

Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, which resulted from the State Veterans Home Unannounced On-Site or Announced Virtual Survey is a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or LSC Identifying Information.) Title 38 CFR Part 51 Federal Regulations for SVHs. §51.210, §51.390, §51.475 Administration, resident personal funds protected in §51.70 (c)(1-6), and all required VA and life safety standards in 38 CFR Part 51.

General Information:

Facility Name: Soldiers' Home in Holyoke

Location: 110 Cherry Street, Holyoke, MA 01040

Onsite / Virtual: Virtual

Dates of Survey: 3/7/22-3/10/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 278

Census on First Day of Survey: 88

Line Item #/Deficiency	Findings
	<p>Initial Comments:</p> <p>A VA Annual survey was conducted from March 7, 2022, through March 10, 2022, at the Soldiers' Home in Holyoke. The survey revealed the facility was not in compliance with 38 CFR part 51 Federal Regulations for State Veterans Homes.</p>
<p>§51.70(a) Exercise of rights. The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility management must protect and promote the rights of each resident, including each of the following rights: (a) Exercise of rights. (1) The resident has a right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. (2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility management in exercising his or her rights. (3) The resident has the right to freedom from chemical or physical restraint. (4) In the case of a resident</p>	<p>Based on observation, interview, record review and facility policy review, the facility failed to provide dignity during catheter and perineal care for one (1) of 15 residents sampled, Resident #4.</p> <p>The findings included:</p> <p>The facility's policy titled "Soldier's Home of Holyoke Plan for the Provision of Veteran Care Services (Scope of Services) 2021 – 2022" dated 10/21 directed, "II. STANDARDS OF PRACTICE AND CARE ... To provide care with honor and dignity by ensuring privacy during all personal and medical care. This includes medical care, nursing treatments and personal care such as shaving, oral care etc..."</p> <p>The facility provided a document titled "NURSING PRACTICE & SKILL Perineal Care: Male and Female – Performing" dated 4/26/19, which directed, "...What You Need to Know Before Performing Perineal Care for Male and Female Patients. ></p>

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<p>determined incompetent under the laws of a State by a court of jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. (5) In the case of a resident who has not been determined incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.</p> <p>Scope and Severity – No Actual Harm, with potential for more than minimal harm</p> <p>Residents Affected – Few</p>	<p>Although it is not a physically invasive procedure, performing perineal care requires sensitivity and the ability to provide emotional support, privacy and reassurance to the patient, who may experience anxiety because he/she will be undressed during the procedure...How to Perform Perineal Care for Male and Female Patients... Drape the patient for privacy and comfort by placing a bath blanket over the patient..."</p> <p>Observation of catheter and perineal care on 3/7/22 from 1:36 p.m. – 1:55 p.m. revealed [Certified Nursing Aide A] uncovered Resident #4's blankets and pulled them down to Resident #4's calves. [Certified Nursing Aide A] then walked to the sink to wash their hands, applied gloves, and filled a basin with warm water. [Certified Nursing Aide A] then removed the resident's brief and performed perineal care. At 1:45 p.m., [Certified Nursing Aide A] left the room to get a clean brief and returned to the room, leaving the resident uncovered. At 1:50 p.m. after the clean brief was applied, [Certified Nursing Aide A] completed other tasks and finally covered the exposed resident at 1:55 p.m.</p> <p>During an interview on 3/7/22 at 1:59 p.m., [Certified Nursing Aide A] acknowledged the resident was left uncovered from 1:36 p.m. until 1:55 p.m. and stated they should have covered the resident.</p> <p>During an interview on 3/7/22 at 2:07 p.m., [Licensed Nurse A] stated staff are trained yearly on privacy. [Licensed Nurse A] stated [Certified Nursing Aide A] should have only removed the bedding for the care area on the resident's body and covered the resident immediately when care was finished.</p> <p>During an interview on 3/8/22 at 9:38 a.m., [Administrative Nurse A] stated they expected staff to cover the resident, should have had supplies together before starting care, and should have pulled down the blanket only as far as needed to perform care. [Administrative Nurse A] stated, "It's a dignity concern of course."</p> <p>During an interview on 3/8/22 at 1:15 p.m., [Administrative Nurse B] stated they expected staff to have all care items up front, bring extra towels to cover the resident, expose the resident for as little time as possible, use the extra towels to cover the resident and expose only the perineal area during care. [Administrative Nurse B] further stated the [Certified Nursing Aide A] "Shouldn't have been away from the bedside at all with (the resident) uncovered. It is a privacy/dignity issue."</p>
<p>§51.70 (b)(9) – (i) Notice of rights and services. (9) Notification of changes. (i) Facility management must immediately inform the resident; consult with the</p>	<p>Based on interview, record review, and review of facility's policy, the facility failed to notify the family of a change in condition for one (1) of 19 sampled residents, Resident #16.</p>

