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: Colorado Community Living Center at Fitzsimmons-Aurora

Location: 1919 Quentin Street Aurora, CO 80045

Onsite / Virtual: Virtual

Dates of Survey: 8/30/22 – 9/2/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 180

Census on First Day of Survey: 118

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from 8/30/22, through 9/2/22, at the Colorado Community Living Center at Fitzsimmons-Aurora. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.43 (b) Drugs and medicines for certain veterans. VA will also furnish drugs and medicines to a State home for a veteran receiving nursing home, domiciliary, or adult day health care in a State home pursuant to 38 U.S.C. 1712(d), as implemented by §17.96 of this chapter, subject to the limitation in §51.41(c)(2). Level of Harm – No Actual Harm, with potential for minimal harm Residents Affected - Few	The facility was unable to demonstrate that the VA only furnished drugs and medicines to a State home for Veterans who were eligible to receive such medications. Based on interviews and record review, it was identified that the facility failed to furnish drugs and medicines to one (1) resident for whom the facility received the prevailing rate of VA Per Diem. The resident was admitted to the SVH in 2018. The facility advised that the resident had been receiving Ibrutinib from the VA for a couple of years, but the exact start date was unknown at the time of the interview. Per the facility, they were unable to obtain these medications from [Business] or any other source until recently. SVH would order the medication through [Business] moving forward. An interview with the facility Administrative Staff A, Administrative Staff B, and Consultant Staff A revealed that the SVH did not reimburse the VA of jurisdiction for the medication

	received for this one (1) resident. The facility reported their pharmacy would order the medication through [Business] moving forward.
§ 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 email response, the facility failed to ensure that a final accounting of a resident's personal funds was conveyed upon the resident's death. The findings include: Review of facility records for residents who expired with trust fund accounts revealed an open account for a resident who expired [DATE]. In an email, dated 9/2/22, at 3:05 p.m., Administrative Staff C stated that the conveyance of funds had not been done due to the staff being new.
§ 51.70 (c) (6) Assurance of financial security. The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on staff interview, the facility failed to provide evidence that a surety bond, or other assurance, was secured for the security of all personal funds of residents deposited with the facility. This affected all residents whose funds were managed by the facility. The findings include: In an interview, on 8/31/22, at 1:00 p.m., Administrative Staff C and Administrative Staff A confirmed that the facility had not been granted approval by the Under Secretary of Health for the Veterans Administration to maintain an alternate form of protection for the residents' personal fund accounts.
§ 51.100 (h) (2) Social Services. For each 120 beds, a nursing home must employ one or more qualified social workers who work for a total period that equals at least the work time of one full-time employee (FTE). A State home that has more or less than 120 beds must provide qualified social worker services on a proportionate basis (for example, a nursing home with 60 beds must employ one or more qualified social workers who work for a total period equaling at least one-half	Based on record review and staff interview, the facility failed to employ a qualified social worker required to accommodate the proportionate census of the facility. The findings include: Review of facility documents revealed 180 recognized beds. Review of facility staff credentials revealed that no qualified Social Worker was employed by the facility. In an interview, on 8/3/22, at 1:30 p.m., Administrative Staff A confirmed that the facility did not employ a full time "BSW"

