Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Georgia War Veterans Home

Location: 2249 Vinson Highway, Milledgeville, GA

Onsite / Virtual: Onsite

Dates of Survey: 7/19/22-7/22/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 375

Census on First Day of Survey: 155

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from July 19, 2022, through July 22, 2022, at the Georgia War Veterans Home. The facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.120 (i) Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on observation, record review, and interview, the facility failed to ensure that residents received adequate supervision to prevent accidents. Resident #18 was observed smoking in an area not designated for smoking. The resident was one (1) of two (2) residents reviewed for smoking. The findings include: A review of the facility policy titled, "Smoking Policy & Procedure," undated, revealed, “Policy: …Smoking is permitted by residents of the Georgia War Veterans Home only in designated smoking areas….Procedure: …2. Smoking shall be permitted only in designated areas. …4. An incident report will be completed if violations occur. The Safety Committee will review a copy of all incidents.” A review of the facility policy titled, "Smoking, Determination of Supervised Needs,” undated, revealed, "Policy: To provide a safe environment for all residents, visitors, and staff, as well as to protect the residents from possible self-inflicted injury due to

	smoking habits. Procedure: 1. Upon each resident's admission, it is to be determined by the RN, Care Plan, or physician if he/she is to be supervised or unsupervised while smoking. 2. Place determination, 'SUPERVISED OR UNSUPERVISED SMOKER' in nurses' notes....7. No fire lighting materials (matches/lighters) are to be in the possession of any resident determined to be a supervised smoker. All staff members must obtain lighting material for the benefit of supervised smokers at the nurses' station. 8. Those residents determined as 'Supervised Smokers' may only smoke in a designated smoking area and are to be supervised by staff or a family member." Resident #18 was admitted in 2021 with a diagnosis including, but not limited to, Nicotine Dependence on Cigarettes. A review of Resident #18's Comprehensive Minimum Data Sheet (MDS) dated [DATE] revealed tobacco use and a Brief Interview of Mental Status (BIMS) of 15 out of 15, indicating intact cognition. A review of Resident #18's Care Plan with a review date of [DATE] revealed that "[Resident #18] is currently an unsupervised smoker. [They] ha[ve] hx [history] of being on cessation program. [Resident #18] has hx of smoking in unapproved areas." A review of Resident #18's medical record revealed a form titled, "Interdisciplinary teaching record," dated [DATE], which listed "smoking policy, resident – verbal instruction – verbalized call/understanding and teaching complete." A review of Resident #18's "Nursing Monthly Assessment" form dated [DATE] revealed under section C, "Daily decision making skills example required," the box for "decisions poor; cues, supervision required," was checked with an example of "Smoking in undesignated areas." A review of Resident #18's "Nursing Monthly Assessment" form dated [DATE] under section C, "Daily decision making skills example required," the box for "decisions poor; cues, supervision required," was checked with an example of "Smoking undesignated areas." A review of Resident #18's "Nursing Monthly Assessment" form dated [DATE] under section C, "Daily decision making skills example required," the box for "decisions poor; cues, supervision required," was checked with an example of "Smoking in undesignated areas." A review of Resident #18's "Nursing Monthly Assessment" form dated [DATE] under section C, "Daily decision making skills

