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: Michigan Veteran Homes at Chesterfield Township

Location: 47901 Sugarbush Road, Chesterfield Township, MI 48047

Onsite / Virtual: Onsite

Dates of Survey: 8/20/24 – 8/22/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 128

Census on First Day of Survey: 117

Surveyed By: Wylona Coleman, RN; Marilyn Klotz, RN; Robin Windhausen, RD; Natasha Cheatham, Generalist; David Walker (LSC); Cicely Robinson, VACO.

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from August 20, 2024 through August 22, 2024 at the Michigan Veteran Homes at Chesterfield Township. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 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** – D **Residents Affected** – Few	Based on observation, interview, record review, and policy review, the facility failed to provide services in accordance with professional standards of quality for two (2) of 28 sampled residents (Resident #26 and Resident #27) reviewed for medication administration practices. The findings include: 1. A review of the policy and procedure titled, “Clinical Services & [and] Quality of Care Medication Administration,” dated 3/20/24, revealed: “Medications are administered by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the provider and in accordance with professional standards of practice…25. Members have the right to refuse medication regardless of cognition status. If a member refuses, even after a reapproach, notify the provider of the refused medication.

	A review of the "Profile" for Resident #26 revealed the facility admitted the resident on 2/6/24. A review of Resident #26's Minimum Data Set (MDS), dated 5/14/24, revealed the resident had the following diagnoses: Venous Insufficiency, Hypertension, Neurogenic Bladder, Diabetes Mellitus, and Hyperlipidemia. Continued review of the MDS revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact and able to be interviewed. A review of the Medication Administration Record (MAR) for Resident #26, dated 8/1/24 through 8/31/24, revealed a prescribed provider order which read: "Colace oral capsule 100 milligrams (MG) (Docusate Sodium) Give [one] (1) capsule by mouth every 12 hours for diagnosis (DX) constipation and hold for loose stools. Notify provider if more than [two] 2 loose stools out per day." The start date was noted to be: "8/14/24 at 1900 [7:00 p.m.]." Continued review of the provider order revealed the resident had refused to take the medication on 8/15/24, at 7:30 a.m., and 7:00 p.m.; 8/16/24, at 7:30 a.m., and 7:00 p.m.; 8/17/24, at 7:30 a.m., and 7:00 p.m.; 8/18/24, at 7:30 a.m., and 7:00 p.m.; 8/19/24, at 7:30 a.m., and 7:00 p.m.; and 8/20/24, at 7:30 a.m., and 7:00 p.m. An interview, on 8/21/24, at 8:40 a.m., during a medication pass with Licensed Practical Nurse (LPN) C, revealed Resident #26 had always refused to take his/her prescribed Colace (stool softener). Observation of Resident #26, on 8/21/24, at 8:45 a.m., revealed the resident was alert, oriented, and lying in his/her bed with the head of the bed elevated approximately 45 degrees. An interview with Resident #26, on 8/21/24, at 8:46 a.m., revealed he/she had refused to take the Colace and did not like when the staff tried to "slip it in on him/her." Continued review of the Electronic Medical Record revealed the nursing staff had not notified Resident #26's provider of their refusals of the Colace medication. An interview with the Director of Nurses (DON), on 8/21/24, at 1:00 p.m., revealed the nurses routinely communicated with the medical provider via a "Tiger Text," which was an encrypted texting platform. He/she revealed the Tiger Text was only retrievable for approximately seven (7) days, and the DON agreed nursing staff should have documented the medication refusals in the Progress Notes per the facility policy.

	An interview with Registered Nurse (RN) B, on 8/21/24, at 1:15 p.m., revealed that anytime a resident refused a medication, the physician should be notified, because all the medications ordered were important. He/she stated the nurses should have made a note in the Progress Notes regarding a resident's refusal of medication, and a note that the provider had been notified. 2. Review of a facility policy and procedure titled, "Subcutaneous Injections," with a revised date of March 2011, revealed: "9. Spread skin tightly across injection site or pinch skin with non-dominant hand." A review of the "Profile" for Resident #27 revealed the facility had admitted the resident on 1/17/23. A review of the Quarterly MDS, dated 7/3/24, revealed the resident had the following diagnoses: Hypertension, Renal Insufficiency, Diabetes Mellitus, Hyperlipidemia, Cerebrovascular Accident, Hemiplegia, Obstructive Sleep Apnea, and Glaucoma. Continued review of the MDS revealed a BIMS of 15, which indicated the resident was cognitively intact and interviewable. An observation of a medication pass for Resident # 27, on 8/20/24, at 11:00 a.m., with LPN A revealed the nurse administered Novolog Insulin Aspart 33 units subcutaneously into the right, lower quadrant of the resident's abdomen. Upon injection, the nurse was not observed to spread the resident's skin tightly across the injection site, or pinch the skin with his/her dominant hand. An interview with the DON, on 8/21/24, at 1:00 p.m., revealed staff should have pinched the resident's skin prior to performing the subcutaneous injection. An interview with RN B, on 8/21/24, at 1:15 p.m., revealed the skin should have been pinched up prior to administering a subcutaneous injection, especially with the elderly population.