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: Georgia War Veterans Nursing Home

Location: 1101 Fifteenth Street Augusta, GA 30901-3196

Onsite / Virtual: Virtual

Dates of Survey: 9/5/23 – 9/8/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 192

Census on First Day of Survey: 123

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from September 5, 2023 through September 8, 2023 at the Georgia War Veterans Nursing Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.70 (e) (1) – (3) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. (1) Residents have a right to personal privacy in their accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility management to give a private room to each resident. (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident's right to refuse release of personal and clinical records does	Based on observation, interview, record review, and policy review, the facility failed to provide privacy for one (1) of 11 residents observed during care. Resident #5 was exposed from the waist down during the provision of care to a suprapubic catheter inserted into their bladder through the abdomen. The findings include: The facility policy titled, "Privacy," revised January, 2022 stated: "1. GENERAL b. All staff are expected to respect each resident's privacy by: … iv. Ensuring that residents are decently covered at all times." Record review revealed Resident #5 was readmitted to the facility on [DATE], and diagnoses included Non-Alzheimer's Dementia, Neurogenic Bladder, and [DIAGNOSIS]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #5 had a Brief Interview for

not apply when— (i) The resident is transferred to another health care institution; or (ii) Record release is required by law. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The resident was independent with set-up assistance for bed mobility, locomotion, eating, and toilet use, and they required staff supervision for transfers, dressing, and personal hygiene. The MDS also indicated Resident #5 had an indwelling urinary catheter. Review of Resident #5's Physician Orders revealed the following order, dated [DATE]: "Urinary Catheter Care every shift." Observation during the care of Resident #5's suprapubic catheter, at 9:30 a.m., on 9/6/23, in the presence of Administrative Nurse A, found Certified Nurse Aide A began by folding down Resident #5's bed linens and incontinence brief, unnecessarily exposing the resident's genitalia and upper thighs. Resident #5 remained exposed in this manner throughout the entire procedure. During an interview, at 11:39 a.m., on 9/7/23, when asked how much of a resident should be exposed during routine care of a suprapubic catheter, Licensed Nurse A stated, "I would cover the lower half of the body – just exposing that center area where that catheter is inserted." When informed that Resident #5 was exposed from above the catheter's insertion site in the abdomen to mid-thigh during the entire procedure, Licensed Nurse A agreed this amount of exposure was not necessary to perform the procedure. During an interview, at 4:11 p.m., on 9/7/23, Administrative Nurse B confirmed that this unnecessary exposure should not have occurred.
§ 51.100 (a) Dignity. (a) Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, record review, and policy review, the facility failed to provide care in a manner to enhance each resident's dignity, when staff wrote the date, time, and initials on dressings after they were applied to two (2) of 11 sampled residents (Resident #5 and Resident #6). The findings include: The facility's policy titled, "Wound Care," revised November, 2022 stated: "PROCEDURE…11. After completing the dressing change, remove gloves and wash your hands. 12. Write the date, time, and nurse's initials on the new dressing." 1. Record review revealed Resident #5 was readmitted to the facility on [DATE], and diagnoses included Non-Alzheimer's Dementia, Neurogenic Bladder, and [DIAGNOSIS].

	Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The resident was independent with set-up assistance for bed mobility, locomotion, eating, and toilet use, and they required staff supervision for transfers, dressing, and personal hygiene. The MDS also indicated Resident #5 had an indwelling urinary catheter. Review of Resident #5's Physician Orders revealed the following orders, dated [DATE]: • "Urinary Catheter Care every shift" • "Apply gauze around suprapubic catheter clean to reduce chance of infection every day shift" [sic] Observation of routine catheter care to Resident #5's suprapubic catheter by Certified Nurse Aide A began at 9:30 a.m., on 9/6/23, in the presence of Administrative Nurse A. After providing catheter care, Certified Nurse Aide A affixed a pad of split gauze around the catheter tubing at the insertion site with three (3) pieces of tape – one (1) piece of tape across the top of the gauze and one (1) piece of tape along each side of the gauze. After Certified Nurse Aide A applied the last piece of tape, they recalled the need to date and initial the dressing, but did not have a pen with which to write. Administrative Nurse A offered Certified Nurse Aide A a pen and directed them to write the date and initials on a piece of the tape that had already been applied to the resident. During an interview, at 11:39 a.m., on 9/7/23, when asked how the dressing over the insertion site should be labeled, Licensed Nurse A stated, "I would recommend putting the date and initials on a piece of tape before putting it on the gauze." 2. Record review revealed Resident #6 was readmitted to the facility on [DATE], and diagnoses included Non-Alzheimer's Dementia. Review of the Quarterly MDS, dated [DATE], revealed Resident #6 had a BIMS score of seven (7), which indicated severely impaired cognition. The resident was independent with bed mobility and locomotion on the unit in their wheelchair, required the extensive assistance of one (1) person with dressing and bathing, and was totally dependent on one (1) person with toilet use and personal hygiene. The MDS also noted the presence of one (1) Stage 4 pressure ulcer and two (2) pressure ulcers that were unstageable due to coverage of the wound bed by slough and/or eschar.

	Review of Resident #6's Physician Orders revealed the following order, dated [DATE]: "Keep left lateral malleolus free of significant pressure (keep objects/items other than dressing from wounds, clean with saline, apply Calcium alginate and dry dressing daily every day shift for Left ankle wound" [sic]. Observation of a treatment to Resident #6's left lateral malleolus by Licensed Nurse B began at 1:57 p.m. on 9/5/23, in the presence of Administrative Nurse A. After cleansing the wound and applying the calcium alginate, Licensed Nurse B covered the calcium alginate with a dressing. Licensed Nurse B then used a pen to write the date/time and their initials on the dressing after it had been applied to the resident. During an interview, at 4:14 p.m., on 9/7/23, Administrative Nurse B confirmed that staff should not have written on a dressing after it had been applied to the resident, and stated this was a "dignity issue." When informed that the facility's Wound Care policy and procedure directed staff to date and initial a dressing after it was applied to a resident, Administrative Nurse B stated the policy would be revised.
§ 51.110 (c) Accuracy of assessments. (1) Coordination— (i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals. (ii) Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment. (2) Certification. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	Based on interviews, record review, and review of facility policy, the facility failed to complete accurate Minimum Data Set (MDS) Assessments for four (4) of 14 residents reviewed (Resident #6, Resident #9, Resident #10, Resident #11). The findings include: Review of the facility policy titled, "MDS-Minimum Data Set," dated 1/22, found documented: "Purpose To provide guidelines for use of the MDS (Minimum Data Set) for a comprehensive assessment of each resident. Policy MDS 3.0 provides a core set of screening, clinical and functional status elements which forms the comprehensive assessment for each resident. 2. Data from the MDS will be used to monitor the quality of care provided to nursing home residents." 1. Observation in the [LOCATION] in the company of Administrative Nurse A, during lunch on 9/6/23, at approximately 12:01 p.m., found Resident #6 began to feed themselves after their meal tray was delivered and set-up by staff. Record review revealed Resident #6 was readmitted to the facility on [DATE], and diagnoses included Non-Alzheimer's Dementia. Review of the Quarterly MDS, dated [DATE], revealed Resident #6 had a BIMS score of seven (7), which indicated severely