	example required," the box for "decisions poor; cues, supervision required," was checked with an example of "History of smoking in undesignated areas." A review of Resident #18's "Nursing Monthly Assessment" form dated [DATE] under section C, “Daily decision making skills example required," the box for "decisions poor; cues, supervision required," was checked with an example of "Smokes in non-designated areas." A review of Resident #18's medical record revealed a "Smoking Observation Form," that was not dated, that indicated that Resident #18 was a supervised smoker with a note stating, "cigarettes and lighter kept for resident at nurses’ station." A review of Resident #18's medical record revealed a "Smoking Observation Form," dated [DATE], that indicated that Resident #18 was a supervised smoker with a note stating, "cigarettes and lighter kept for resident at nurses’ station." A review of Resident #18's Nurse's Progress Notes and Provider Progress Notes from [DATE] to [DATE], revealed no documentation of smoking incidents or smoking in undesignated areas. During an observation on 7/19/22, at 12:41 p.m., Resident #18 was observed smoking in an undesignated area on the unit balcony. Administrative Nurse A was observed instructing the resident to put their cigarette out. During an interview on 7/19/22, at 1:52 p.m. with Administrative Nurse A, stated that they saw Resident #18 smoking on the unit balcony, which was an undesignated area, and told them to put out their cigarette. They stated that Resident #18 had a history of smoking in undesignated areas like the balcony, in their room, and in their bathroom. The nurses held onto their cigarettes and lighter. They provided them with a cigarette and lighter when they wanted to go and smoke. They did not escort them to the designated smoking area. During an interview on 7/22/22, at 8:46 a.m. with Administrative Nurse B, they stated that an incident report for Resident #18's violation of smoking in an undesignated area on 7/19/22, per the facility policy for the safety committee review, was not completed. During an interview on 7/22/22, at 9:15 a.m. with Administrative Nurse C, they stated that they did not review Resident #18's "Nursing Monthly Assessment" when they updated the Care Plan in [DATE]. The nurses who identified Resident #18’s behavior of smoking in undesignated areas should have

	updated the Care Plan with new interventions. Administrative Nurse C stated that they thought Resident #18 was an unsupervised smoker since the nurses only held their cigarettes and lighter and did not escort them to the smoking area because Resident #18 was capable of lighting and safely putting out their own cigarettes. They stated that they should have put that Resident #18 was a supervised smoker. They stated that they assumed that the undated "Smoking Observation Form" listed above was the assessment for [DATE].
§ 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 – Many	Based on facility observations and staff interviews, the facility failed to ensure that food was stored, prepared, distributed, and served under sanitary conditions. Specifically, the facility failed to ensure: -food was dated, labeled, and stored appropriately -dishwasher temperatures were properly monitored -food temperatures were properly monitored The findings include: Review of the facility's policy, "Receipt and Storage of Food and Supplies," was provided on 7/22/22, and had an effective date of 9/1/01, and was last revised 3/24/16. The policy stated in pertinent part: "Procedure: 1. The Dietary [Staff] or trained designee is accountable for receiving and storage of food and supplies. 5. All food will be checked for vermin infestations and damage. Infested or damaged items, i.e. rodent remains, dented cans, cracked eggs, etc. will not be accepted. 9. Bent and/or damaged cans and/or supplies should not be placed on storeroom shelves or bins. These items are to be placed in a labeled designated area and stored separately to be picked up by the vendor." Review of the facility policy, "Food Temperatures," was provided on 7/22/22, and had an effective date of 9/1/01, and was last revised 3/24/16. The policy stated in pertinent part: "Procedure: 3. Food temperatures will be taken before and after serving, temperatures will be logged directly on the Food Temperature Log Form. The recorded food temperatures should be kept in a file for six months." Observations, on 7/20/22, beginning at 9:05 a.m., at the facility's main offsite kitchen, were made with Dietary Staff A. There were 36 number (#) 10 Sysco food cans on a pantry shelf. Numerous cans were observed with varying degrees of dents and indentations dispersed among the shelves. Dietary Staff A said that not all of the cans on these shelves were dented, and they