FTE and a nursing home with 180 beds must employ qualified social workers who work for a total period equaling at least one and one-half FTE). Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Many	(Bachelor of Social Work) or "MSW" (Master of Social Work) employee.
§ 51.120 (l) Special needs. The facility management must ensure 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	Based on observations and interviews, the facility failed to change and label the oxygen tubing every week as planned for two (2) residents of the sample (Resident #102 and Resident #117). The findings include: Observation during the initial tour on 8/30/22, at 11:01 a.m., revealed Resident #117 received oxygen via nasal cannula. Observation revealed the oxygen tubing was not labeled when it was last changed. Observation, on 8/30/22, at 11:27 a.m., revealed Resident #103 received oxygen via nasal cannula from the room concentrator. Observation revealed no label on the tubing. There was no indication when the tubing was changed. In an interview with Administrative Nurse A, on 8/30/22, at 11:30 a.m., they stated that the staff should date the oxygen tubing when they change it every week. Observation, on 8/31/22, at 10:44 a.m., revealed Resident #103 sat in their wheelchair and received oxygen via portable concentrator and nasal cannula. Observation revealed no label on the tubing. There was no indication when the tubing was changed. In an interview with Administrative Nurse B, on 9/1/22, at 1:50 p.m., they stated the staff should change the oxygen tubing every week. The plan was for the oxygen tubing to be changed on Sunday nights, but the days may vary. In an interview with Administrative Staff A, on 9/1/22, at 3:05 p.m., they stated that prior to COVID, the facility had an oxygen company that came in and changed the oxygen tubing. During COVID the nurses were responsible for changing the oxygen tubing; "I guess they didn't do a good job." Administrative Staff A stated that the facility did not have a policy for changing the oxygen tubing.

§ 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 observation and interview, the facility failed to dispose of garbage and refuse properly, as evidenced by sanitizer buckets and used oil barrels stored around the dumpster. The findings include: During an observation, on 9/1/22, at 2:05 p.m., with Dietary Staff A, it was noted that the compactor area had 60, five (5)-gallon buckets from [Business] of Activate and Sanspot, which Dietary Staff A said were two (2) chemicals for the dish machine that needed to be returned. The buckets were observed to have one (1) to three (3) inches of chemical inside. Dietary Staff A said that those buckets had been stacked in the dumpster area for a month, but the company should pick up every two (2) weeks. During the same observation of the dumpster area there were noted three (3) 50-gallon drums of used oil. One 50-gallon barrel lid was completely rusted. Dietary Staff A said they used that oil for making French fries in the deep fryer, and those three (3) drums were there for four (4) months. Dietary Staff A said that they do not use the fryer much anymore because they bake food more than they fry food. On 9/1/22, at 4:07 p.m., during the daily debrief, the concern with the dumpster area being littered with 60, five (5)-gallon buckets of chemicals and three (3) 50- gallon drums were brought to the attention of Administrative Staff A, who said, “I am not disagreeing about it,” and that they should be removed. On 9/2/22, at 9:23 a.m., in an interview with Maintenance Staff A, they said that they had been trying to get rid of those buckets and drums, because they had been there a couple of weeks. Maintenance Staff A said they was not aware how many buckets were out there now, but was sure there were more than the last time they looked. The kitchen should be disposing of them as soon as possible. Maintenance Staff A said that there were about three (3) inches of chemicals left in some of the five (5)-gallon buckets. An email from Administrative Staff A, received on 9/2/22, at 1:50 p.m., read “So the [Business] who does the oil pick is also a vender (meaning they had no contract with them to remove the used buckets and drums). We call and then they are pick-up.” [sic]
§ 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.	**<u>Smoke Barriers and Sprinklers</u>** 1. Based on observation and interview, the facility failed to properly install and maintain equipment protected by the kitchen hood extinguishing system. The deficient practice affected one (1) of 16 smoke compartments, staff, and zero

Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Many	(0) residents. The facility had the capacity for 180 beds with a census of 118 on the day of survey. The findings include: Observation during the building inspection tour on 8/31/22, at 10:13 a.m., revealed the wheeled, gas-fired, stove located on the cooking line in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning, as required by section 12.1.2.3 and 12.1.2.3.1 of NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. An interview at that time with Maintenance Staff A revealed that the facility was not aware of the requirement. The census of 118 was verified by Administrative Staff A on 8/30/22. The finding was acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 9/2/22. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** 19.3.2.5 Cooking Facilities. 19.3.2.5.1 Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4. 19.3.2.5.2* Where residential cooking equipment is used for food warming or limited cooking, the equipment shall not be required to be protected in accordance with 9.2.3, and the presence of the equipment shall not require the area to be protected as a hazardous area. 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service. **Actual NFPA Standard: NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011)** 12.1.2 Installation. 12.1.2.1 All listed appliances shall be installed in accordance with the terms of their listings and the manufacturer's instructions. 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system.