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<p>primary physician; and if known, notify the resident's legal representative or an interested family member when there is— (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §51.80(a) of this part.</p> <p>Scope and Severity – No Actual Harm, with potential for more than minimal harm</p> <p>Residents Affected – Few</p>	<p>The finding included:</p> <p>Review of the facility's policy titled, "Notification of Family/Responsible Party: Change in Veteran Status" reviewed 11/2018 revealed "...Procedure:</p> <p>3.1 The SHH (Soldiers' Home in Holyoke) staff is to observe the veteran for any of the following and notify the family/responsible party of: ...</p> <p>3.1.9 Any significant bruise/injury, whether explained or not, discovered by staff.</p> <p>3.2 The staff member will complete the documentation of the contact including time, outcome, family/responsible party response etc..."</p> <p>Review of Resident #16's "Resident Profile" revealed the resident was admitted to the facility on [DATE] with a principal diagnosis of Parkinson's disease. Review of Resident #16's "Resident Profile" revealed the resident's spouse was the Responsible Party (RP).</p> <p>Review of Resident #16's Progress Note dated [DATE] revealed "While staff bathing and dressing veteran, staff noted large bruise to upper abdomen area. Upon assessment bruise measures approx. (approximately) 22 cm (centimeters) X 7.5 cm and is yellowish/green and faint light purple in color. Vet (Veteran) denies pain to area. Will monitor bruise every shift for changes. Nursing Supervisor notified. MD (Medical Doctor) notified."</p> <p>Review of Resident #16's Progress Notes for [DATES] revealed no documentation showing the Responsible Party was notified of the bruising found on the resident's abdomen.</p> <p>Review of Resident #16's "Veteran Skin Injury Report" dated [DATE] revealed no documentation showing the RP was notified of the bruising found on the resident's abdomen.</p> <p>Interview on 3/10/22 at 9:16 a.m. with [Administrative Nurse B] revealed staff should notify the family/responsible party and Physician for any changes the veteran may experience. [Administrative Nurse B] stated they expected notifications to be done if there were changes to the skin, medical condition, dietary, meal changes, the whole list. [Administrative Nurse B] stated they expected staff to attend to the Veteran first then notify the family/RP and the Physician. [Administrative Nurse B] stated if the change was to occur in the middle of the night and was not an emergency, the night staff was to pass notification to the day shift. [Administrative Nurse B] stated the incident regarding Resident #16 occurred on night shift. [Administrative Nurse B] stated when they spoke with the Veteran Care Coordinator, they was informed the resident's spouse visited all</p>
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	<p>the time and may have been informed at that time. [Administrative Nurse B] stated there was no documentation to support the resident's spouse was notified.</p>
<p>§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.</p> <p>Scope and Severity – No Actual Harm, with potential for more than minimal harm</p> <p>Residents Affected – All</p>	<p>Based on interview and record review, the facility failed to ensure resident funds were protected by a surety bond to assure the security of all personal funds of residents which were deposited with the facility. This deficient practice had the potential to affect all residents whose funds were protected by the facility.</p> <p>The findings included:</p> <p>Review of facility documents provided by the accounting office revealed a Resident Fund Balance as of 3/11/22 in the amount of \$143,242.67.</p> <p>Review of an undated cover letter addressed to the Under Secretary for Health stated the facility applied for approval of the current Crime Policy dated 5/7/21 thru 5/7/24.</p> <p>An interview on 3/9/22 at 1:00 p.m. with [Administrative Staff A] who oversaw the residents' personal funds accounts revealed that there was no surety bond maintained by the facility for assurance of security of the resident fund deposits. [Administrative Staff A] stated they were under the impression that the Crime Policy was sufficient until at the last annual survey where they were informed that the current Crime Policy was insufficient unless approved by the Under Secretary of Health. [Administrative Staff A] stated the cover letter, request for approval and copy of the current policy was emailed to the Under Secretary's office on 6/1/21, but no response on an approval has been received.</p> <p>In an interview with [Administrative Staff B], on 3/9/22 at 2:45 p.m., it was stated that the facility did not maintain a surety bond. [Administrative Staff B] also stated the facility had not received approval of the current Crime Policy submitted to the Under Secretary for Health on 6/1/21.</p>
<p>§51.110(c) Accuracy of assessments</p> <p>(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.</p>	<p>Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's status for one (1) of 19 sampled residents, Resident #10, reviewed for Quality of Care/Treatment.</p> <p>The findings included:</p> <p>Review of the facility's policy titled "MDS 3.0 Assessment Process LTC (Long Term Care) dated May 2021 revealed "Purpose: To establish a system to complete a clinical assessment of every veteran from pre-admission throughout their stay at the Soldiers' Home in Holyoke (SHH) to determine</p>