	would be used if they were not too dented. The cans were not separated by level of dentation, and were not designated as useable or not usable, and were not separated from the stock of cans. One (1) five (5)-pound (lb.) 10-ounce (oz.) bottle of sesame sauce was observed opened and undated on a pantry shelf. The bottle said to refrigerate after opening. Dietary Staff A was not sure when it was opened and said it would be thrown out. There were two (2) large, opened bags of breadcrumbs on a shelf, tied closed, and not dated. Dietary Staff A said that they were not sure when they were opened, so they would throw them out. They said that the food items should be dated and labeled if opened. On 7/20/22, at 10:00 a.m., the low-temperature dish machine cycle was run after having already completed the breakfast dishes. The dishwasher temperature did not surpass 100 degrees Fahrenheit (F) after three (3) cycles. Continuous observations revealed the temperature not rising after over 10 minutes. The sanitizer ppm (parts per million) was appropriate. Dietary Staff A said that they would like to see the dish machine temperatures logged at least twice a day for compliance, and the wash cycle at 120 degrees F, the rinse cycle at 140 degrees F, and the sanitizer at 100 ppm. The “Dish machine Temperature Log” Form for July 2022 was reviewed 7/20/22, at 10:15 a.m., and had been filled out three (3) times a day, for breakfast, lunch, and supper. The wash cycle was completed each day at exactly 120 degrees F, the rinse cycle was completed each day between 120 degrees F and 160 degrees F, and the sanitizer was completed each day at between 100 ppm and 140 ppm. On 7/20/22, at 10:20 a.m., the breakfast, lunch, and supper temperature log had already been completed for 7/20/22. These were the only documented directions found for temperature guidance of the dish machine. On 7/20/22, at 10:25 a.m., Dietary Staff A said that they were not aware that the dish machine temperature log had already been completed for the entire day of 7/20/22, or that there was a temperature problem. They said that it was a concern so they would contact maintenance to come and check the machine. There was no observation of temperature or ppm logging of the dish machine during these cycles. On 7/20/22, at 10:28 a.m., Dietary Staff B said that they took the temperature of the food items as they were done cooking, and before the food was boxed to be sent over to the main buildings (approximately two (2) miles away). They said that the staff at the facility onsite kitchens took temperatures again before

	serving the food. The food temperature logs were reviewed as Dietary Staff B was completing the form. The lunch for 7/20/22, was being logged on the 7/21/22, section of the form, and the lunch temperatures for 7/20/2022, had already been completed. Reviewing the food temperature logs, they said that they must have gotten their days mixed up. Food Temperature Logs Reviewed 7/20/22, at 10:30 a.m.: --6/19/22-6/21/22, no temperatures were logged for the 6/19/22, breakfast or lunch meals, the dinner for 6/21/22, the breakfast, lunch, or dinner for 6/24/22, or the dinner for 6/25/22. --6/26/22-7/2/22, no temperatures were logged for 6/28/22, for breakfast or dinner, 6/29/22, for lunch, 6/30/22, for breakfast, lunch, or dinner, 7/1/22, for breakfast, lunch or dinner, or the breakfast and lunch for 7/2/22. --7/3/22-7/9/22, no temperatures were logged for the dinner on 7/9/22. --7/10/22-7/16/22, no temperatures were logged for breakfast or lunch on 7/13/22, and 7/14/22, for breakfast, lunch, or dinner on 7/15/22, and breakfast and lunch on 7/16/22. --7/17/22-7/21/22, the temperatures were logged for 7/20/22, for breakfast and lunch. Dinner was not logged for 7/20/22. Temperatures for breakfast were not logged for 7/21/22, but lunch was completed. On 7/20/22, at 10:40 a.m., Maintenance Staff A arrived and reviewed the dish machine. They said that the temperatures were running appropriately, after a dish machine staff member had reset the booster. Temperatures were observed running between 140F and 160F. They said that they thought the gauge might be faulty and they had called for service. On 7/20/22, at 10:50 a.m. Dietary Staff A said that they expected each meal to have temperatures logged. Reviewing the last few weeks of temperature logs, they said that it looked like the Dietary Staff had forgotten to log temperatures for all of the meals. They said that they looked at the logs at the end of each week, but the Dietary Staff were responsible for doing them before they loaded the food into the boxes to go to the main facility buildings. Dietary Staff A said the staff at the kitchenettes at the facility would then put the food on the serving line and take the temperatures again. On 7/20/22, at 12:10 p.m. Dietary Staff C was interviewed in the [LOCATION] building kitchen (main facility). they said that they were the only Dietary Staff manager and oversaw the main