	12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. 2. Based on records review and interview, the facility failed to maintain the sprinkler system. The deficient practice affected 16 of 16 smoke compartments, staff, and all residents. The facility had the capacity for 180 beds with a census of 118 on the day of survey. The findings include: Records review on 9/2/22, at 7:30 a.m., of the sprinkler system inspection, testing, and maintenance records revealed there was no documentation of the five (5) year internal pipe inspection, gauge replacement or test and calibration, and the internal valve inspection, as required by sections 14.2, 5.3.2, 13.4.1.2, and 13.4.2.1 of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. An interview with Maintenance Staff A, on 9/2/22, at 8:46 a.m., revealed that they did not have records available of the required inspections. The census of 118 was verified by Maintenance Staff A on 8/30/22. The finding was acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 9/2/22. **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. **9.7.1** 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: NFPA13, Standard for the Installation of Sprinkler Systems (2010)**

	Chapter 26 System Inspection, Testing, and Maintenance **26.1*** General. A sprinkler system installed in accordance with this standard shall be properly inspected, tested, and maintained by the property owner or their authorized representative in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, to provide at least the same level of performance and protection as designed. **Actual NFPA Standard: NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011)** **5.3.2*** Gauges. **5.3.2.1** Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. **5.3.2.2** Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. **13.4.1.2 *** Alarm valves and their associated strainers, filters, and restriction orifices shall be inspected internally every 5 years unless tests indicate a greater frequency is necessary. **13.4.2** Check Valves. **13.4.2.1** Inspection. Valves shall be inspected internally every 5 years to verify that all components operate correctly, move freely, and are in good condition. **14.2** Internal Inspection of Piping. **14.2.1** Except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. **14.2.1.1** Alternative nondestructive examination methods shall be permitted. **14.2.1.2** Tubercules or slime, if found, shall be tested for indications of microbiologically influenced corrosion (MIC). **<u>Building Services (Elevators, Escalators, Laundry Chutes, etc.)</u>** 3. Based on records review and interview, the facility failed inspect and test the fire and smoke dampers in accordance with the code. The deficient practice affected 16 of 16 smoke compartments, staff, and all residents. The facility had the capacity for 180 beds with a census of 118 on the day of survey. The findings include: Records review, on 8/30/22, at 9:26 a.m., of the fire and smoke damper inspection report revealed the dampers had not been

	inspected in the four (4) year period prior to the survey, as required by section 19.4 of NFPA 80, Standard for Fire Doors and Other Opening Protectives and section 6.5 of NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. The last damper inspection report was dated 3/8/18, with a handwritten note on it stating, "Due again 2023." An interview via email with Maintenance Staff A, on 8/30/22, at 1:00 p.m., revealed that the facility was on a five (5) year cycle with their contractor for damper testing, and was not aware dampers were required to be inspected and tested every four (4) years. The census of 118 was verified by Administrative Staff A on 8/30/22. The finding was acknowledged by Administrative Staff AS and verified by Maintenance Staff A during the exit interview on 9/2/22. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.5.2.1** Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications, unless otherwise modified by 19.5.2.2. **9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment.** Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, *Standard for the Installation of Air-Conditioning and Ventilating Systems*, or NFPA 90B, *Standard for the Installation of Warm Air Heating and Air-Conditioning Systems*, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service. **Actual NFPA Standard: NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems (2012)** **5.4.8 Maintenance.** **5.4.8.1** Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, *Standard for Fire Doors and Other Opening Protectives*. **5.4.8.2** Smoke dampers shall be maintained in accordance with NFPA 105, *Standard for Smoke Door Assemblies and Other Opening Protectives.* **Actual NFPA Standard: NFPA 80, Standard for Fire Doors and Other Opening Protectives (2010)** **19.4* Periodic Inspection and Testing.** **19.4.1** Each damper shall be tested and inspected 1 year after installation. **19.4.1.1** The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.