	impaired cognition. The resident was independent with bed mobility and locomotion on the unit in their wheelchair, required the extensive assistance of one (1) person with dressing and bathing, and was totally dependent on one (1) person with toilet use and personal hygiene. The MDS also indicated Resident #6 was totally dependent on one (1) person for eating. Review of the preceding Quarterly MDS assessments, dated [DATE], and [DATE], also found Resident #6 was totally dependent on one (1) person for eating. Review of Resident #6's Annual MDS, dated [DATE], found that Resident #6 was independent with eating with set-up help only. Review of documentation entered in Resident #6's electronic health record by direct care staff, during the lookback periods for both the [DATE] MDS and the [DATE] MDS, showed Resident #6 was independent with eating. During an interview beginning at 9:30 a.m., on 9/8/23, regarding Resident #6's self-performance of activities of daily living, Administrative Nurse A reported Resident #6 was independent with eating. When informed that Resident #6's MDS, dated [DATE], stated the resident was totally dependent on staff for eating, Administrative Nurse A stated, "We just set the tray up." Administrative Nurse A then left the room to consult with Administrative Staff A. At 10:00 a.m., on 9/8/23, Administrative Nurse A reported, "They said that was an error. They are correcting it now." The surveyor then informed Administrative Nurse A that the [DATE] MDS and [DATE] MDS were also coded to indicate the resident was dependent with eating. Administrative Nurse A conveyed this information to Administrative Staff A. 2. Review of Resident #9's clinical record listed an admission date of [DATE], and the diagnoses included: Hemiplegia and Hemiparesis following Cerebral Vascular Accident (CVA), Epilepsy, and Congestive Heart Failure (CHF). Resident #9's Quarterly MDS, dated [DATE], under Section M, question M0100 did not answer the question "Resident has a stage 1 [one] or greater, a scar over bony prominence, or a non-removable dressing/device" as a "yes." Further review revealed the staff documented the resident had five (5) Stage two (2) pressure ulcers (PU) and one (1) unstageable PU. Review of the "Skin and Wound Evaluation" revealed the resident had PUs to the right great toe, right posterior heel, left great toe, and right heel. Further review revealed on [DATE], the resident continued to have the PUs to the right great toe,

	right posterior heel, left great toe, and right heel, along with a PU to the buttock. In an interview with Administrative Staff B and C, on 9/7/23, at 10:00 a.m., they stated Resident #9's MDS was inaccurate; the facility should have documented the resident had a Stage one (1) or greater PU. 3. Review of Resident #10's clinical record listed a readmission date of [DATE], and the diagnoses included: Alzheimer's Disease, Congestive Heart Failure, and Chronic Kidney Disease Stage Three (3). Review of Resident #10's Quarterly MDS, dated [DATE], documented the resident had one (1) fall with no injury, one (1) fall with injury but not a major injury, and one (1) fall with a major injury. Review of Resident #10's clinical record lacked evidence the resident sustained those three (3) falls. Review of Resident #10's Annual MDS, dated [DATE], documented the resident had one fall with injury but not a major injury fall. In an interview with Administrative Staff B and C, on 9/7/23, at 10:00 a.m., they stated Resident #10's MDSs, dated [DATE] and [DATE], were inaccurate. The resident had not experienced the falls that were listed on the MDSs. 4. Review of Resident #11's clinical record listed an admission date of [DATE], and the diagnoses included: Parkinson's Disease, Dementia, and Epilepsy. Review of Resident #11's Quarterly MDS, dated [DATE], documented under section P the resident utilized a floor mat alarm. Observation, on 9/6/23, at 2:17 p.m., revealed Resident #11 lying in bed on their back. The resident had floor mats on both sides of the bed. The floor mats were not the alarm type. In an interview with Administrative Nurse C, on 9/6/23, at 2:18 p.m., they stated the floor mats did not alarm. In an interview with Administrative Staff B and C, on 9/7/23, at 10:00 a.m., they stated Resident #11's MDS, dated [DATE], was inaccurate.

§ 51.110 (e) (1) Comprehensive care plans. (1) The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following— (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §51.120; and (ii) Any services that would otherwise be required under §51.120 of this part but are not provided due to the resident's exercise of rights under §51.70, including the right to refuse treatment under §51.70(b)(4) of this part. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interviews, record review, and review of facility policy, the facility failed to develop a comprehensive Care Plan for one (1) of 14 residents (Resident #10). The findings include: Review of facility policy titled, "Resident Care Plan," dated 1/22, documented: "Policy Care plans are formatted from the basis of the Medical Director's written orders and CAAS [Care Area Assessments] analysis of the MDS 3.0 (Minimum) Data Set) information. 3. Care plans will be updated as needed by the interdisciplinary care team members." Review of Resident #10's clinical record listed the readmission date of [DATE], and the diagnoses included: Alzheimer's Disease, Congestive Heart Failure, and Chronic Kidney Disease, Stage Three (3). Review of Resident #10's Physician Orders listed an order, dated [DATE], for Oxygen (O2) as needed at two (2) liters (L) per minute (/min) via nasal cannula (nc) and titrate to maintain O2 saturation (sat) greater than 92 percent. Review of the Care Plan, dated [DATE], lacked interventions for the use of the O2. Observation, on 9/5/23, at 10:23 a.m., revealed Resident #10 sitting in a wheelchair in the [LOCATION] with O2 at three (3) L/min via nc, and they used a concentrator. Further observation revealed the tubing was not labelled as to when staff changed the tubing. Observation, on 9/7/23, at 2:17 p.m., revealed Resident #10 lying in bed with O2 in place at three (3) L/min. Further observation revealed the O2 tubing was unlabeled as to when staff changed the O2 tubing. In an interview with Administrative Staff B and C, on 9/7/23, at 10:00 a.m., they stated they were responsible for the Care Plan that would address O2 use and confirmed the Care Plan did not address Resident #10's use of oxygen.
§ 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.	Based on observation, interview, record review, and policy review, the facility failed to provide nail care for one (1) of 11 sampled residents who was dependent on staff for personal hygiene (Resident #4). The findings include: The facility policy titled, "Bathing a Resident – Bed Bath," revised February, 2023 stated:

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	"PROCEDURE …4. Shave resident, apply lotion to skin, brush hair, trim nails, and provide oral care. Request a podiatrist if toenails are difficult to care for." Record review revealed Resident #4 was admitted to the facility on [DATE], and diagnoses included: Cerebrovascular Accident with Hemiplegia, Chronic Kidney Disease, and Vascular Dementia. Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #4 was unable to participate in a Brief Interview for Mental Status (BIMS), and their cognitive skills for daily decision-making were assessed to be moderately impaired. The resident required total assistance from one (1) or more persons for all activities of daily living, including bed mobility, transfers, dressing, bathing, and personal hygiene. Observation of treatments to Resident #4's feet by Licensed Nurse C, with the assistance of Licensed Nurse B, began at 11:00 a.m., on 9/6/23. Administrative Nurse A was also present during the treatments. As Licensed Nurse C was cleansing a wound at the base of the fifth metatarsal of Resident #4's left lateral foot, observation found the nails on several of the resident's toes were thick, elongated, and extended past the tips of the toes. During an interview, at 11:26 a.m., on 9/6/23, Administrative Nurse A agreed that at least three (3) toenails on Resident #4's left foot were excessively long and extended past the tips of their toes. When asked about toenail trimming, Administrative Nurse A stated that residents with foot wounds had their nails trimmed by the podiatrist. When asked about podiatric services, Administrative Nurse A stated the podiatrist saw residents every three (3) months. Administrative Nurse A reviewed the resident's electronic health record and reported that they were last seen by the podiatrist in [DATE] and that they would not be seen again by the podiatrist until [DATE]. During a subsequent interview, at 9:20 a.m., on 9/8/23, Administrative Nurse A reported that Resident #4 may not have been seen by the podiatrist in [DATE] because they were in the hospital during that time frame.
§ 51.120 (i) Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and	Based on observation, interviews, record review, and review of facility policy, the facility failed to provide interventions to prevent falls for one (1) of four (4) residents reviewed for falls (Resident #11). The findings include:

(2) Each resident receives adequate supervision and assistance devices to prevent accidents. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Review of the facility policy titled, "Fall Prevention Subcommittee," dated 2/21, documented: "The Safety Program is designed to reduce safety hazards and establish an environment that reduces the risk of injury for all residents. Residents admitted to our facility are inherently at risk for falls due to their multiple diagnoses, advanced age, and/or cognitive decline. The Safety Committee has formed an interdisciplinary Fall Risk Subcommittee to address these risks, review all falls, and provide interventions for those residents at high risk for falls and for those residents with frequent falls. The Safety Committee will oversee the Fall Risk Subcommittee, provide guidance, make recommendations, and advise as appropriate. The Subcommittee will provide a monthly report of activities to the Safety Committee. The subcommittee will: 1. Meet weekly 2. Review those residents of the Resident Care Conference list the week prior to their conference date. The subcommittee will review those residents for: a. Fall Risk Assessments b. Alarms c. Restraints 3. Review Resident Injury Report of falls from the preceding week 4. Make recommendations, as appropriate, for interventions to decrease the probability of additional falls, and/or to decrease injury related to falls 5. Review current interventions in place for effectiveness 6. Document interventions in each resident's chart, as appropriate." Review of Resident #11's clinical record listed an admission date of [DATE], and the diagnoses included: Parkinson's Disease, Dementia, Age Related Physical Debility, and Epilepsy. Review of Resident #11's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident had short and long-term memory problems, had severely impaired decision-making skills, exhibited inattention and disorganized thinking continuously and did not fluctuate, and wandered daily. The MDS documented the resident was independent with bed mobility, transfers, walking, and locomotion around the unit. The resident was totally dependent on one (1) person for toilet use, personal hygiene, and bathing. Resident #11 was not steady, but able to stabilize without staff assistance when moving from a seated to standing position, walking and surface to surface transfers. The activity of turning around and facing the opposite direction while walking and moving on and off the toilet did not occur. Resident #11 did not use a mobility device and had two (2) or more no injury falls and one injury fall, but not a major injury fall since the last assessment completed on [DATE]. The MDS documented the resident did not receive therapy or restorative services and had a bed and chair alarm, floor mat alarm, and a wander alarm daily. Review of Resident #11's Care Plan for falls, initiated [DATE], included the interventions: bed alarm and hipsters, chair alarm

	added [DATE], treaded socks (hospital type non-skid socks), and low bed. The surveyor asked for the investigations of the falls, but was told the investigations would not be shared. Review of the Nurses' Notes and Fall Committee Notes revealed the following 22 falls since [DATE]: [DATE], at 5:30 a.m. – Certified Nurse Aide reported the resident got out of bed and stumbled backward onto their buttocks. Skin tear noted to right elbow. No new interventions added. [DATE], at 3:50 a.m. – resident found on floor in the [LOCATION]. No injury documented and no new intervention added. [DATE], at 2:45 p.m. – staff witnessed the resident fall in the [LOCATION]. No injury noted and no new interventions documented. [DATE], at 7:30 p.m. – staff found the resident on the floor between A and B bed. No injury noted and staff added floor mats to beside the bed on [DATE]. [DATE], at 3:39 p.m. – staff found the resident in another resident's room on the floor. No injury noted and no interventions added. [DATE], at 9:04 a.m. – resident had a witnessed fall. Staff stated the resident was walking and tripped after they got their foot caught in one (1) of the chair legs. No injuries noted and no additional interventions initiated. [DATE], at 5:30 p.m. – staff found the resident on the floor in the [LOCATION]. No injury noted and the physician discontinued the resident's Risperidone (antipsychotic) increased the Sinemet (used to treat symptoms of Parkinson's Disease) to three (3) times per day and started the resident on Seroquel (antipsychotic) 50 milligrams (mg) two (2) times per day. [DATE], at 7:24 a.m. – resident woke up and got up too fast and lost their balance. No injury noted and no new intervention added. [DATE], at 4:45 p.m. – fall witnessed by Certified Nurse Aide in another resident's room. No injury noted and no intervention added.

	[DATE], at 8:29 a.m. – staff observed the resident get up from a chair and the resident started stumbling backwards and fell, resident hit their back on a chair. No injury and no new intervention added. [DATE], at 8:42 a.m. – Certified Nurse Aide informed the nurse that the resident got up, attempted to turn, and fell back onto a table hitting their head. Skin tear noted to the left elbow. The facility initiated the use of a helmet. [DATE], at 5:30 p.m. – staff notified the nurse that the resident was on the floor in the [LOCATION]. A skin tear was noted to the right hand. No new intervention attempted. [DATE], at 5:45 a.m. – as nurse was entering the room, the resident was sliding to the floor. A skin tear to the right hand was noted. No new intervention attempted. [DATE], at 2:48 p.m. – staff heard a thud and observed the resident lying across the base of the overbed table that they had been pushing about the unit. Staff noted a bluish discoloration to the right, upper thigh. No new intervention attempted. [DATE], at 12:35 p.m. – staff found the resident on the floor with a skin tear to the left forearm. No new intervention attempted. [DATE], at 7:30 a.m. – resident had a fall and no injury or intervention attempted. [DATE], no time – resident had a fall, and the intervention was to remove their shoes; the resident either trips over them or tries to take them off. [DATE], at 8:53 a.m. – the resident fell backwards in the [LOCATION]. Staff to provide redirection. On [DATE], the resident was transferred to the hospital and x-ray revealed a fractured fifth finger. The resident returned to the facility on [DATE], with a soft cast to the right hand and arm. [DATE], at 5:00 p.m. – the resident had a fall with no injury noted. Staff did not add any new interventions. [DATE], at 9:59 a.m. – resident had a fall with no injury. Staff to redirect the resident. [DATE], at 8:54 a.m. – the resident was walking in the hallway and fell. No injury noted and no new intervention attempted. The physician increased the dose of Seroquel from two (2) times a day to three (3) times per day.

