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: Veterans Home of California - Barstow

Location: 100 East Veterans Parkway, Barstow CA, 92311

Onsite / Virtual: Onsite

Dates of Survey: 3/27/23-3/30/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 180

Census on First Day of Survey: 68

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from March 27, 2023 through March 30, 2023 at the Veterans Home of California-Barstow. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes. The census on the first day of the survey was 68.
§ 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 provide an executed Sharing Agreement for medications between the facility and the VA of jurisdiction and/or the VA which is required due to the facility obtaining medications purchased from the Pharmaceutical Prime Vendor (PPV) as well as receiving reimbursement from the VA of Jurisdiction for Veterans eligible under §51.43. Based on interviews and record review, the facility is obtaining medications from the onsite pharmacy at the Veterans Home of California in Chula Vista. “AGREEMENT FOR USE OF DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE RESOURCES”, Agreement Number 36C26221S0011 effective July 17, 2021, was reviewed which reveals an agreement between the VA San Diego Healthcare System and the Veterans Home of California in Chula Vista. The Veterans Home of California in Barstow is not addressed in the document. The facility sends electronic order requests to the State Veterans Home onsite pharmacy in Chula Vista who fills the order and sends the medications through overnight mail

	back to Barstow. The SVH onsite pharmacy in Chula Vista confirms eligibility for VA to furnish medications and submits an invoice to the VA Loma Linda Health Care System. During interviews on 3/29/23 with the Consultant Staff A, Administrative Staff B, and Consultant Staff B, it was confirmed that the SVH has been actively working with the VA of jurisdiction to establish a written sharing agreement. The facility was unable to provide a written sharing agreement to meet the requirements under §51.43 to allow the State Veterans Home onsite pharmacy in Chula Vista to provide medications to the facility as well as bill the facility's VA of jurisdiction. This is a repeat finding.
§ 51.70 (c) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected –** Few	Based on record review and interview, the facility failed to ensure that a final accounting and conveyance of resident trust funds were completed upon death for two (2) of seven (7) resident trust accounts reviewed. The findings include: Review of trust account records revealed open accounts for two (2) expired residents selected for review. In an interview, on 3/29/23, at 10:40 a.m., Administrative Staff A confirmed that the conveyance of funds had not been done for any of the selected accounts within the required 90 days. The reason provided was they were required to wait for permission from the legal department of the state's Veteran's Administration.
§ 51.120 (d) Pressure sores. Based on the comprehensive assessment of a resident, the facility management must ensure that— (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. **Level of Harm** – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	Based on observations, interviews, record review, and review of facility policy, the facility failed to prevent the development of multiple pressure sores (PS) for two (2) of two (2) residents reviewed for the development of PS, (Resident #1 and Resident #2). The findings include: Review of the facility policy titled, "Wound Management and Skin Breakdown Prevention," dated 10/3/22, documented: "A Resident with pressure ulcers receives necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing. I. Responsibilities A. The Licensed Nurse will…2. Assess, measure, and document any wound on admission, PRN [as needed], and weekly…C. [Dietary Staff] Responsibilities In collaboration with the Interdisciplinary Team (IDT), the [Dietary Staff] develops nutritional goals for the resident to meet nutritional needs for wound healing. Wound Prevention and Treatment…B. Risk Identification: An individualized preventative care plan is initiated and implemented whenever the resident is identified to be at risk for

	the development of pressure injuries or at risk of any skin breakdown." In an interview with Administrative Nurse A on 3/28/23, at 2:11 p.m., they stated that the nurses that worked on the floor measured the wounds, and the Licensed Nurse that worked the floor was notified of any new wounds and should assess the resident if they developed a PS. In an interview with Licensed Nurse A on 3/29/23, at 2:15 p.m., they stated that if a resident with a PS was on their assigned Weekly Summary, then they were supposed to measure the PS. Prior to that, Administrative Nurse A and Administrative Nurse B completed the weekly PS assessment and measurements. In an interview with Administrative Nurse C, on 3/29/23, at 2:41 p.m., they stated Administrative Nurse A and the Licensed Nurse would decide what interventions to put in place for the prevention and treatment of PS. In an interview with Administrative Nurse A, on 3/30/23, at 8:30 a.m., they stated that on admission, the Licensed Nurse would do the Braden assessment. If the resident was at risk, they would initiate preventive interventions. Administrative Nurse A stated the staff should measure the PS when they find it and notify them. In an interview with Dietary Staff A, on 3/30/23, at 9:11 a.m., they stated they found out who had PS every week on Thursday, when the weekly wound rounds were completed. Dietary Staff A stated when the PS developed, they looked at the staging and the labs to see if the resident required any new interventions. 1. Review of Resident #1's clinical record listed a readmission date of [DATE], and the diagnoses included: Displaced Intertrochanteric Fracture of the Right Femur, Pain in the Right Hip, Difficulty in Walking, Dementia, and Essential Tremor. Review of Resident #1's Braden Scale, dated [DATE], listed the score of 18, with a range of 15 to 18, indicating the resident at risk for skin breakdown. Review of Resident #1's Admission Minimum Data Set (MDS) Assessment, dated [DATE], documented the Brief Interview for Mental Status (BIMS) score of nine (9), with a score of eight (8) to 12 indicating modified cognitive impairment. The resident required extensive assistance of one (1) person with bed mobility, transfers, locomotion, dressing, toilet use, personal hygiene, and bathing. The resident was at risk for the