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<p>Scope and Severity - No Actual Harm, with potential for more than minimal harm</p> <p>Residents Affected – Few</p>	<p>their functional capabilities, health, and psychosocial needs. The SHH (Soldiers' Home in Holyoke) follows Center for Medicare and Medicaid Services (CMS) guidelines and the current Resident Assessment Instrument (RAI) manual instructions from CMS.”</p> <p>Review of Resident #10's medical record revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis of tobacco use.</p> <p>Review of Resident 10's "Safe Smoking Evaluation" dated 12/29/21 revealed "Veteran may smoke unsupervised in designated smoking areas. Veteran representative/family have been informed of smoking evaluation results. Comment: Vet comes from DOM – independent with smoking.”</p> <p>Review of Resident #10's Admission Minimum Data Set (MDS) dated [DATE] revealed the resident was coded as having no current tobacco use.</p> <p>Review of Resident #10's undated "Safety" Care Plan revealed "Interaction: ... Smoking: I smoke, please assess my safety with smoking quarterly and prn (as needed). Document any safety measures needed. I am safe to smoke independently. Complete the assessment quarterly..."</p> <p>Interview with [Administrative Nurse C] on 3/9/22 at 2:20 p.m. revealed they agreed and acknowledged Resident #10's Admission MDS was coded incorrectly. They stated the resident should have been coded for tobacco use. They stated smoking was a part of the resident's activity program. They stated they will make the correction and transmit it today.</p>
<p>§51.120(b)(3) Activities of daily living</p> <p>(3) 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.</p> <p>Scope and Severity - No Actual Harm, with potential for more than minimal harm</p> <p>Residents Affected – Few</p>	<p>Based on observation, interview, and record review, the facility failed to provide necessary services to maintain personal hygiene for one (1) of one (1) resident sampled for perineal care. [Certified Nursing Aide A] did not provide complete perineal care to Resident #4, who was dependent on staff for care.</p> <p>The findings included:</p> <p>On 3/10/22 at 8:57 a.m., according to [Administrative Nurse B], the facility did not have a policy for complete perineal care but referenced the Nursing Reference Center procedure. The facility provided a document titled "NURSING PRACTICE & SKILL Perineal Care: Male and Female – Performing" dated 4/26/19, which directed, "What is Perineal Care? ... How: Perineal care is performed by using a washcloth, mild soap or a perineal skin cleanser, and warm water to clean the perineal area. The area is rinsed using a new washcloth and clean, warm water and gently patted dry... How to Perform Perineal</p>