	[DATE], at 3:33 p.m. – several staff observed the resident in the [LOCATION] get out of their chair, try to stand up, and fall. Staff placed the resident in a Juditha chair (tilt wheelchair) and made a Physical and Occupational Therapy (PT and OT) referral. Review of the Provider Note, dated [DATE], at 4:33 p.m., documented: "will get [resident] to work with PT/OT for deconditioning secondary to recent isolation precautions will also have a wheelchair alarm." The wheelchair alarm was already in place. Observation, on 9/26/23, at 10:26 a.m., revealed Resident #11 sitting in a tilt chair with Hoyer lift sling under them in their room. The resident had a helmet and treaded socks on. The surveyor asked Administrative Nurse C if the resident had their alarm on. Administrative Nurse C was unable to find the wheelchair alarm. Administrative Nurse C left the room and came back with a clip alarm and attached it to the resident's left shoulder. During an observation, on 9/6/23, at 2:17 p.m., with Administrative Nurse C, they confirmed Resident #11 had floor mats on the floor on each side of the bed, but the floor mats were not alarmed as documented on the MDS. During an interview with Consultant Staff A, on 9/7/23, at 1:34 p.m., they stated, they were the Fall Committee Chairperson. They stated the Fall Committee met each week and discussed the falls that had occurred since the previous meeting. Consultant Staff A stated the committee reviewed the investigation of the fall and what interventions were put in place. Consultant Staff A stated the committee consisted of themselves, Consultant Staff B, Administrative Nurse D, activity staff, restorative staff, Consultant Staff C and Administrative Staff B and C. Consultant Staff A also stated they were not working with the resident and had not seen the Provider Note requesting Consultant Staff A to work with the resident. In an interview with Certified Nurse Aide B, on 9/8/23, at 9:37 a.m., they stated that for the prevention of falls, the resident had a bed alarm, helmet, treaded socks, and used hipsters. Certified Nurse Aide B also stated the resident no longer walked or stood, and staff used the Hoyer lift to transfer the resident. In an interview with Administrative Nurse C, on 9/8/23, at 9:39 a.m., they stated the resident's cause of falls were Parkinson's Disease and Dementia. Administrative Nurse C also stated the licensed nurses were responsible to see if the interventions were in place for the resident.
§ 51.120 (l) Special needs. The facility management must ensure	Based on observation, interviews, record review, and review of the facility policy, it was revealed one (1) of one (1) resident

that residents receive proper treatment and care for the following special services: (1) Injections; (2) Parenteral and enteral fluids; (3) Colostomy, ureterostomy, or ileostomy care; (4) Tracheostomy care; (5) Tracheal suctioning; (6) Respiratory care; (7) Foot care; and (8) Prostheses. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	reviewed for oxygen use did not have evidence the oxygen tubing was changed as planned (Resident #10). The findings include: Review of the facility policy titled, "Oxygen Therapy," dated 11/22, documented: "Procedure Points to Remember: …5. Cannulas and masks should be change monthly." Review of Resident #10's clinical record listed the readmission date of [DATE], and the diagnoses included: Alzheimer's Disease, Congestive Heart Failure, and Chronic Kidney Disease, Stage Three (3). Review of the Resident #10's Physician Orders listed an order, dated [DATE], for Oxygen (O2) as needed at two (2) liters (L) per minute (/min) via nasal cannula (nc) and titrate to maintain O2 saturation (sat) greater than 92 percent. Review of the Care Plan, dated [DATE], lacked interventions for the use of the O2. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR), for [DATE], and [DATE], lacked documentation about the changing of the O2 tubing. Observation, on 9/5/23, at 10:23 a.m., revealed Resident #10 sitting in a wheelchair in the [LOCATION] with O2 via three (3) L/min via nasal cannula and use of a concentrator. Further observation revealed the tubing was not labelled as to when staff changed the tubing. In an interview with Administrative Nurse C, on 9/5/23, at 10:24 a.m., they stated they did not know how often the staff should change the O2 tubing. In an interview with Administrative Nurse C, on 9/6/23, at 10:09 a.m., they stated the staff should change the O2 tubing every week. Observation, on 9/7/23, at 2:17 p.m., revealed Resident #10 lying in bed with O2 in place at three (3) L/min. Further observation revealed the O2 tubing was unlabeled as to when staff changed the O2 tubing. In an interview with Administrative Nurse C, on 9/7/23, at 2:17 p.m., they stated the facility's policy documented the staff should change the O2 tubing every month.

§ 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 observation, interviews, record review, and review of facility policy, the facility failed to administer medications without errors for two (2) of five (5) residents observed (Resident #15 and Resident #16). The findings include: Review of the facility policy titled, "Medication Administration – Eye Drops," dated 11/22, did not document the staff should hold the inner canthus after administering steroid eye drops. Review of *Lippincott Nursing Procedures*, 8th Edition, Copyright 2019 found documented: "■ After instilling the eyedrops, instruct the patient to close both eyes gently, without squeezing the lids shut. ■ To prevent systemic absorption of medication, gently press your thumb on the inner canthus for two (2) to three (3) minutes while the patient closes both eyes. Doing so helps prevent medication from flowing into the tear ducts." Review of Resident #15's Physician Order, dated [DATE], listed the order, Dorzolamide – Timolol Ophthalmic Solution, one (1) drop in both eyes two (2) times a day for glaucoma. Observation, on 9/6/23, at 8:32 a.m., revealed Licensed Nurse D instilled one (1) drop of Dorzolamide - Timolol Ophthalmic Solution in Resident #15's left eye and did not instruct the resident to close their eye and did not hold the inner canthus. Licensed Nurse D then administered one (1) drop of the eye medication to the right eye and did not instruct the resident to close their right eye, and did not hold the inner canthus to prevent systemic reaction. In an interview with Licensed Nurse D, on 9/7/23, at 1:57 p.m., they stated they did not know they should hold the inner canthus or have the resident close their eyes to prevent systemic reaction. Review of Resident #16's Physician Order revealed the orders: [DATE] – Losartan Potassium 50 milligrams (mg) for hypertension and Losartan Potassium 25 mg, both scheduled for the same time. [DATE] an order for Flonase one (1) spray in each nostril two (2) times per day for rhinitis. Observation, on 9/6/23, at 9:45 a.m., revealed Licensed Nurse E was going to administer two (2) tabs of 25 mg Losartan

