maintain acceptable parameters of nutritional status by failing to assist residents with meals as indicated by the comprehensive assessment and Care Plan for one (1) of one (1) resident reviewed for nutrition from a total of 21 sampled residents (Resident #6).

and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when a nutritional deficiency is identified **Rating** – Not Met **Scope and Severity** – G **Residents Affected** – Few	The findings include: A review of Resident #6's medical record revealed an initial admission date of 7/29/21. His/her medical history included Disorganized Schizophrenia and Abnormal Weight Loss. A significant change in the Minimum Data Set (MDS) assessment, dated 11/21/23, revealed a BIMS score of 12 out of a possible 15 points suggesting moderate cognitive impairment. The assessment further indicated Resident #6 required partial to moderate assistance with eating and identified significant weight loss with a weight of 139 pounds at the time of the assessment. During an initial tour of the facility, on 1/23/24, at 12:00 p.m., Resident #6 was observed sitting in a chair next to his/her bed with his/her legs elevated. An overbed table was positioned in front of Resident #6, and his/her lunch tray was on the table. Upon observing the tray, no food items had been eaten. When asked whether he/she was planning to eat lunch, Resident #6 stated, "I don't know." A review of Resident #6's comprehensive Care Plan revealed a focus area for Nutrition Risk related to a disordered eating pattern. A related intervention directed staff to provide Resident #6 with one-to-one assistance with meals. The intervention also read: "Assist feeding [Resident #6] side by side assistance." A second intervention, dated 11/9/23, directed staff to obtain Resident #6's weight daily and observe for significant weight changes. On 1/24/24, at 12:02 p.m., CNA A rolled a cart to the entrance of Resident #6's room containing his/her lunch tray. CNA B approached CNA A and stated to CNA A, "Just set everything up and let [Resident #6] know it's there. Oh and don't take the tray out until [Resident #6] is for sure done." CNA A set the tray up on the overbed table in Resident #6's room and stated, "You've got your lunch right here." CNA A then immediately left the room. On 1/24/24, at 12:12 p.m., Resident #6 was observed moving the overbed table with his/her lunch tray on it, against the wall and away from him/herself, and began ambulating to the restroom with a shuffling gate. On 1/24/24, at 12:14 p.m., CNA B entered a room directly adjacent to Resident #6's room and picked up a meal tray. CNA B did not offer encouragement or assistance to Resident #6 with his/her meal. On 1/24/24, at 12:16 p.m., CNA B entered another room directly adjacent to Resident #6's room and picked up a meal tray. CNA

	B did not offer encouragement or assistance to Resident #6 with his/her meal. On 1/24/24, at 12:20 p.m., Licensed Practical Nurse (LPN) C entered a room directly adjacent to Resident #6's room and began holding a conversation with the resident in that room. LPN C did not offer encouragement or assistance to Resident #6 with his/her meal. Review of Resident #6's weight history revealed a most recent weight of 142.2 pounds on 1/8/24. Resident #6 remained under his/her ideal body weight range at that time. Daily weights recommended by the Dietitian and referenced in the comprehensive Care Plan were not documented in the care flow records. Continued review of Resident #6's medical record revealed the most recent Nutritional Assessment, dated 11/27/23, which was completed by the Dietitian due to Resident #6's significant change. The assessment identified Resident #6 as being 71 inches tall and weighing 139 pounds. The assessment also identified Resident #6's ideal body weight range as 172 pounds plus or minus 17 pounds. A narrative written by the Dietitian read: "Appears frail, muscle and fat loss." No causative factors for Resident #6's weight loss were identified in the assessment. An additional assessment narrative by the Dietitian read: "1:1 [one-to-one] assistance to feed member initiated in hopes to improve PO [by mouth] intake." On 1/25/24, at 12:27 p.m., Resident #6's lunch tray was observed on the overbed table in his/her room. The table was pushed up against the wall near Resident #6's restroom. None of the food had been eaten. Resident #6 was not observed in his/her room. A brief interview was conducted with CNA D at that time. He/she stated, "[Resident #6] might be in the restroom." CNA D then walked down to Resident #6's room, opened the restroom door, and confirmed that Resident #6 was in the restroom (unattended). CNA D stated to Resident #6, "Just checking on you," and then immediately left Resident #6 unattended in the restroom and exited the room. On 1/25/24, at 2:03 p.m., an interview was conducted with CNA E. CNA E explained that he/she had been working with Resident #6 for approximately two (2) years and was familiar with his/her care. CNA E explained that Resident #6 liked food items such as French Toast and oatmeal and stated Resident #6 did "pretty good for breakfast." When asked how much assistance Resident #6 required for meals, CNA E stated: "[He/she] eats by [him/her] self. We just set everything up. We do have to remind [him/her] that it's there because if we don't then [he/she] will leave it." When asked whether Resident #6

	had recently lost any weight, CNA E stated: "I know at one point we had to weigh [him/her] every day. I do think [he/she] was losing weight at one point." On 1/25/24, at 2:42 p.m., an interview was conducted with the Dietitian regarding Resident #6. The Dietitian explained that he/she was still getting used to the residents as he/she had only been working at the facility since the Spring of 2023. The Dietitian acknowledged that Resident #6 had lost weight over the past six (6) months or more. When asked whether the causative factors for Resident #6's weight loss had been identified, the Dietitian stated: "I don't know." When asked about the level of assistance Resident #6 required with meals, the Dietitian stated: "I think [he/she] is able to physically feed [him/herself] but needs a lot of encouragement. Staff should definitely be with [him/her] during meals." When asked whether weights were being obtained and recorded daily as recommended by the Dietitian, he/she stated, "No. Actually thank you for reminding me because I think we need to move [him/her] to weekly weights because the daily ones haven't necessarily been done."