	offsite kitchen and the onsite kitchens in [LOCATION] and [LOCATION] buildings. They said that Dietary Staff A was the Dietary Staff manager for the offsite kitchen, and Dietary Staff D was the Dietary Staff manager for the [LOCATION] kitchen. An observation, on 7/21/22, at 4:45 p.m., of the [LOCATION] kitchen, revealed two (2) bags of cereal were opened and undated in the pantry. Dietary Staff D was not aware that the cereal was not dated. On 7/22/22, at 8:35 a.m., the [LOCATION] kitchen was observed with Dietary Staff C. A five (5) lb. container of creamy peanut butter was observed opened, with a "best by" date of 4/22/22, printed on the jar. Two (2) packages of Seven (7) 1/4 oz. low-sodium tomato soup cans were observed in the pantry with expiration dates of April 2022 and May 2022. Dietary Staff C was surprised to find the expired items and said they would be thrown out. They said that their staff had regularly checked the food items to remove expired items but had not seen these. On 7/22/22, at 9:05 a.m., Dietary Staff E and Dietary Staff C were interviewed. They said that they were aware of the dish machine temperature logs being prefilled out and had addressed the concern. They said the dish machine items from the offsite kitchen only washed the offsite cookware, and the kitchenettes in the [LOCATION} and [LOCATION] buildings had their own dishwashers to wash resident utensils, dishware, and glassware (no identified concerns). They said that they were made aware of the food temperature logs not being completed. They both stated that they expected food to be logged for each meal at the offsite kitchen, and again before service from the onsite kitchenettes. Dietary Staff E said that the confusion the Dietary Staff B had with documenting food temperatures on the wrong date was due to the dinner meal being prepped early, and the cook logging that time in the wrong box.
§ 51.180 (c) Drug regimen review. (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (2) The pharmacist must report any irregularities to the primary physician and the director of nursing, and these reports must be acted upon. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on record review and interview with facility staff, the facility failed to ensure recommendations from Consultant Staff A were acted upon in a timely manner for one (1) (Resident #9) of four (4) residents whose records were reviewed for medications. The findings include: Review of facility policy titled, "Consultant [Staff] Services Provider Requirements," with an effective dated of 4/1/98, and most recently revised on 8/10/21, revealed, "Procedure: 3. The Consultant [Staff], or [their] designee, provides consultant [staff] services, including but not limited to the following:

	*Reviewing the medication regimen of each patient/resident at least monthly, utilizing federally-mandated standards of care in addition to other applicable standards, and documenting significant findings in the patient/resident's medical record. *Communicating to the responsible physician potential or actual problems detected relating to medication therapy orders. *Submitting a written report of findings and recommendations resulting from the review of medication regiment and nursing documentation records to the attending physician and the Director of Health Services, respectively." The policy does not identify who is to follow up on the recommendations to ensure each abnormality or recommendation submitted from Consultant Staff A was addressed in a timely manner; it only identifies who received the monthly reports. Review of the medical record for Resident #9 revealed they were admitted to the facility in 2021. Diagnoses included, but were not limited to, Schizophrenia, Schizoaffective Disorder, and Depression. Additional review of the medical record for Resident #9 revealed a Physician Order for Remeron 30 (milligrams) mg to be taken orally every night at bedtime. This order was dated [DATE], which was an increase from the previous order for 15 mg daily at bedtime. Continued review of the medical record for Resident #9 revealed Consultant Staff A conducted monthly medication reviews. On the review dated [DATE], Consultant Staff A made a recommendation to decrease the dose of Remeron as part of the Gradual Dose Reduction (GDR). Licensed Nurse A reviewed the recommendation and wrote on the staff recommendation sheet to decrease the Remeron to 7.5 mg orally every night at bedtime. This recommendation was signed by Licensed Nurse A and the Physician on [DATE]. Review of the Progress Note dated [DATE] and written by Licensed Nurse A, noted, "Writer will also < [decrease] Remeron 7.5 mg orally (po) every night at bedtime (qHS) per [Staff] recommendations." Review of the Physician's Order revealed there was no order to decrease the Remeron to 7.5 mg every night at bedtime. On 7/20/22, at 9:58 a.m., an interview with Administrative Nurse D revealed when Consultant Staff A completed their review, they gave the recommendations to Administrative Nurse B. They gave the recommendations to the Licensed Nurse and the Licensed Nurse gave the completed review to the floor nurse