	development of PS and had one (1) Stage two (2) PS that was not present on admission. Review of Resident #1's Care Area Assessment for PS, dated [DATE], revealed the resident had a history of an open reduction and internal fixation of the right hip after a fall on [DATE], in the [LOCATION]. Resident #1 required extensive assistance with bed mobility, transfers, locomotion, dressing, toilet use, and personal hygiene. The resident had a Stage one (1) PS to their ankle and was at risk for further breakdown. Review of the Potential for Skin Integumentary Care Plan, dated [DATE], listed the interventions: observe skin for redness, swelling, or open area and notify the physician if present; assess for signs/symptoms of breakdown weekly and as needed; keep areas of risk clean and dry. Review of the Nurses' Notes revealed: [DATE] – right heel blister, with no measurements documented [DATE] – Stage two (2) to right heel blister that measured 4 by 5 centimeters (cm) with drainage noted. [DATE] – blister to right anterior ankle and right heel [DATE] - right heel Stage two (2) which measured 1 by 0.6 cm. The clinical record lacked weekly measurements or measurements when the PS were first observed. Review of Resident #1's Physician Orders, dated [DATE], revealed and order for a heel protector on the right heel and to float the heel to always keep pressure off the heel every shift and wound care to the right anterior ankle blister and the right heel blister. Review of the laboratory results, dated [DATE], revealed: a low total protein level of 5.7 milligrams per deciliter (mg/dl) with a normal range of 6.4 to 8.9 mg/dl and a low albumin level of 3.1 mg/dl with a normal range of 3.5 to 5.7 mg/dl. Review of Dietary Staff A's notes revealed Resident #1 was not evaluated after the development of the PS on [DATE], until [DATE]. Review of Dietary Staff A's Progress Note, dated [DATE], documented the resident had blisters to the right anterior ankle and the right heel, and Dietary Staff A would continue to monitor and provide nutrition interventions as needed. Observation, on 3/29/23, at 9:18 a.m., revealed Resident #1 sat in a wheelchair in the hallway with the right foot in a lambs' wool cushion boot.

	Observation of Resident #1, on 3/29/23, at 10:00 a.m., with Administrative Nurse A revealed the right anterior ankle PS measured 0.1 by 0.2 cm and the right heel measured 0.5 by 0.7 cm. In an interview with Administrative Nurse A, on 3/29/23, at 10:12 a.m., they stated the PS to the right anterior ankle was caused by the strap of the boot. Resident #1 at that time stated they thought the PS on the right heel came from their heel sliding up and down the mattress. Observation, on 3/29/23, at 2:12 p.m., revealed Resident #1 lying in bed and their legs off the pillow and laying directly on the bed. During an interview with Administrative Nurse C, on 3/29/23, at 2:41 p.m., they stated the staff should apply heel boots on both heels to prevent additional PS. In an interview with Administrative Nurse A, on 3/30/23, at 8:30 a.m., they stated the staff educated the resident to turn and reposition. They stated the resident only used one (1) heel protector because they used the other foot to transfer. In an interview with Dietary Staff A, on 3/30/23, at 9:11 a.m., they stated they had not seen Resident #1 since they developed the PS. Dietary Staff A stated the resident definitely needed a supplement for the treatment of the PS. 2. Review of Resident #2's clinical record revealed an admission date of [DATE], and the diagnoses included: [DIAGNOSIS], Cerebrovascular (CV) Disease, Hemiplegia following CV Disease and Major Depressive Disorder. Review of Resident #2's Braden Scale, dated [DATE], scored the resident at a 17, with a range of 15 to 18 placing the resident at risk for skin breakdown. Review of a right ankle x-ray, dated [DATE], revealed Resident #2 sustained a displaced transverse fracture of the medial malleolus, displaced oblique fracture of the distal fibula, fracture along the distal posterior aspect of the tibia and disruption of the ankle mortise. Review of Resident #2's Significant Change MDS Assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, with a score of 13 to 15 indicating intact cognition. The MDS documented the resident required extensive assistance of two (2) people with bed mobility and required extensive assistance of one (1) person with transfers,