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	<p>Care for Male and Female Patients ... > Perform perineal care for male patients ... • Moisten a washcloth in the warm water in one basin. Add a small amount of soap or skin cleanser to the cloth • Explain each of the following steps before initiating them to avoid startling the patient and to reduce anxiety –Gently separate the patient's legs to expose the perineal area. Assess area for erythema, IAD (Incontinence-associated dermatitis), skin breakdown, or abnormal drainage or secretions –Gently grasp the shaft of the penis. Retract the foreskin if the patient is uncircumcised...–Moisten a washcloth with soap or skin cleanser and starting at the urethral meatus wash in circular motion moving outward to cleanse the glans. Repeat cleansing using a separate, unused section of the cloth...- If a urinary catheter is present do not place tension on the catheter and gently clean around it. Avoid using water from the basin...– Moisten a clean washcloth in the second basin of warm water and use this cloth to rinse this area and pat dry. Return foreskin to its normal position...–Moisten a new washcloth and apply soap or skin cleanser and carefully clean down the shaft of the penis. Moisten a clean washcloth in the second basin of water, rinse area. Pat dry...–Moisten a new washcloth, apply soap or skin cleanser, wash scrotum. Rinse with a new, moistened washcloth/ and pat dry...–Turn/assist the patient with turning to one side. Help the patient maintain the side-lying position by placing a pillow behind his back and stabilize him by supporting his hips with your nondominant hand –Moisten a clean washcloth in the soapy water and use the cloth to gently clean the anal area...–Moisten a clean washcloth in the basin of clean warm water and use it to rinse the anal area. Gently pat the area dry with a dry washcloth..."</p> <p>Resident #4 was readmitted to the facility on [DATE]. The resident had a medical history to include a diagnosis of Urinary Retention.</p> <p>Resident #4's Quarterly Minimum Data Set with an assessment reference date of [DATE] indicated the resident had an Indwelling Foley Catheter and was totally dependent on staff for toilet use.</p> <p>Observation of catheter and perineal care on 3/7/22 from 1:36 p.m. – 1:55 p.m. revealed [Certified Nursing Aide A] uncovered Resident #4 then walked to the sink to wash their hands, applied gloves, and filled one (1) basin with warm water. [Certified Nursing Aide A] then removed the resident's brief and performed perineal care by cleaning around the urethral meatus, glans and catheter tubing only. At 1:45 p.m., [Certified Nursing Aide A] left the room to get a clean brief, and upon return to the room, used the same washcloth, wettened in the basin to clean the rectal area of Resident #4.</p>
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	<p>During an interview on 3/7/22 at 2:07 p.m., [Licensed Nurse A] stated they expected catheter care to include wiping the perineal area and groin, clean, rinse and dry the meatus and then clean the tubing.</p> <p>During an interview on 3/8/22 at 9:38 a.m., the [Administrative Nurse A] stated perineal care should have included cleaning the perineum, genital area, and the whole area was part of perineal care.</p> <p>During an interview on 3/8/22 at 1:15 p.m., [Administrative Nurse B] stated [Certified Nursing Aide A] should have cleaned the entire perineal area front to back.</p>
<p>§51.160(a) Specialized rehabilitation services. (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech therapy, occupational therapy, and mental health services for mental illness are required in the resident's comprehensive plan of care, facility management must— (1) Provide the required services; or (2) Obtain the required services from an outside resource, in accordance with §51.210(h) of this part, from a provider of specialized rehabilitative services.</p> <p>Scope and Severity - No Actual Harm, with potential for more than minimal harm</p> <p>Residents Affected – Few</p>	<p>Based on interview and record review, the facility failed to obtain outside mental health services under a written agreement in accordance with 51.210(h) (use of outside resources). One (1) resident of one (1) resident, Resident #3, received mental health services at the medical center without a written sharing agreement for those services.</p> <p>The findings included:</p> <p>Review of Resident #3's medical record revealed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included but were not limited to Bipolar Disorder and Major Depressive Disorder.</p> <p>Review of "Letter" dated 8/28/2020 sent from "Veteran Administration Central Western Massachusetts Healthcare System" revealed "Subject: Healthcare Sharing Agreement: VA Central Western Massachusetts Healthcare System (CWM) is in receipt of your request to enter into a Sharing Agreement for CWM to be a provider of Mental Health (MH) services for Veterans who reside at the Holyoke Solders' Home (HSH)... The Sharing Agreement process will take time to develop and implement... We know that the VA annual survey team cited HSH for absence of a Sharing Agreement. Should that issue arise at your next survey, we urge you to share this letter with the survey team. It should clarify that the delay in establishing the agreement residents with the Medical Center."</p> <p>Review of Resident #3's Consultation Requests revealed the resident was last seen by psych services on [DATE] and was to have a follow-up appointment in four (4) months.</p> <p>Interview on 3/10/22 at 9:20 a.m. with [Administrative Nurse B] revealed the sharing agreement was being managed by the facility's Attorney. They stated according to the attorney, there was a draft agreement dated within the same time period as the letter given. They stated there were no other correspondence</p>