	Potassium and not 75 mg of the Losartan. At that time, the surveyor stopped and alerted Licensed Nurse E of the wrong dosage. Licensed Nurse E then administered the correct dose. Further observation during the medication pass, revealed Licensed Nurse E handed Resident #16's their Flonase spray. The resident administered one (1) spray of the Flonase into each nostril but did not hold the alternate nares. Licensed Nurse E did not instruct the resident to hold the alternate nares. In an interview with Licensed Nurse E, at 9/6/23, at 9:46 a.m., they confirmed they had the wrong dosage of the Losartan. During a further interview with Licensed Nurse E, on 9/7/23, at 1:52 p.m., they stated they did not know they were supposed to hold the opposite nares when administering nasal spray. In an interview with Administrative Nurse C, on 9/7/23, at 2:04 p.m., they stated that having the resident close their eyes after eye administration and holding the opposite nares when administering nasal spray "is basic nursing."
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	Based on observations, interviews with staff, and record review, the facility failed to store food under sanitary conditions. This had the potential to affect all residents who obtained food from the [LOCATION] refrigerator/freezer. The findings include: During a tour of the facility, on 9/5/23, at approximately 10:00 a.m., three (3) plastic bags of food were observed in the nourishment refrigerator with no name or date on them. During an interview with Administrative Nurse A, on 9/5/23, at approximately 10:00 a.m., they stated that they did not know whether the bags of food belonged to the residents or the staff. During an interview, on 9/7/23, at approximately 4:00 p.m., Administrative Nurse B stated that the staff meals stored in the refrigerator needed to have a name and date. Observations were made in the pantry on the [LOCATION], in the presence of Administrative Nurse A, and began at 10:48 a.m., on 9/5/23. Inside the refrigerator were two (2) plastic bags stored on a shelf below food items intended for resident consumption. Administrative Nurse A identified the bags as containing staff's lunches. One (1) lunch was in a clear, closed, resealable bag which was labeled and dated. The other lunch was in a grocery bag with no clear labeling present. Review of the facility policy titled, "Refrigerator Monitoring & Cleaning," revised January, 2022 stated:

	"POLICY …1. Monitoring of temperature…f. Ensure thermometers are located in each freezer and refrigerator." Review of the policy found no directive to monitor and record the temperatures of freezer units. Observation was made of the freezer compartment to the refrigerator in the [LOCATION], in the presence of Administrative Nurse A, beginning at 10:50 a.m., on 9/5/23. Inside the freezer compartment were multiple, single-serving containers of ice cream. There was no thermometer in the freezer compartment; this was confirmed by Administrative Nurse A. During an interview, at 4:18 p.m., on 9/7/23, Administrative Nurse B confirmed thermometers should be present in all refrigerators and freezers. Administrative Nurse B also confirmed that all staff lunches were to be in sealed bags or containers, dated, and labeled with the staff member's name.
§ 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, policy review, and review of the manufacturer's instructions for use of a piston syringe during enteral feeding, the facility failed to provide care in a manner to prevent the spread of infection for two (2) of 11 residents as evidenced by: 1. For Resident #4, staff failed to rinse the components of a piston syringe and allow them to air dry after use during the administration of enteral feeding. 2. For Resident #9 staff failed to change gloves between removing the dressing from the wound, cleansing the wound, applying the ointment, and applying the new dressing. The findings include: 1. The facility policy titled, "Tube Feeding," revised February, 2023 stated: "PROCEDURE…8. Un-cap the end of the feeding tube and check for placement: a. Presence of gastric contents – Using 60ml [milliliter] syringe, insert tip snuggly into the end of feeding tube and pulling backward with slight force, within 15ml to 20ml gastric contents. [sic] OR b. Auscultation – Pull back 15ml to 20ml of air into syringe, place end of stethoscope just above area where feeding tube is inserted, and with tip of the syringe snuggly in the end of the

	feeding tube, with steady but gentle force push air into tube listening to hear air. [sic] …Clean the syringe after each use and place on a clean towel." According to the product information provided by [Company Name] for the Enteral Feeding 60 ml Piston Irrigation Syringe: "How to Irrigate a Feeding Tube: …Follow Tube Feeding Procedure According to your Institution's Protocol…Remove Syringe and Close the Cap. Wash and Rinse Syringe Well and Allow to Air Dry." 1. Record review revealed Resident #4 was admitted to the facility on [DATE], and diagnoses included: Cerebrovascular Accident with Hemiplegia, Chronic Kidney Disease, and Vascular Dementia. Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #4 was unable to participate in a Brief Interview for Mental Status (BIMS), and their cognitive skills for daily decision-making were assessed to be moderately impaired. The resident required total assistance from one (1) or more persons for all activities of daily living, including bed mobility, transfers, dressing, bathing, and personal hygiene. The MDS also indicated Resident #4 received nutrition through a gastrostomy tube (G-tube). Review of Resident #4's Physician Orders revealed the following order, dated [DATE]: "Enteral Feed Order five [5] times a day Jevity 1.5 (5 Cans/day) via PEG [Percutaneous Endoscopic Gastrostomy], 300ml water flush 5x/day." Observation of the administration of enteral feeding to Resident #4 by Licensed Nurse F began at 9:50 a.m., on 9/6/23, in the presence of Administrative Nurse A. Using a 60ml piston syringe obtained from a resealable plastic bag stored in the resident's room, Licensed Nurse F connected the piston syringe to the Lopez valve attached to the port of Resident #4's G-tube and verified placement of the G-tube in the resident's stomach by both auscultation of an air bolus injected into the G-tube and aspiration of gastric contents. Licensed Nurse F then removed the plunger and disconnected the barrel of the syringe from the Lopez valve while they went to the sink to fill two (2) graduated cups with warm water for flushes. Licensed Nurse F reconnected the barrel of the syringe to the Lopez valve and administered a warm water flush by gravity. After detaching the barrel of the syringe, Licensed Nurse F connected the administration set to the Lopez valve, poured one (1) carton of Jevity 1.5 into the gravity feeding bag, and started the flow of the tube feeding.