	19.4.2 All tests shall be completed in a safe manner by personnel wearing personal protective equipment. **19.4.3** Full unobstructed access to the fire or combination fire/smoke damper shall be verified and corrected as required. **19.4.4** If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in place if so equipped. **19.4.5** The operational test of the damper shall verify that there is no damper interference due to rusted, bent, misaligned, or damaged frame or blades, or defective hinges or other moving parts. **19.4.6** The damper frame shall not be penetrated by any foreign objects that would affect fire damper operations. **19.4.7** The damper shall not be blocked from closure in any way. **19.4.8** The fusible link shall be reinstalled after testing is complete. **19.4.8.1** If the link is damaged or painted, it shall be replaced with a link of the same size, temperature, and load rating. **19.4.9** All inspections and testing shall be documented, indicating the location of the fire damper or combination fire/smoke damper, date of inspection, name of inspector, and deficiencies discovered. **19.4.9.1** The documentation shall have a space to indicate when and how the deficiencies were corrected. **19.4.10** All documentation shall be maintained and made available for review by the AHJ. **Actual NFPA Standard: NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives (2010)** **6.5** Periodic Inspection and Testing. **6.5.1** Smoke dampers for dedicated and non-dedicated smoke control systems shall be inspected and tested in accordance with NFPA 92A, Standard for Smoke-Control Systems Utilizing Barriers and Pressure Differences. **6.5.2*** Each damper shall be tested and inspected one year after installation. The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years. **<u>Fire Safety and Operations</u>** 4. Based on records review and interview, the facility failed to conduct all required fire drills. The deficient practice affected 16 of 16 smoke compartments, staff, and all residents. The facility had the capacity for 180 beds with a census of 118 on the day of survey. The findings include:

	Records review, on 9/2/22, at 8:42 a.m., of the facility's fire drill records for the 12-month period prior to the survey revealed there was no fire drill conducted on the third shift during the fourth quarter (October-November-December) of 2021, as required by section 19.7.1.6 of NFPA 101, Life Safety Code. An interview at that time with Maintenance Staff A revealed that they were aware of the missing drill. The census of 118 was verified by Administrative Staff A on 8/30/22. The finding was acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 9/2/22. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.7.1** Evacuation and Relocation Plan and Fire Drills. **19.7.1.6** Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. **Electrical Systems** 5. Based on records review and interview, the facility failed to maintain documentation of inspections on the Patient-Care Related Electrical Equipment (PCREE). The deficient practice affected 16 of 16 smoke compartments, staff, and all residents. The facility had the capacity for 180 beds with a census of 118 on the day of survey. The findings include: Records review, on 9/2/22, at 8:29 a.m., of the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE revealed the facility only had documentation for the patient lifts throughout the facility. An interview with Maintenance Staff A, on 9/2/22, at 8:52 a.m., revealed the facility did not have records for the other equipment in the facility, as required by sections 10.3 and 10.5.6.2 of NFPA 99, Health Care Facilities Code. The census of 118 was verified by Administrative Staff A on 8/30/22. The finding was acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 9/2/22. **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 and interview, the facility failed to test all components of the Emergency Generator. The deficient practice affected 16 of 16 smoke compartments, staff, and all residents. The facility had the capacity for180 beds with a census of 118 on the day of survey. The findings include: Records review on 8/31/22, at 8:45 a.m., of the generator inspection, testing, and maintenance records for the 12-month period prior to the survey revealed there was no record of a fuel quality test, as required by section 8.3.8 of NFPA 110, Standard for Emergency and Standby Power Systems. An interview with Maintenance Staff A at that time revealed the last fuel quality test was recorded in 2020. The census of 118 was verified by Administrative Staff A on 8/30/22. The finding was acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 9/2/22. **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)** **8.3.8** A fuel quality test shall be performed at least annually