	who would have written the order and placed the recommendation in the resident's chart. After review of Resident #9's medical record, Administrative Nurse D confirmed the dose reduction of the Remeron was not done as written. On 7/20/22, at 10:12 a.m., an interview with Licensed Nurse B revealed that when Consultant Staff A completed their review, they gave the recommendations to Administrative Nurse B. Administrative Nurse B gave the recommendation to the Licensed Nurse. After the Licensed Nurse completed the review, they placed the recommendation in the "doctor book" for the physician to sign. After the doctor signed it, they placed it in the Medical Records box to be filed. On 7/20/22, at 10:13 a.m., an interview with Administrative Staff A revealed that when they received the monthly Consultant Staff A recommendation reports, they filed them in the resident chart. They stated that they did not review them for completeness or accuracy before filing them. On 7/20/22, at 10:20 a.m., an interview with Administrative Nurse B revealed that after the physician signed the recommendations, nobody reviewed the monthly Consultant Staff A recommendation reports. They stated that it was the responsibility of the Licensed Nurse to write the order for any changes they made on the monthly Consultant Staff A recommendation report. They confirmed the order to decrease the Remeron was not completed as it should have been so the dose reduction was not done. On 7/20/22, at 10:40 a.m., an interview with Licensed Nurse A revealed that they wrote the recommendation on the Consultant Staff A review sheet and in their Progress Note, both dated [DATE]. They stated that they failed to write the order on the Physician Order so the order was never completed, and the dose reduction was not done. On 7/20/22, at 2:05 p.m., an interview with Consultant Staff A revealed that they had completed monthly medication reviews for Resident #9 on [Date], [DATE], [DATE] and [DATE]. They stated on [DATE], they made a recommendation to decrease the Remeron from 15 mg daily at bedtime to 7.5 mg daily at bedtime as part of a recommended dose reduction. Consultant Staff A stated that when they conducted the review on [DATE], they realized the Licensed Nurse had written on the [DATE] recommendation to decrease the Remeron as recommended but the order was not written so they made the recommendation to bring the order forward. Consultant Staff A also stated that when they completed the review of Resident #9's medications on [DATE], the order to decrease the Remeron still had not been written, so again they made the recommendation to bring

	the order forward. Consultant Staff A confirmed the order for the dose reduction of the Remeron was not written so the dose reduction was not completed. The facility failed to ensure the recommended dose reduction of Remeron for Resident #9 was acted upon completely and thoroughly for 54 days, by failing to obtain a Physician Order reflecting Consultant Staff A's recommendation that was agreed upon by the Licensed Nurse and signed by the Licensed Nurse and the physician.
§ 51.180 (e) (1) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Some	Based on observation, record review, and interview, the facility failed to store drugs in locked compartments, permit only authorized personnel to have access to medications, and store medications to prevent cross-contamination. Nurses were observed leaving medication on top of the medication cart unattended, the medication cart unlocked, storing a personal drink in the medication cart with resident medications, and leaving a treatment cart with topical medications unlocked. Two (2) of five (5) medication carts were reviewed for medication storage. The findings include: A review of the facility policy titled, "Medication Administration: General Guidelines," reviewed 5/20/22, revealed, "Policy Statement: Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication…Procedure: …16. During routine administration of medications, the medication cart is kept in the doorway of the patient/resident's room, with open drawers facing inward and all other sides closed and locked. No medications are kept on top of the cart, and all outward sides must be inaccessible to patients/resident or others passing by." During an observation on 7/20/22, at 8:28 a.m**.,** Licensed Nurse C left nasal spray and medications, some of which had been crushed and placed in a medication cup with some still whole in the same medication cup, on top of the medication cart. Licensed Nurse C left the cart to get pudding, leaving the medications on top of the medication cart, which was not within their eyesight. At 8:50 a.m. on 7/20/22, during a medication pass observation, Licensed Nurse C walked into a resident's room with their medications in a medication cup, placed the cup on the bedside table, and left the resident's room before the resident took their medications. Licensed Nurse C went back to their cart outside of the resident's room and started to pull medications for the next resident. When asked by the surveyor how they knew the