	dressing, toileting, personal hygiene, and bathing. The resident was at risk for the development of PS and did not have a PS. Review of the Care Plan, dated [DATE], revealed that it lacked interventions for the prevention of PS development. Review of the Physician's Progress Note, dated [DATE], documented the resident had a right heel blister that measured 4 by 5 cm. The blister was starting to have a blackish discoloration in the middle. Review of the Physician's Progress Note, dated [DATE], documented the resident had multiple wounds secondary to bandage/splint. Review of Resident #2's Care Plan, dated [DATE], (after the development of the PS's) included the interventions: document size, location, and condition of wounds at least weekly, treatment as ordered, elevate affected area, and keep pressure off, diet as ordered, and educate resident about importance of floating heel/foot so there were no pressure areas. Review of the Physician Orders revealed: [DATE] – "to the right heel, clean with normal saline, paint with betadine every day and place foam on the heel and may secure with Kerlix." [DATE] – "to the right anterior great toe, clean with normal saline, paint with betadine every day and cover with foam dressing." [DATE] – "to the right anterior ankle, clean with normal saline, and cover with foam dressing every day." Review of the Nurses' Notes for Resident #2 revealed: [DATE] – Stage two (2) blister to the right upper heel which measured 4 by 5 cm, and 1.5 by 1.0 cm wound to the right great toe. [DATE] – area to left heel (mistake for right) 3.5 by 4 cm and 1.5 by 1 cm blister to the right great toe. [DATE] – area to right heel measured 6 by 7 cm, suspected deep tissue injury (SDTI), three (3) areas to the right ankle measuring, 0.6 by 0.8, 0.4 by 0.9, and 0.2 by 1.9 cm, and right anterior toe that measured 1.2 by 1 cm. [DATE] – area to right heel measured 3.9 by 4.6 cm, right anterior ankle measured 0.2 by 0.5 and 0.6 by 0.6 cm, right great toe measured 1.2 by 0.9 cm, and new wound to the right lateral foot SDTI which measured 4.5 by 3.1 cm. [DATE] – area to right heel measured 3.4 by 4.5 cm, right lateral foot measured 4.5 by 3.4 cm, right great toe measured 0.3 by 0.3 cm and right anterior ankle measured 0.3 by 0.4 cm.

	[DATE] – area to right anterior ankle measured 0.9 by 0.6 cm, right great toe measured 0.3 by 0.3 cm, right lateral foot measured 4.2 by 3.0 cm, and right heel measured 5.5 by 5.5 cm. [DATE] – area to right lateral foot measured 4 by 3 cm, right heel measured 3.6 by 4.5 cm and area to right great toe was resolved. There was no documentation regarding the right anterior ankle. [DATE] – area to right lateral foot measured 4 by 3 cm, right heel measured 3.6 by 4.5 cm. The facility failed to assess the wounds on a weekly basis from [DATE], to [DATE]. Review of Dietary Staff A's Nutrition Notes revealed the last assessment was completed on [DATE]. The resident was on a regular, self-select diet. Dietary Staff A recommended the resident eat more fruit and vegetables, avoid sweets, and drink more water. Dietary Staff A documented the resident's skin was intact. Observation of Resident #2, on 3/27/23, at 12:10 p.m., revealed the resident sat in the motorized wheelchair with their right foot in a walking boot. In an interview with Resident #2, on 3/27/23, at 12:10 p.m., they stated they had a blood blister on their right foot from just laying on it, or from the position of the right foot when sitting. In an interview with Administrative Nurse A, on 3/29/23, at 9:05 a.m., they stated the resident saw the podiatrist the day before, who did not want staff to remove the dressing and wanted to see Resident #2 later that day. In an interview with Resident #2, on 3/29/23, at 9:15 a.m., they stated the day prior the Podiatrist trimmed the blood blister and wanted the resident to see them the next day. In an interview with Dietary Staff A, on 3/30/23, at 9:11 a.m., they stated they had not seen Resident #2 since they developed PS.
§ 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.	Based on observation, interview, and record review, the facility did not administer medications without error for one (1) of five (5) residents observed (Resident #15). Observation included 27 opportunities. The findings include: Observation during the medication pass, on 3/28/23, at 8:05 a.m., revealed Licensed Nurse B prepared Resident #15's