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	<p>with the medical center regarding the sharing agreement. They stated Resident #3 was the only resident receiving mental health services using an outside resource.</p> <p>Interview on 3/10/22 at 12:45 p.m. with [Administrative Nurse B] revealed Resident #3 was still receiving mental health services at the VA Medical Center. They stated the resident four-month follow-up was cancelled in January and February. They stated Resident #3 was scheduled to go to a mental health appointment on [DATE].</p>
<p>§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 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.</p> <p>Scope and Severity - No Actual Harm, with potential for more than minimal harm</p> <p>Residents Affected – Few</p>	<p>Based on observation, interview, and facility policy review, the facility failed to prevent potential spread of infection during and after catheter care for one (1) of one (1) resident sampled for catheter care, Resident #4.</p> <p>The findings included:</p> <p>The facility's policy titled "IP-055 Cleaning Resident Care Equipment and Environment" dated 2/21, directed, "... Cleaning/Disinfection Criteria for Non-Critical equipment and Surfaces ... 3. Non-critical medical equipment surfaces should be cleaned with the facility approved disinfectant on a regular basis, after resident use, or when soiled with body fluids..."</p> <p>Observation of catheter and perineal care on 3/7/22 from 1:36 p.m. – 1:55 p.m. revealed [Certified Nursing Aide A] uncovered Resident #4 then walked to the sink to wash their hands, applied gloves and filled one (1) basin with warm water. [Certified Nursing Aide A] then removed the resident's brief and performed perineal care by applying soap to one (1) corner of a washcloth, dipping it in the basin of water, cleaning around the urethral meatus, glans and back up to the urethral meatus. [Certified Nursing Aide A] then dipped a second corner of the washcloth into the basin of water, rinsed the meatus, down the glans area and back up to the meatus. [Certified Nursing Aide A] then dipped the washcloth in the basin of water and cleaned down the catheter tubing. At 1:45 p.m., [Certified Nursing Aide A] left the room to get a clean brief, and upon return to the room, used the same washcloth, dipped in the basin to clean the rectal area of Resident #4. At 1:53 p.m., [Certified Nursing Aide A] emptied the basin of water and set it on top of the bedside cabinet.</p> <p>During an interview on 3/7/22 at 1:59 p.m., [Certified Nursing Aide A] acknowledged the cleaning of the meatus, the glans and back up to the meatus, and stated, "Yes, I had a hard time pulling back the foreskin." [Certified Nursing Aide A] stated they should have disinfected the basin, bagged it, and put in in the cupboard.</p>