	resident took all of their medications since they did not stay in the room with the resident while they were taking their medications, Licensed Nurse C stated, "because [they] always take [their] medications." Licensed Nurse C was observed to have an open bottle of soda that was approximately ¾ full. They took the soda bottle off the top of their cart and placed it in the drawer with the residents' medications. When asked whose soda it was, they stated that it was theirs. After medication pass observations, the surveyor discussed the above concerns with Licensed Nurse C. They did not comment. During an observation on 7/20/22, at 10:06 a.m., Licensed Nurse C left the medication cart unlocked in the hallway, with drawers facing the hallway while they were in room [LOCATION]. The door to room [LOCATION] was partially closed, leaving the medication cart out of the nurse's sight. A medication cart was observed unlocked and unsupervised on 7/21/22, at 5:08 p.m., in the [LOCATION] building outside resident room [LOCATION]. On top of the medication cart was a plastic cup with a slurry in it. There were no staff observed on the hallway. Residents were observed down the hallway in the common area approximately 20 feet away, eating meals. Four (4) minutes later, at 5:12 p.m., Licensed Nurse D exited resident room [LOCATION]. They went to the medication cart and stirred the slurry. They said that the slurry contained Tylenol and Senna for a resident in the room they just exited. They said that they were getting ready to administer it to the resident. During an interview on 7/21/22, at 3:06 p.m., with Administrative Nurse B, they stated that nursing staff should not leave medications on top of the medication carts unattended and out of sight. There were a lot of residents with Dementia who walked up and down the hall. One (1) of them could come up to the cart and take the medications. They expected the medication carts to be locked at all times when unattended. They stated that personal drinks were not to be stored in the medication carts. They stated that the nurse was to administer medications, and medications were not to be left in the room unattended by the nurse for the resident to take on their own. This would be considered self-administration of medication, and they do not do that at this facility.
§ 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.	1. Based on observation and interview, the facility failed to maintain the smoke barriers ([LOCATION]). The deficient practice affected one (1) of 32 smoke compartments in the [LOCATION] building, staff, and 19 residents. The facility had the capacity for 375 beds with a census of 155 on the first day of survey.

(a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Many	The findings include: Observation during the building inspection tour on 7/19/22, at 1:44 p.m., of the smoke barrier above the lay in ceiling tile at the cross-corridor doors outside of [LOCATION] across from room [LOCATION], revealed an unsealed, two (2) inch opening with cables passing through the wall, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code. An interview with Maintenance Staff B revealed that the facility was not aware of the unsealed opening. Observation during the building inspection tour on 7/19/22, at 1:45 p.m., of the smoke barrier above the lay in ceiling tile at the cross-corridor doors inside of [LOCATION] adjacent to the nurse's station, revealed an unsealed, two (2) inch opening with cables passing through the wall, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code. An interview with Maintenance Staff B revealed that the facility was not aware of the unsealed opening. The census of 155 was verified by Administrative Staff B on 7/19/22. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff B during the exit interview on 7/20/22. **Actual NFPA Standard: NFPA 101 (2012) Life Safety Code** **19.3.7.3** Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1⁄2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2)*Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. **8.5** Smoke Barriers. **8.5.6** Penetrations. **8.5.6.1** The provisions of 8.5.6 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations of smoke barriers. **8.5.6.2** Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly

	constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. 2. Based on observations and interview, the facility failed to ensure occupant notification was installed in accordance with the code. The deficient practice affected one (1) of 14 smoke compartments in the [LOCATION], staff, and 62 residents. The facility had the capacity for 375 beds with a census of 155 on the first day of survey. Observation of the physical therapy room in [LOCATION] on 7/20/22, at 10:23 a.m., revealed that there were no occupant notification device installed (fire alarm strobe) in the room, as required by section 19.3.4.3.1 of NFPA 101, Life Safety Code. An interview with Maintenance Staff B revealed the facility was not aware that an occupant notification device was not installed in the physical therapy room since they were installed in all the other therapy rooms. The census of 155 was verified by Administrative Staff B on 07/19/22. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff B during the exit interview on 07/20/22. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.4.3.1** Occupant Notification. Occupant notification shall be accomplished automatically in accordance with 9.6.3, unless otherwise modified by the following: (1)*In lieu of audible alarm signals, visible alarm-indicating appliances shall be permitted to be used in critical care areas. (2) Where visual devices have been installed in patient sleeping areas in place of an audible alarm, they shall be permitted where approved by the authority having jurisdiction **9.6.3** Occupant Notification. **9.6.3.1** Occupant notification shall be provided to alert occupants of a fire or other emergency where required by other sections of this Code. **9.6.3.3** Where permitted by Chapters 11 through 43, a presignal system shall be permitted where the initial fire alarm signal is automatically transmitted without delay to a municipal fire department, to a fire brigade (if provided), and to an on-site staff person trained to respond to a fire emergency. **9.6.3.4** Where permitted by Chapters 11 through 43, a positive alarm sequence shall be permitted, provided that it is in accordance with NFPA 72, National Fire Alarm and Signaling Code. **9.6.3.5** Unless otherwise provided in 9.6.3.5.1 through 9.6.3.5.8, notification signals for occupants to evacuate shall be audible,

	and visible signals in accordance with NFPA 72, National Fire Alarm and Signaling Code, and ICC/ANSIA117.1, American National Standard for Accessible and Usable Buildings and Facilities, or other means of notification acceptable to the authority having jurisdiction shall be provided 3. Based on observations and interview, the facility failed to ensure electrical equipment was installed in accordance with the code. The deficient practice affected one (1) of 32 smoke compartments in the [LOCATION], staff, and 19 residents. The facility had the capacity for 375 beds with a census of 155 on the first day of survey. The findings include: Observation on 7/19/22, at 1:44 p.m., revealed exposed wires above the lay-in ceiling tile adjacent to the nurse's station. Further observation revealed the exposed wires were live after they were tested with a voltage meter, measuring over 120-volts, and were not protected in a junction box with a cover, as required by article 314.28 of NFPA 70, National Electrical Code. An interview with Maintenance Staff B revealed the facility was not aware of the exposed wiring. The census of 155 was verified by Administrative Staff B on 7/19/22. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff B during the exit interview on 7/20/22. **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** Utilities. **9.1.2** Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. **Actual NFPA Standard: NFPA 70, National Electrical Code (2010)** **314.28** Pull and Junction Boxes and Conduit Bodies. Boxes and conduit bodies used as pull or junction boxes shall comply with 314.28(A) through (E). (C) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110.

§ 51.200 (h) (2) Other environmental conditions. Have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on observation and interview, the facility failed to have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two (2). The deficient practice affected two (2) of 14 compartments in the [LOCATION], staff, and 46 residents. The facility had the capacity for 375 beds with a census of 155 on the first day of survey. The findings include: Observation on 7/19/22, at 3:33 p.m., of the Janitor's Closet on [LOCATION] across from resident room [LOCATION] revealed there was not adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two (2), as required by the VA standard. AN interview with Maintenance Staff B revealed that the facility was unaware there was no ventilation in the Janitor's Closet. Observation on 7/19/22, at 3:41 p.m., of the Janitor's Closet on [LOCATION] across from resident room [LOCATION] revealed there was not adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two (2), as required by the VA standard. An interview with Maintenance Staff B revealed that the facility was unaware there was no ventilation in the Janitor's Closet. The census of 155 was verified by Administrative Staff B on 7/19/22. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff B during the exit interview on 7/20/22.