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: Missouri Veterans Home – Mexico

Location: 1 Veterans Drive, Mexico, MO 65265

Onsite / Virtual: Onsite

Dates of Survey: 4/8/24 – 4/11/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 150

Census on First Day of Survey: 120

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from April 8, 2024, through April 11, 2024, at the Missouri Veterans Home – Mexico. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 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.	Based on record review, observation, and interview, the facility failed to ensure staff followed infection control guidelines during a Covid-19 outbreak. This had the potential to affect all residents on two (2) out of three (3) Neighborhoods ([LOCATIONS]), who shared the [LOCATION] located on the [LOCATION], and all residents on the [LOCATION]. The findings include: Review of facility policy titled, "INFECTION CONTROL POLICIES," dated January 5, 2024, noted the following: "1. POLICY: Each Missouri Veterans Home 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…TRANSMISSION-BASED PRECAUTIONS…c) AIRBORNE: Infectious organisms are contained in tiny droplet nuclei and can remain suspended in the air for extended periods of time and may by dispersed over long distances. A susceptible host can contract the infection by inhaling these organisms. Staff must wear a fit-tested N95 or higher respirator

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	donned before entering room. Special air handling and ventilations systems (airborne infection isolation room or AIIR) must be in place to contain and remove infectious agent. Veterans requiring an AIIR must be transported to an acute care setting. In the event of a Veteran who requires an AIIR, the facility must have a plan in place to manage the Veteran while awaiting transfer and to notify public health and prepare workup" [sic]. An interview was conducted, on 4/9/24, at 3:00 p.m., with Administrative Staff A. Administrative Staff A stated the facility had identified two (2) residents on the [LOCATION] as being COVID-19 positive, and the facility was currently in an outbreak for COVID-19. Administrative Staff A stated staff were to wear surgical masks when in resident care areas outside the COVID-19 positive units, and staff on the COVID-19 units were to wear N95 masks when caring for residents. An observation was made, on 4/10/24, at 10:56 a.m., and noted the following: Dietary Staff A was noted to be in the [LOCATION] on the [LOCATION] with the door open and exposed to the [LOCATION]. Dietary Staff A was noted to have a surgical mask under their chin and not covering both mouth and nares. An interview was conducted, on 4/10/24, at 10:57 a.m., with Dietary Staff A and noted the following: Dietary Staff A was on the [LOCATION] in the [LOCATION] and the doors to the [LOCATIONS] were closed. Dietary Staff A stated they did not know why the doors to part of the unit were closed, and did not know what was happening on the [LOCATION]. Dietary Staff A stated they were not wearing their mask correctly. Dietary Staff A covered their mouth and nares with the mask during the interview. An observation was made, on 4/10/24, at 10:57 a.m., during the above noted interview with Dietary Staff A, and noted the following: Certified Nurse Aide A was noted on [LOCATION] assisting residents with meals, and their surgical mask was below the nares. An interview was conducted, on 4/10/24, at 10:58 a.m., with Certified Nurse Aide A and noted the following: Certified Nurse Aide A stated the surgical mask should be covering both the mouth and nares. An interview was conducted on 4/10/24, at 11:00 a.m., with Administrative Nurse A. Administrative Nurse A stated staff should be wearing an N95 mask when entering the unit due to positive COVID-19 cases being identified on the [LOCATION].

	An observation was made, on 4/10/24, at 11:03 a.m., on the [LOCATION] and noted the following: Licensed Nurse A was sitting at the [LOCATION] on the [LOCATION] donning a surgical mask. An interview was conducted, on 4/10/24, at 11:04 a.m., with Licensed Nurse A and noted the following: Licensed Nurse A stated they were only required to wear a surgical mask while in the [LOCATION] on the [LOCATION], but would have to change to a N95 mask if entering the patient area. An interview was conducted with Dietary Staff B, on 4/10/24, at 11:23 a.m., and noted the following: Dietary Staff B stated the facility administration staff would notify each department letting each department know that the facility was currently in a COVID-19 outbreak status. Dietary Staff B stated the dietary department was notified on 4/9/24, and all dietary staff were educated on the use of appropriate PPE if needing to be on [LOCATIONS]. Dietary Staff B stated Dietary Staff A was educated on the COVID-19 outbreak in the facility and was instructed to wear a mask when in resident care areas. An observation was made, on 4/10/24, at 11:27 a.m., in the [LOCATION] on the [LOCATION] and noted the following: Certified Nurse Aide B was noted to be assisting a resident in the [LOCATION] with their surgical mask below the chin exposing both the mouth and the nares. An interview was conducted with Certified Nurse Aide B, on 4/10/24, at 11:28 a.m., and noted the following: Certified Nurse Aide B stated their mask should have been covering both their mouth and nares, and stated they were not wearing the surgical mask appropriately. An observation was made, on 4/10/24, at 11:28 a.m., in the [LOCATION] on the [LOCATION] and noted the following: Certified Nurse Aide C was walking through the [LOCATION] during meal service, and multiple residents were present, with their mask below their chin. An interview was conducted with Certified Nurse Aide C on 4/10/24, at 11:29 a.m. They stated they were not wearing their surgical mask correctly and should have ensured that both their mouth and nares were covered by the mask when in an area where other residents were residing. An interview was conducted, on 4/10/24, at 11:36 a.m., with Administrative Nurse B and Administrative Nurse C and noted the following: Administrative Nurse C stated that two (2) residents on the [LOCATION] had tested positive for COVID-19