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	<p>During an interview on 3/7/22 at 2:07 p.m., [Licensed Nurse A] stated they expected catheter care to include wiping the scrotal area and groin, clean, rinse and dry the meatus and then clean the tubing. [Licensed Nurse A] stated they would retrain [Certified Nursing Aide A] to use a clean washcloth for the meatus and then another clean washcloth for the catheter tubing. [Licensed Nurse A] further stated the facility had enough linens and at least a couple washcloths should have been used, so [Certified Nursing Aide A] didn't have to use the corners. [Licensed Nurse A] stated [Certified Nursing Aide A] should have disinfected after washing the basin and put it in the cupboard.</p> <p>During an interview on 3/8/22 at 9:38 a.m., [Administrative Nurse A] stated perineal care should have included cleaning the perineum, genital area, and the whole area was part of perineal care. [Administrative Nurse A] stated [Certified Nursing Aide A] should not have gone back to the meatus. [Administrative Nurse A] stated [Certified Nursing Aide A] should have washed out the basin, wiped it, and made sure it was clean before leaving the room.</p> <p>During an interview on 3/8/22 at 1:15 p.m., [Administrative Nurse B] stated [Certified Nursing Aide A] should have cleaned the entire perineal area front to back. [Administrative Nurse B] stated he/she expected staff to clean the meatus and never backtrack; wash once with soap, once to rinse, "[It's an] infection control risk -increased opportunities for UTIs [Urinary Tract Infections]." [Administrative Nurse B] further stated a clean washcloth should have been used for the rectal area. [Administrative Nurse B] stated [Certified Nursing Aide A] should have disinfected the basin inside and outside and put it away.</p> <p>During an interview on 3/8/22 at 1:37 p.m., [Administrative Staff A] stated when the washcloth was used and went down the penis it became dirty and should not have been used around the meatus going back up. [Administrative Staff A] stated a fresh washcloth should have been used for the backside, and not dipped back into the same basin of water.</p>
<p>§51.200(a) – Life safety from fire. The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. (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.</p>	<p>1. Based on observations and interview, the facility failed to provide the required separation of hazardous areas from other areas of the facility. The deficient practice affected three (3) of 20 smoke compartments in the Main Building, staff, and 23 residents. The facility has the capacity for 278 beds with a census of 89 on the day of survey.</p> <p>The findings include:</p> <p>Observation during the building inspection tour on 3/8/2022 at 9:52 am revealed Room 348 on the Three (3) West unit was</p>