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	medications (consisting of 16 pills/capsules) and placed them in a medication cup. Licensed Nurse B handed the medication cup to the resident who put the cup up to their mouth and took in an undisclosed amount of pills/capsules. When handing the cup to Licensed Nurse B, the cup fell, and multiple pills came out of the medication cup. Licensed Nurse B picked up two (2) pills from between the resident's legs and one (1) pill from on the floor in front of Resident #15's wheelchair and placed them into the medication cup and left the room. Licensed Nurse B did not look further on the floor, such as under the bed, the chair, or the plastic drawers on rolling casters. Resident #15 then left the facility for an appointment on 3/28/23, after the medication pass. Licensed Nurse B notified the physician and received an order to administer the medications when the resident returned to the facility. Licensed Nurse B replaced each of the medications that were left in the medication cup with new medications and administered them to Resident #15 on 3/28/23, at 12:39 p.m. On 3/28/23, at 2:35 p.m., the surveyor went to Resident #15's room and looked under the plastic rolling cart and found a pill and notified Licensed Nurse B. They identified the pill as Eliquis (blood thinner) and noted the Eliquis was again assigned to be given at 5:00 p.m., and notified the physician, who gave an order to hold the Eliquis. In an interview with Licensed Nurse C, on 3/29/23, at 2:22 p.m., they stated the staff, if medication drops, should look around the floor and under items for any missed medications.
§ 51.120 (g) Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility management must ensure that a resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, and record review, it was determined the facility failed to ensure psychiatric services were provided to a resident who had a diagnosis of Depression and exhibited aggressive behaviors toward others. This failure affected one (1) of 15 sampled residents. (Resident #8) The findings include: Resident #8 was admitted to the facility on [DATE], with diagnoses that included Major Depression. The most recent Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) that coded the resident as having a score of 10, which indicated moderately impaired cognition. The MDS also indicated the resident was

	independent with activities of daily living and that the resident had no behaviors in the seven (7) day look back period. Review of the Care Plan, dated [DATE], and updated [DATE], documented under "Problems/Concerns," that the resident had behaviors which included angry outbursts toward staff with verbal aggression. The resident also had a history of physical aggression toward a roommate. The goal listed was for the behaviors to decrease. Interventions listed were to provide psychosocial assessments quarterly, educate about appropriate conduct, staff to approach calmly without judgement, remind resident to use non-threatening language to express themselves, refer to Consultant Staff A for assistance. Review of the medical record revealed a psychological consult, dated [DATE], which documented Resident #8 having been seen for recurrent Major Depression and Anxiety. The evaluation documented the resident was impulsive with neurocognitive disorder and had increase in agitation and irritability. This was the last evaluation by a psychologist in the medical record. Review of the Nursing Progress Note, dated [DATE], documented that Resident #8 had occasional episodes of verbal aggression toward others, but if given time and space to express themselves, they would calm down. The note documented the resident had no episodes of physical aggression. Review of the Physician Orders revealed an order, dated [DATE], which documented: "Referral to LLVA [Loma Linda Veterans Administration] psych mental health regarding depression/anxiety/ and medication management. I am concerned about this problem: Patient resides in our facility, [they] at this time [are] not established with psychiatry, [they are] currently prescribed citalopram(antidepressant) daily and Zanax (antianxiety) daily and donepezil (anti Alzheimer's) daily. [They] also becomes very agitated, accusatory of staff, and [have] delusional thinking of suspicious people/paranoia. Please evaluate for medical management." On 3/27/23, at 10:45 a.m., in an interview with Licensed Nurse C during the initial tour, they stated that Resident #8 hadn't been to psychological services since [DATE], when the psychologists they went to stopped working with the facility. They stated the resident might benefit from psych visits due to verbal outbursts and refusing treatments, but the facility had no one to send them to. On 3/30/23, at 11:15 a.m., in an interview with Licensed Nurse D, they stated that they were not able to provide psych services