	on 4/9/24, and the facility immediately notified the headquarters office for further guidance. Administrative Nurse C stated: the facility was required, as a directive by Headquarters, to test all residents on the [LOCATIONS], along with all employees, as these [LOCATIONS] share a [LOCATION] together on the [LOCATION]. They were not advised to test residents on the [LOCATION], as that is a [LOCATION]. The facility had an emergency Quality Assurance meeting, at 2:30 p.m., on 4/9/24, to discuss the two (2) positive COVID-19 cases on the [LOCATION]. They agreed to test residents on the [LOCATION]. After testing all residents on the [LOCATION], the facility identified seven (7) residents who were COVID-19 positive. The seven (7) positive residents on the [LOCATION] all resided on [LOCATIONS]. The facility currently did not have any positive cases on the [LOCATION]. On the [LOCATION], [LOCATIONS], which were all located on one section of the unit, were isolated by keeping the doors to the [LOCATIONS] closed. Staff on [LOCATIONS] were required to wear surgical masks only, and were to wear them appropriately per infection control guidelines. In all areas outside [LOCATIONS], staff were to wear N95 masks. It was the expectation that all staff would wear the appropriate mask during a COVID-19 outbreak, and all masks should be donned appropriately per policy and procedure. Administrative Nurse C stated all masks worn should cover both the mouth and the nares. Administrative Nurse B stated it was possible that the staff, who did not wear masks correctly, were not available at the time education on the outbreak was provided. Administrative Nurse C stated residents on the [LOCATIONS] shared the [LOCATION], which was located on the [LOCATION], and that not all residents from the [LOCATIONS] used the [LOCATION]. An interview was conducted, on 4/10/24, at 12:10 p.m., with Administrative Staff B and noted the following: Administrative Staff B stated they had identified staff not wearing masks appropriately when out on the floor monitoring infection control. An interview was conducted, on 4/10/24, with Administrative Nurse C at 2:15 p.m., and noted the following: Administrative Nurse C stated that the facility did not have a policy and procedure for COVID-19, and did not have a policy outlining the use of masks.
§ 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.	**Means of Egress** Based on observations and interview, the facility failed to install required exit and directional signage. The deficient practice affected two (2) of 16 smoke compartments, staff, and 20

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	residents. The facility had a capacity for 150 beds with a census of 120 on the first day of the survey. The findings include: Observation during the building inspection tour, on 4/8/24, at 1:09 p.m., of the area leading out from the corridor exit doors of the [LOCATION] on the [LOCATION] revealed a wood, stockade-style fence was installed where the metal exterior guards, rails, and fencing were present. It was extremely difficult to determine what portion of the wood, stockade-style fence was stationary, and what part was the gate used for exiting. Additional observation revealed there was no sign indicating what portion of the stockade fence assembly was an Exit, as required by section 7.10.1.1 of NFPA 101, Life Safety Code. An interview, on 4/8/24, at 1:09 p.m., with Maintenance Staff A revealed the facility installed the wood, stockade-style fencing to prevent a [LOCATION] resident from falling to the lower level if the locks on the exit doors were defeated. The census of 120 was verified by Administrative Staff A, on 4/8/24, 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the LSC exit interview on 4/9/24, at 1:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.2.10 Marking of Means of Egress.** **19.2.10.1** Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4. **7.10 Marking of Means of Egress.** **7.10.1 General.** **7.10.1.1 Where Required.** Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 43. **7.10.1.2 Exits.** **7.10.1.2.1*** Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. **7.10.1.2.2*** Horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. **7.10.1.5 Exit Access.** **7.10.1.5.1** Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. **7.10.1.5.2*** New sign placement shall be such that no point in

	an exit access corridor is in excess of the rated viewing distance or 100 ft (30 m), whichever is less, from the nearest sign. **7.10.1.6* Floor Proximity Exit Signs.** Where floor proximity exit signs are required in Chapters 11 through 43, such signs shall comply with 7.10.3, 7.10.4, 7.10.5, and 7.10.6 for externally illuminated signs and 7.10.7 for internally illuminated signs. Such signs shall be located near the floor level in addition to those signs required for doors or corridors. The bottom of the sign shall be not less than 6 in. (150 mm), but not more than 18 in. (455 mm), above the floor. For exit doors, the sign shall be mounted on the door or adjacent to the door, with the nearest edge of the sign within 4 in. (100 mm) of the door frame. **7.10.1.7* Floor Proximity Egress Path Marking.** Where floor proximity egress path marking is required in Chapters 11 through 43, an approved floor proximity egress path marking system that is internally illuminated shall be installed within 18 in. (455 mm) of the floor. Floor proximity egress path marking systems shall be listed in accordance with ANSI/UL 1994, Standard for Luminous Egress Path Marking Systems. The system shall provide a visible delineation of the path of travel along the designated exit access and shall be essentially continuous, except as interrupted by doorways, hallways, corridors, or other such architectural features. The system shall operate continuously or at any time the building fire alarm system is activated. The activation, duration, and continuity of operation of the system shall be in accordance with 7.9.2. The system shall be maintained in accordance with the product manufacturing listing. **7.10.1.8* Visibility.** Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted. **7.10.1.9 Mounting Location.** The bottom of new egress markings shall be located at a vertical distance of not more than 6 ft 8 in. (2030 mm) above the top edge of the egress opening intended for designation by that marking. Egress markings shall be located at a horizontal distance of not more than the required width of the egress opening, as measured from the edge of the egress opening intended for designation by that marking to the nearest edge of the marking. **7.10.2 Directional Signs.** **7.10.2.1*** A sign complying with 7.10.3, with a directional indicator showing the direction of travel, shall be placed in every location where the direction of travel to reach the nearest exit is not apparent.

	7.10.2.2 Directional exit signs shall be provided within horizontal components of the egress path within exit enclosures as required by 7.10.1.2.2