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<p>Scope and Severity - No Actual Harm, with potential for more than minimal harm</p> <p>Residents Affected – All</p>	<p>over 50 square feet and used for storage of combustibles, including paper products and incontinence underwear. Additional observation revealed the door was not equipped with a self-closing or automatic-closing device, as required by section 19.3.2.1.3 of NFPA 101, Life Safety Code.</p> <p>Interview at that time with [Maintenance Staff A] revealed the rooms had recently been converted from a resident room to a utility/storage room; staff were not aware of the requirement for a self-closing or automatic-closing device on the door.</p> <p>Observation during the building inspection tour on 3/8/2022 at 10:05 am revealed Room 241 on the Two (2) West unit was over 50 square feet and used for storage of combustibles, including paper products and incontinence underwear. Additional observation revealed the door was not equipped with a self-closing or automatic-closing device, as required by section 19.3.2.1.3 of NFPA 101, Life Safety Code.</p> <p>Interview at that time with [Maintenance Staff A] revealed the rooms had recently been converted from a resident room to a utility/storage room; staff were not aware of the requirement for a self-closing or automatic-closing device on the door.</p> <p>The census of 89 was verified by [Administrative Staff B] on 3/7/2022. The findings were acknowledged by [Administrative Staff B] and verified by [Maintenance Staff A] during the exit interview on 3/10/2022.</p> <p>Actual NFPA Standard: NFPA 101, Life Safety Code (2012) 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. 19.3.2.1.1 An automatic extinguishing system, where used in hazardous areas, shall be permitted to be in accordance with 19.3.5.9. 19.3.2.1.2* Where the sprinkler option of 19.3.2.1 is used, the areas shall be separated from other spaces by smoke partitions in accordance with Section 8.4. 19.3.2.1.3 The doors shall be self-closing or automatic closing. 19.3.2.1.4 Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (1220 mm) above the bottom of the door. 19.3.2.1.5 Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops</p>
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	<p>(5) Rooms with soiled linen in volume exceeding 64 gal (242 L)</p> <p>(6) Rooms with collected trash in volume exceeding 64 gal (242 L)</p> <p>(7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</p> <p>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard</p> <p>2. Based on observations and interview, the facility failed to install the sprinkler system in accordance with the code. The deficient practice affected three (3) of 20 smoke compartments in the Main Building, staff, and 23 residents. The facility has the capacity for 278 beds with a census of 89 on the day of survey.</p> <p>The findings include:</p> <p>Observation during the building inspection tour on 3/8/2022 at 10:07 am in Bathing Room 240B on the Two (2) West unit revealed the sprinkler in the linen closet was missing the escutcheon. Interview at that time with [Maintenance Staff A] revealed the facility was not aware the escutcheon was missing.</p> <p>The census of 89 was verified by [Administrative Staff B] on 3/7/2022. The findings were acknowledged by [Administrative Staff B] and verified by [Maintenance Staff A] during the exit interview on 3/10/2022.</p> <p>Actual NFPA Standard: NFPA 101, Life Safety Code (2012)</p> <p>19.3.5 Extinguishment Requirements.</p> <p>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.</p> <p>19.3.5.2 High-rise buildings shall comply with 19.4.2.</p> <p>19.3.5.3 Where required by 19.1.6, buildings containing hospitals or limited care facilities 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.</p> <p>19.3.5.4* The sprinkler system required by 19.3.5.1 or 19.3.5.3 shall be installed in accordance with 9.7.1.1(1).</p> <p>9.7.1 Automatic Sprinklers.</p> <p>9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following:</p> <p>(1) NFPA 13, Standard for the Installation of Sprinkler Systems</p>
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	<p>Actual NFPA Standard: NFPA 13, Standard for the Installation of Sprinkler Systems (2010)</p> <p>8.3.1 General.</p> <p>8.3.1.1* Sprinklers shall be installed in accordance with their listing.</p> <p>6.2.7 Escutcheons and Cover Plates.</p> <p>6.2.7.1 Plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler.</p> <p>6.2.7.2* Escutcheons used with recessed, flush-type, or concealed sprinklers shall be part of a listed sprinkler assembly.</p> <p>6.2.7.3 Cover plates used with concealed sprinklers shall be part of the listed sprinkler assembly.</p> <p>3. Based on records review and interview, the facility failed to include all required elements in the fire safety plan. The deficient practice affected 20 of 20 smoke compartments in the Main Building and three (3) of three (3) smoke compartments in the North Building, staff, and all residents. The facility has the capacity for 278 beds with a census of 89 on the day of survey.</p> <p>The findings include:</p> <p>Records review on 3/8/2022 of the facility's Fire Prevention and Preparedness Plan revealed there was no provision for staff to place an emergency call to the fire department in addition to the transmission of the fire alarm, as required by section 19.7.2.2 of NFPA 101, Life Safety Code. Interview at that time with [Maintenance Staff A] revealed the facility was not aware that component was missing and would update the policy.</p> <p>The census of 89 was verified by [Administrative Staff B] on 3/7/2022. The findings were acknowledged by [Administrative Staff B] and verified by [Maintenance Staff A] during the exit interview on 3/10/2022.</p> <p>Actual NFPA Standard: NFPA 101, Life Safety Code (2012)</p> <p>19.7.2.2 Fire Safety Plan. A written health care occupancy fire safety plan shall provide for all of the following:</p> <ol style="list-style-type: none">(1) Use of alarms(2) Transmission of alarms to fire department(3) Emergency phone call to fire department(4) Response to alarms(5) Isolation of fire(6) Evacuation of immediate area(7) Evacuation of smoke compartment(8) Preparation of floors and building for evacuation(9) Extinguishment of fire
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