	Licensed Nurse F then reassembled the piston syringe and placed it in the resealable plastic bag without first rinsing the plunger and the barrel, and allowing both components to air dry. During an interview, at 11:57 a.m., on 9/7/23, when asked what should be done with a piston syringe after it was used to check placement of a G-tube, Licensed Nurse A stated: "I rinse off my syringe and use a paper towel – turn the cylinder upside down on paper towel, leave the plunger out, and let everything dry." During an interview, at 4:20 p.m., on 9/7/23, Administrative Nurse B confirmed that the components of piston syringes should be rinsed and allowed to air dry after each use. Administrative Nurse B also confirmed that the piston syringes used by the facility were [Company Name] products. 2. Review of Resident #9's clinical record listed an admission date of [DATE], and the diagnoses included: Hemiplegia and Hemiparesis following Cerebral Vascular Accident (CVA) and Obesity. Review of Resident #9's Physician Orders revealed an order, dated [DATE], to apply Iodsorb and two (2) by two (2) island dressing to the right great toe every other day. Observation, on 9/6/23, at 1:19 p.m., revealed Licensed Nurse C donned gloves and removed the old dressing off the right great toe, cleaned the area with normal saline and four (4) by four (4) three (3) times, dried the area with a four (4) by four (4) two (2) times, and applied Idosorb with a tongue blade and covered with a dressing without changing their gloves between removing the dressing, cleaning, and applying the ointment and clean dressing. In an interview with Administrative Nurse C, on 9/7/23, at 2:04 p.m., they stated staff should change their gloves between removing the old dressing and applying the new dressing.
§ 51.190 (b) Preventing spread of infection (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident. (2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact	Based on observation, interview, record review, and policy review, the facility failed to ensure staff performed hand hygiene when indicated for two (2) of 11 residents observed. Staff did not perform hand hygiene between glove changes: 1. When providing catheter care to Resident #5. 2. When providing wound care to Resident #6. The findings include: The facility policy titled, "PPE [Personal Protective Equipment] Use and Hand Hygiene,' revised July, 2021 stated:

with residents or their environment that would transmit the disease. (3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	"When and How to Wear Gloves Standard (universal) precautions will be use [sic] at all times while caring for the resident, regardless of suspected or confirmed infection status of the resident. • Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. • Gloves are not a substitute for hand hygiene. o If your task requires gloves, perform hand hygiene prior to donning gloves, before touching the resident or the resident environment. o Perform hand hygiene immediately after removing gloves. • Change gloves and perform hand hygiene during resident care, if … o moving from work on a soiled body site to a clean body site on the same resident or if another clinical indication for hand hygiene occurs, such as when performing perineal care [sic] … Hand Hygiene All staff will use an alcohol-based hand rub or wash with soap and water for the following clinical indications: - Immediately before touching a resident - Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices - Before moving from work on a soiled body site to a clean body site on the same resident - After touching a resident or the resident's immediate environment - After contact with blood, body fluids, or contaminated surfaces - Immediately after glove removal." 1. Record review revealed Resident #5 was readmitted to the facility on [DATE], and diagnoses included: Non-Alzheimer's Dementia, Neurogenic Bladder, and [DIAGNOSIS]. Review of the Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The resident was independent with set-up assistance for bed mobility, locomotion, eating, and toilet use. For transfers, dressing, and personal hygiene, the resident

	required staff supervision. The MDS also indicated Resident #5 had an indwelling urinary catheter. Review of Resident #5's Physician Orders revealed the following order, dated [DATE]: "Urinary Catheter Care every shift." Observation of routine catheter care to Resident #5's suprapubic catheter by Certified Nurse Aide A began at 9:30 a.m., on 9/6/23, in the presence of Administrative Nurse A. With gloved hands, Certified Nurse Aide A used the bed controller to raise the height of the resident's bed, folded down the bed linens, and unfastened the resident's incontinence brief and folded it down, too. Certified Nurse Aide A then removed and discarded their gloves and donned a new pair of gloves. While washing around the catheter insertion site and down a short segment of the catheter tubing from the insertion site to just above the catheter securement device adhered to the resident's upper right thigh, Certified Nurse Aide A changed gloves three (3) more times. Certified Nurse Aide A also changed gloves after cleaning the short length of catheter tubing and before applying a pad of split gauze around the insertion site. Over the course of the entire procedure, ending at 9:43 a.m., on 9/6/23, Certified Nurse Aide A changed gloves a total of five (5) times without performing hand hygiene between any of the glove changes. During an interview, at 11:39 a.m., on 9/7/23, when asked when should hand hygiene be performed during this procedure, Licensed Nurse A stated: "Hopefully, washing the hands before starting the cleaning and before donning the gloves. After they perform the 'dirty portion,' I would expect them to change gloves, perform hand hygiene, and put on new gloves before performing the 'clean portion' of the procedure. Between all glove changes." 2. Record review revealed Resident #6 was readmitted to the facility on [DATE], and diagnoses included Non-Alzheimer's Dementia. Review of the Quarterly MDS, dated [DATE], revealed Resident #6 had a BIMS score of seven (7), which indicated severely impaired cognition. The resident was independent with bed mobility and locomotion on the unit in their wheelchair, required the extensive assistance of one (1) person with dressing and bathing, and was totally dependent on one (1) person with toilet use and personal hygiene. The MDS also noted the presence of one (1) Stage 4 pressure ulcer and two (2) pressure ulcers that were unstageable due to coverage of the wound bed by slough and/or eschar.

	Review of Resident #6's Physician Orders revealed the following order, dated [DATE]: "Keep left lateral malleolus free of significant pressure (keep objects/items other than dressing from wounds, clean with saline, apply Calcium alginate and dry dressing daily every day shift for Left ankle wound" [sic], Observation of wound care to Resident #6's left lateral malleolus by Licensed Nurse B began at 1:57 p.m., on 9/5/23, in the presence of Administrative Nurse A. Licensed Nurse B placed a clean barrier on an overbed table, donned gloves without first performing any hand hygiene, and placed packages of sterile dressing materials needed for the treatment to Resident #6's left lateral malleolus on the clean barrier. Licensed Nurse B then accessed Resident #5's electronic medical record on a nearby laptop to view the current treatment order. Licensed Nurse B then removed and discarded their gloves, donned a new pair of gloves, and opened the packages of sterile dressing materials. At 2:03 p.m., on 9/5/23, Licensed Nurse B removed and discarded the old dressing from Resident #6's left lateral malleolus, doffed their gloves, washed their hands for less than 20 seconds, and donned a new pair of gloves. Licensed Nurse B then cleansed and dressed the wound, used a pen to write their initials and the date on the resident's dressing, removed and discarded their gloves, and washed their hands. During an interview, at 11:28 a.m., on 9/7/23, when asked when should hand hygiene be performed, Licensed Nurse A reported that staff should perform hand hygiene before beginning a procedure and between glove changes. Licensed Nurse A stated: "Once they remove their gloves, they need to make sure they are sanitizing or washing their hands before putting on new gloves…The expectation is that they use hand sanitizer or some type of sanitization before putting on new gloves." During an interview, at 4:22 p.m., on 9/7/23, Administrative Nurse B confirmed that hand hygiene was to be performed between glove changes.
§ 51.200 (a) Life safety from fire. (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. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	**<u>Smoke Barriers and Sprinklers</u>** 1. Based on records review and interview, the facility failed to test and inspect the Fire Alarm in accordance with the code. The deficient practice affected 10 of 10 smoke compartments, staff, and all residents. The facility had a capacity for 192 beds with a census of 123 on the first day of the survey. The findings include:

	Records review of the fire alarm inspection reports for the 12-month period prior to the survey revealed there was no documentation of semi-annual visual inspections of the smoke detectors, as required by table 14.3.1 of NFPA 72, National Fire Alarm and Signaling Code. The last inspections of the smoke detectors were during the annual inspection of the fire alarm on 10/20/22. An interview with Maintenance Staff A, on 9/5/23, at 9:23 a.m., revealed the facility was not aware that the smoke detectors were required to be inspected semiannually and that the inspections were done annually when the fire alarm contractor comes to test the fire alarm. Records review of the fire alarm inspection report, dated 10/20/22, revealed there was no indication of semiannual testing of the battery charger, load voltage, or discharge test for the back-up batteries either six (6) months prior to the fire alarm inspection or six (6) months after the fire alarm inspection, as required by table 14.4.5 of NFPA 72, National Fire Alarm and Signaling Code. The facility had no other documentation of testing of the battery charger, load voltage, or discharge test for the back-up batteries. An interview with Maintenance Staff A, on 9/5/23, at 9:24 a.m., revealed the facility was not aware that testing of the battery charger, load voltage, or discharge test for the back-up batteries in the fire alarm was required semiannually and that the testing was done annually when the fire alarm contractor came to test the fire alarm. The census of 123 was verified by Administrative Staff D on 9/5/23, at 8:30 a.m. The findings were acknowledged by Administrative Staff D and verified by other facility staff during the Life Safety Code (LSC) exit interview on 9/7/23, at 4:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.4.1 General.** Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. **9.6 Fire Detection, Alarm, and Communications Systems.** **9.6.1* General.** **9.6.1.1** The provisions of Section 9.6 shall apply only where specifically required by another section of this Code. **9.6.1.2** Fire detection, alarm, and communications systems installed to make use of an alternative permitted by this Code shall be considered required systems and shall meet the provisions of this Code applicable to required systems. **9.6.1.3** A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the

	applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. **9.6.1.4** All systems and components shall be approved for the purpose for which they are installed. **9.6.1.5*** To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. **4.6.12 Maintenance, Inspection, and Testing.** **4.6.12.1** Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. **4.6.12.2** No existing life safety feature shall be removed or reduced where such feature is a requirement for new construction. **4.6.12.3*** Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. **4.6.12.4** Any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. **10.2 Purpose.** The purpose of fire alarm and signaling systems shall be primarily to provide notification of alarm, supervisory, and trouble conditions; to alert the occupants; to summon aid; and to control emergency control functions. **10.3 Equipment.** **10.3.1** Equipment constructed and installed in conformity with this Code shall be listed for the purpose for which it is used. **Actual NFPA Standard: NFPA 72, National Fire Alarm and Signaling Code (2010)** **14.4.2* Test Methods.** **14.4.2.1*** At the request of the authority having jurisdiction, the central station facility installation shall be inspected for complete information regarding the central station system, including specifications, wiring diagrams, and floor plans that have been submitted for approval prior to installation of equipment and wiring.

	14.4.2.2* Systems and associated equipment shall be tested according to Table 14.4.2.2. **14.3 Inspection.** **14.3.1*** Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. **14.4.5* Testing Frequency.** Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. **Table 14.3.1 Visual Inspection Frequencies** **Table 14.4.2.2 Testing Schedule Frequencies** 2. Based on observations and interview, the facility failed to install sprinklers in all required areas. The deficient practice affected one (1) of 10 smoke compartments, staff, and no residents. The facility had a capacity for 192 beds with a census of 123 on the first day of the survey. The findings include: Observation during the facility inspection tour, on 9/5/23, at 1:18 p.m., of the [LOCATION] located in the [LOCATION], revealed the room was not provided with sprinkler protection, as required by section 8.15.5 of NFPA 13, Standard for the Installation of Sprinkler Systems. Additional observation, on 9/5/23, at 1:18 p.m., revealed that the elevator car served by the [LOCATION] was hydraulically powered and not traction type. An interview with Maintenance Staff A, on 9/5/23, at 1:18 p.m., revealed the facility was not aware of the requirements for sprinklers in elevator machine rooms. The census of 123 was verified by Administrative Staff D on 9/5/23, at 8:30 a.m. The findings were acknowledged by Administrative Staff D and verified by other facility staff during the Life Safety Code (LSC) exit interview on 9/7/23, at 4:00 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.3.5 Extinguishment Requirements.** **19.3.5.1** Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. **9.7 Automatic Sprinkler and Other Extinguishing Equipment.** **9.7.1 Automatic Sprinklers.**

	9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following: **(1)** NFPA 13, Standard for the Installation of Sprinkler Systems **Actual NFPA Standard: NFPA 13 (2010), Standard for the Installation of Sprinkler Systems** **8.1.1*** The requirements for spacing, location, and position of sprinklers shall be based on the following principles: **(1)** Sprinklers shall be installed throughout the premises. **8.15.5 Elevator Hoistways and Machine Rooms.** **8.15.5.1*** Sidewall spray sprinklers shall be installed at the bottom of each elevator hoistway not more than 2 ft (0.61 m) above the floor of the pit. **8.15.5.2** The sprinkler required at the bottom of the elevator hoistway by 8.15.5.1 shall not be required for enclosed, noncombustible elevator shafts that do not contain combustible hydraulic fluids. **8.15.5.3*** Automatic sprinklers in elevator machine rooms or at the tops of hoistways shall be of ordinary- or intermediate temperature rating. **8.15.5.4*** Upright, pendent, or sidewall spray sprinklers shall be installed at the top of elevator hoistways. **8.15.5.5** The sprinkler required at the top of the elevator hoistway by 8.15.5.4 shall not be required where the hoistway for passenger elevators is noncombustible or limited-combustible and the car enclosure materials meet the requirements of ASME A17.1, Safety Code for Elevators and Escalators. **8.15.5.6** Sprinklers shall be installed at the top and bottom of elevator hoistways where elevators utilize polyurethane-coated steel belts or other similar combustible belt material. **<u>Fire Safety and Operations</u>** 3. Based on observation, records review, and interview, the facility failed to document the inspection and testing of the required fire doors installed throughout the facility. The deficient practice affected 10 of 10 smoke compartments, staff, and all residents. The facility had a capacity for 192 beds with a census of 123 on the first day of the survey. The findings include: Records review revealed there was no documentation available to indicate that the required fire doors were inspected and functionally tested annually for open holes or breaks that may exist in surfaces of either the door or frame; that doors, frames, hinges, hardware, and noncombustible thresholds were secured, aligned, and in working order with no visible signs of