	using tests approved by ASTM standards.
§ 51.200 (c) Space and equipment. Facility management must— (1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and (2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Level of Harm – No Actual Harm, with potential for more than minimal harm Resident Affected - Many	Based on observation, interview, and record review, the facility failed to maintain the steam table in safe operating condition on two (2) of two (2) serving steam tables (first floor and second floor for Eagle/Constitution and Patriot/Heritage). The findings include: On 8/30/22, at 11:22 a.m., Dietary Staff B explained that dietary staff take temperature of the food in the kitchen when it was placed in the hot box, and before it was sent to the neighborhood. Temperatures were taken again when food was transferred from the hot box and placed on the steam table, and again 30 minutes after the meal service began. On 8/30/22, at 11:33 a.m., dietary staff were observed placing food on the steam tables and taking the food temperatures to serve the [LOCATION] and [LOCATION] neighborhoods. On 8/30/22, at 11:43 a.m., there was no water observed in the right side of the steam table for the [LOCATION] and [LOCATION] neighborhoods. In an interview with the Dietary Staff B, on 8/30/22, at 11:59 a.m., they reported that one portion of each neighborhood ([LOCATION] and [LOCATION]) steam table was broken. When asked how long the steam tables had been broken, Dietary Staff A responded by laughing, and said, “I do not remember- that is how long. That is why there was no hot water in it to keep the food within safe food serving temperatures.” On 9/1/22, at 8:58 a.m., an interview with Dietary Staff B, revealed that both steam tables were broken, the [LOCATION] and the LOCATION] ones- the whole steam table needed to be replaced. Dietary Staff B noted that dietary staff had delimed the wells too many times, and it had made holes in the wells, so it was not able to hold the hot water to keep the food temperatures to maintain appropriate food safe temperatures. Dietary Staff B said they asked months ago to get the steam table fixed. At dining time, they took the temperatures at 12:00 p.m., downstairs, and the food traveled to the second floor where it was temped again after 30 minutes and corrected if necessary. On 9/1/22, at 1:57 p.m., during an interview, Dietary Staff A said that the right side on each steam table had not been working. Per record review, the last maintenance request placed regarding both steam tables (B43 and B03) not working was on March 14, 2022, at 7:20 a.m. Dietary Staff A reported that if

	dietary management did not hear anything about the repair, they pull the work orders and check again. On 9/1/22, at 4:08 p.m., during the daily debrief, Administrative Staff A was informed about the concern with the two kitchen steam tables not working due to holes in the wells, so there was no hot water in them to maintain safe food temperatures. Administrative Staff A replied, “I am not disagreeing about it.” During an interview, on 9/2/22, at 9:19 a.m., Maintenance Staff A said that they were aware there was an issue with one drain basin on the first floor and said, “that one should not have water in it, the other was replaced a year ago. The last work order received was in June, 2022 to repair the fill valve and drain valve underneath.” Maintenance Staff A was aware dietary could not add hot water to the steam tables due to the cracks. Maintenance Staff A said, “there are a lot of maintenance that needs to be done in the kitchen. We got quotes for the repairs.” [sic]
§ 51.210 (c) (7) Required Information. Annual State Fire Marshall's report; Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Many	Based on records review and interview, the facility failed to provide an annual State Fire Marshal report. The deficient practice affected 16 of 16 smoke compartments, staff, and all residents. The facility had the capacity for 180 beds with a census of 118 on the day of survey. The findings include: Records review, on 8/30/22, at 9:10 a.m., revealed the facility had not been inspected in by the State Fire Marshal, as required by the VA regulation. An interview, via email, with Maintenance Staff A, on 8/30/22, at 1:00 p.m., revealed that they had been in contact with the Fire Marshal to schedule the inspection, but that there was a backlog of inspections, and it would be several months before an inspection would take place. The census of 118 was verified by Administrative Staff A on 8/30/22. The finding was acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 9/2/22.

§ 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. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on record review and interview, the facility's management failed to obtain a sharing agreement that governed mental health services provided to six (6) residents by the Veterans Administration Medical Center (VAMC). The findings include: Review of documents provided by the facility revealed there was no sharing agreement with the Veterans Administration to provide mental health services for the residents. An email provided by Administrative Staff A, on 9/2/22, at 1:58 a.m., confirmed that the facility had not completed the approval process for a sharing agreement with the VAMC (Veterans Administration Medical Center) to cover the residents who received mental health services.