	in the facility because there was no contract, but now they had a new contract as of this week. Licensed Nurse D wrote an order for a psych consult on [DATE]. On 3/30/23, at 11:30 a.m., in an interview with Administrative Staff B, they stated that often times Resident #8 would refuse psychological services and felt it wasn't for them. They stated that Consultant Staff A worked with them a lot and tried to keep them calm. They stated that Resident #8 would sometimes have the appearance of "glassy eyes," and then it was difficult to know what you would get from them. On 3/30/23, at 12:00 noon, in an interview with Consultant Staff B, they stated that Resident #8 would often refuse appointments and medications. They commented that the resident was very non-compliant. They stated that you can usually calm them down. They believed the resident would probably not go to the psych eval appointment.
§ 51.190 (a) Infection control program. The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection control program. The facility management must establish an infection control program under which it— (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, record review, and review of facility policy, the facility failed to provide care using infection control techniques for two (2) residents during medication administration (Resident #14, Resident #15). The findings include: Review of the facility policy titled, "Cleaning and Disinfecting Resident Equipment," dated 7/27/22, documented: "Procedure, A. Standard Precautions: All Resident and their equipment will be handled with 'Standard Precautions.' In the event Transmission-Based Precautions are recommended, they will be used in addition to Standard Precautions. Examples of Transmission-Based Precautions are 'Contact'... E. Nursing Personnel: Non-critical Resident equipment will be wiped down by nursing personnel, with disinfectant, after each use and if they become contaminated." Observation, on 3/28/23, at 8:05 a.m., during medication administration revealed Licensed Nurse B administered Systane Ophthalmic Eye Drops (used to treat dry eyes) to Resident #15. Observation revealed Licensed Nurse B used their first and second finger to open the resident's eyes and instilled one (1) drop into each eye. Licensed Nurse B did not wear gloves when they administered the eye drops. Observation, on 3/29/23, at 11:05 a.m., revealed Licensed Nurse C checked Resident #14's blood sugar. Observation revealed Licensed Nurse C took the glucometer machine and case into the resident's room and placed them on Resident #14's furniture without placing a barrier down. When exiting the

	room, Licensed Nurse C used a sanitization wipe to cleanse the glucometer, but did not clean the glucometer case. In an interview with Licensed Nurse C, on 3/29/23, at 2:22 p.m., they stated the staff should wear gloves when administering eye drops, if they used their hands to open the resident's eyes. Licensed Nurse C also stated the staff should cleanse the glucometer case since the nurse did not place the equipment on a barrier.
§51.200(a) Life safety from fire (a) The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	**<u>Smoke Barriers and Sprinklers</u>** Based on observation and interview, the facility failed to maintain the corridor doors to resist the passage of smoke. The deficient practice affected two (2) of 16 smoke compartments, staff, and 20 residents. The facility had a capacity for 180 beds with a census of 68 on the day of the survey. The findings include: Observation during the building inspection tour, on 3/29/23, at 2:15 p.m., revealed that the corridor doors adjacent to [LOCATION] would not stay latched and closed when a gentle pressure was applied to the latch edge of the door, as required by section 19.3.6.3.5 of NFPA 101, Life Safety Code. An interview, on 03/29/23, at 2:15 p.m., with Maintenance Staff A revealed that the facility was not aware that corridor doors would not stay closed. The census of 68 was verified by Administrative Staff C on 3/27/23, at 9:00 a.m. The findings were acknowledged by Administrative Staff C and verified by Maintenance Staff A during the exit interview on 3/30/23, at 3:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.6.3*** Corridor Doors. **19.3.6.3.1*** Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 13⁄4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes **19.3.6.3.2** The requirements of 19.3.6.3.1 shall not apply where otherwise permitted by either of the following: (1) Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials shall not be required to comply with 19.3.6.3.1. (2) In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance

	with 19.3.5.7, the door construction materials requirements of **19.3.6.3.1** shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. **19.3.6.3.3** Compliance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, shall not be required. **19.3.6.3.4** A clearance between the bottom of the door and the floor covering not exceeding 1 in. (25 mm) shall be permitted for corridor doors. **19.3.6.3.5*** Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. (2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7.
§ 51.210 (h) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section. (2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. (3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed services and will notify the veteran or the authorized representative of the veteran.	Based on record review and interview, the facility's management failed to obtain a sharing agreement that governed mental health services provided to 16 residents by the Veterans Administration Medical center (VAMC). The findings included: Review of Administrative documents provided by the facility did not identify a sharing agreement with the VAMC to cover residents who received mental health services. From the start of the survey, on 3/27/23, the survey team made daily requests for a list of residents who received mental health services from the VAMC. A list of 16 nursing home residents was provided on 3/29/23. In an interview, on 3/30/23, at 11:15 a.m., Administrative Staff C replaced the list of residents who received mental health services from the VAMC, provided on 3/29/23, with a new list which indicated services were being provided by a source other than the VAMC and reported that the facility had entered into a verbal agreement, on 3/27/23, with the private provider.

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	