	damage; that parts were not missing or broken; where coordinator(s) were installed, the inactive leaves closed before the active leaves; that auxiliary hardware items that interfere or prohibit operation were not installed on the door or frame; that no field modifications to the door assembly had been performed that void the label; or, that gasketing and edge seals, where required, were inspected to verify their presence and integrity, as required by section 5.2.4.2 of NFPA 80, Standard for Fire Doors and Other Opening Protectives. Additional records review revealed there was documentation available to indicate that the required fire doors were inspected and functionally tested annually for glazing, vision light frames, and glazing beads were intact; and securely fastened in place, if so equipped; that the self-closing device was operational; that is, the active door completely closed when operated from the full open position; that door clearances did not exceed clearances allowed; and that latching hardware operated and secured the door when it was in the closed position. The logs for Fire Doors Check Yearly indicated the last checks were completed on 3/6/23, and included three (3) columns: one (1) column indicated "[LOCATION]" and "[LOCATION]" with the five (5) inspection/testing points; the middle column included "Repair Needed (Y) or (N)," and the last column indicated "Date and Name." Specific doors were not identified or provided individual entries. A comments or remarks section was not provided. An interview with Maintenance Staff A, on 9/5/23, at 10:16 a.m., revealed that the facility performed and documented some kind of fire door inspection and testing, but not as detailed in nature as the inspection and testing that was required. The door inspection and testing that the facility conducted focused on only the two (2) exit stair enclosures and the doors that led into each of them on each floor. The interview went on to reveal that there were five (5) items that were inspected and tested by the facility, where there are 11 items that were required at a minimum by the LSC. The facility was not aware of the specific annual inspection and testing requirements for required fire doors. Observations during the building inspection tour, on 9/5/23, from 1:09 p.m., to 2:30 p.m., and on 9/6/23, from 11:00 a.m., to 1:30 p.m., revealed that the building that the facility was located in was a five (5) story building that had exit stair enclosures provided around each of the nursing units. The two (2) hour exit stair enclosures were provided with 90-minute rated fire doors. There were eight (8) fire doors that were present in the openings to the exit stair enclosures from the nursing units on the upper stories.

	The census of 123 was verified by Administrative Staff D on 9/5/23, at 8:30 a.m. The findings were acknowledged by Administrative Staff D and verified by other facility staff during the Life Safety Code (LSC) exit interview on 9/7/23, at 4:00 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.7.6 Maintenance and Testing.** See 4.6.12. **4.6.12 Maintenance, Inspection, and Testing.** **4.6.12.1** Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. **8.3.3 Fire Doors and Windows.** **8.3.3.1** Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. **Actual NFPA Standard: NFPA 80 Standard for Fire Doors and Other Opening Protectives (2010)** **5.2* Inspections.** **5.2.1*** Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. **5.2.3 Functional Testing.** **5.2.3.1** Functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. **5.2.3.2** Before testing, a visual inspection shall be performed to identify any damaged or missing parts that can create a hazard during testing or affect operation or resetting. **5.2.4** Swinging Doors with Builders Hardware or Fire Door Hardware. **5.2.4.1** Fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. **5.2.4.2** As a minimum, the following items shall be verified: **(1)** No open holes or breaks exist in surfaces of either the door or frame. **(2)** Glazing, vision light frames, and glazing beads are intact; and securely fastened in place, if so equipped.

	(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. **(4)** No parts are missing or broken. **(5)** Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. **(6)** The self-closing device is operational; that is, the active door completely closes when operated from the full open position. **(7)** If a coordinator is installed, the inactive leaf closes before the active leaf. **(8)** Latching hardware operates and secures the door when it is in the closed position. **(9)** Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. **(10)** No field modifications to the door assembly have been performed that void the label. **(11)** Gasketing and edge seals, where required, are inspected to verify their presence and integrity. **Electrical Systems** 4. Based on records review, observation, and interview, the facility failed to maintain documentation of inspections on the Patient-Care Related Electrical Equipment (PCREE). The deficient practice affected eight (8) of 10 smoke compartments, staff, and all residents. The facility had a capacity for 192 beds with a census of 123 on the first day of the survey. The findings include: Records review, on 9/5/23, at 10:21 a.m., revealed there was no documentation of testing of the electric, resident beds in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. All other PCREE at the facility appeared and was listed upon a report that was issued by the facility vendor for PCREE testing. An interview with Maintenance Staff A, on 9/5/23, at 10:21 a.m., revealed that the facility was not aware that the electric, resident beds were considered PCREE and had not had any electrical safety testing completed on them. Observations during the building inspection tour, on 9/5/23, from 1:09 p.m., to 2:30 p.m., and on 9/6/23, from 11:00 a.m., to 1:30 p.m., revealed that the facility provided electric beds for all residents and that PCREE, such as vital sign monitors, portable suction units, nebulizers, concentrators, air pumps for air mattresses, and other medical equipment that was present at the facility.

	The census of 123 was verified by Administrative Staff D on 9/5/23, at 8:30 a.m. The findings were acknowledged by Administrative Staff D and verified by other facility staff during the Life Safety Code (LSC) exit interview on 9/7/23, at 4:00 p.m. **Actual NFPA Standard: NFPA 99, Health Care Facilities Code (2012)** **3.3.137 Patient-Care-Related Electrical Equipment.** Electrical equipment appliance that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care vicinity. **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, 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. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	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 10 of 10 smoke compartments, staff, and all residents. The facility had a capacity for 192 beds with a census of 123 on the first day of the survey. The findings include: Records review of the monthly emergency generator inspection and testing records dating back 12 months prior to the survey, revealed there was no documentation of monthly 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. An interview with Maintenance Staff A, on 9/5/23, at 10:40 a.m., confirmed the batteries on the generator were lead-acid and revealed the facility was not aware of the monthly testing requirements for generator batteries. The census of 123 was verified by Administrative Staff D on 9/5/23, at 8:30 a.m. The findings were acknowledged by Administrative Staff D and verified by other facility staff during the Life Safety Code (LSC) exit interview on 9/7/23, at 4:00 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, Standard for Emergency and Standby Power Systems (2010)** **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. **8.3.4** A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available.
§ 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	Based on document review and interview, the facility failed to ensure there was a sharing agreement with Veterans Administration (VA) for mental health services received by six (6) of 123 residents in the facility. The findings include: A review of the facility provided documents revealed there was no mental health sharing agreement for mental health services that were provided to the residents of the facility by the VA Medical Center of jurisdiction. A sharing agreement was requested, and a provider agreement was provided, which did not represent a sharing agreement between the facility and the VA. During an interview, on 9/8/23, at 12:00 pm, Administrative Nurse B stated that they were unsure if the facility had a sharing agreement. No sharing agreement was documented.

the authorized representative of the veteran. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	