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 31061

Onsite / Virtual: Onsite

Dates of Survey: 7/11/23 – 7/14/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 375

Census on First Day of Survey: 142

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from July 11, 2023 through July 14, 2023 at the Georgia War Veterans Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.70 (a) (1) – (5) Exercise of 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 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.	Based on observations, interviews, and record review, the facility failed to protect the resident's right to be free from physical restraint by failing to disengage their wheelchair brakes upon the resident's request. This deficient practice affected one (1) resident from a total of 29 residents sampled. The findings include: According to the facility's policy for restraints titled, "Restraint Use," and dated 6/7/21, the facility defined a physical restraint as any device, material, or equipment that restricts the resident's movement or access to the body, which can include side rails that prevent the resident from independently getting out of bed, or chairs, trays, tables, belts, or other devices that prevent residents from independently rising. A review of Resident #15's medical record revealed an initial admission date of [DATE]. Resident #15's medical diagnoses included: Paraplegia, Post-Traumatic Stress Disorder, Depression, and Anxiety. A Significant Change Minimum Data Set (MDS) assessment, dated [DATE], indicated a Brief

(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. **Level of Harm** – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #15 required extensive assistance with most activities of daily living. They were able to independently propel themselves in a wheelchair. On 7/11/23, at 11:40 a.m., an initial tour of the [LOCATION] was conducted. Staff were observed assisting residents to tables in the [LOCATION] in preparation for lunch. Licensed Nurse A was observed pushing Resident #15 to a dining table and locking the wheelchair brakes. Resident #15 was in a modified Broda wheelchair which reclined. The wheelchair brakes were located near the bottom of the chair in a location where Resident #15 would not be able to reach them independently. On 7/11/23, at 12:16 p.m., Resident #15 finished their meal and attempted to leave the dining room table in their wheelchair. Resident #15 asked Licensed Nurse A whether the wheelchair brakes were locked. Licensed Nurse A replied, "Yes, until everyone is done eating." Resident #15 replied, "Please just unlock my wheelchair. I'm done eating and I'm ready to go." Licensed Nurse A replied, "You need to wait until everyone is done eating." Resident #15 replied, "Ok. Yes ma'am." Resident #15 placed their arms in their lap and did not engage in further conversation with Licensed Nurse A. On 7/11/23, at 12:21 p.m., Administrative Nurse A approached Resident #15's table and asked the residents seated at the table how their lunch was. Resident #15 asked Administrative Nurse A to unlock their wheelchair because they did not want to continue sitting at the table. Administrative Nurse A replied, "You're going to have to wait a few minutes." Administrative Nurse A did not disengage Resident #15's wheelchair brakes. Resident #15 did not engage in any further conversation with Administrative Nurse A. At approximately 1:15 p.m., after most residents had finished lunch, Licensed Nurse A released Resident #15's wheelchair brakes and they were able to leave the dining table. On 7/11/23, at approximately 1:15 p.m., an interview was conducted with Licensed Nurse A. Licensed Nurse A explained that Resident #15's brakes were locked to "keep [Resident #15] from bumping into other people when [Resident #15] leaves the dining room." Licensed Nurse A acknowledged that Resident #15 was alert, oriented, and able to make their own decisions, including when to leave the dining room. Licensed Nurse A was then asked why Resident #15 would not be positioned in the dining room in such a way that they could exit without having to maneuver around furniture and fellow residents. Licensed Nurse A stated, "that is something we can look at."

	On 7/12/23, at approximately 11:00 a.m., an interview was attempted with Resident #15. They were lying in bed with their eyes open. When asked how they were doing, Resident #15 stated, "I'm not in a good mood. Please come back later. I've been trying to get up since early this morning and no one will help me." On 7/12/23, at 12:48 p.m., a follow up observation of Resident #15 was conducted. They were lying in bed conversing with a visitor who was sitting at the bedside. On 7/13/23, at 10:22 a.m., an interview was conducted with Resident #15. During the interview, Resident #15 explained that staff had kept them at the dining room table with their wheelchair brakes locked on "several occasions." Resident #15 was not able to recall any particular staff member, and explained that they had very poor vision in both eyes, so they were not able to identify people most of the time. When asked whether they had reported the concern to any of the facility's administrative staff, Resident #15 stated, "I've talked to somebody before, but I don't know who it was." Resident #15 went on to explain that they felt "imprisoned" when they weren't able to move around in the wheelchair independently, and that they were "tired of it."
§ 51.70 (f) (1) – (2) Grievances. A resident has the right to— (1) Voice grievances without discrimination or reprisal. Residents may voice grievances with respect to treatment received and not received; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on interview, record review, and review of facility policy, it was determined for two (2) of 29 residents (Resident #10 and Resident #23) that the facility failed to make prompt efforts to resolve grievances when residents and/or a responsible party (RP) voiced concerns with treatment not received. Resident #10 voiced a grievance regarding being served cold food. The facility responded by telling the resident to ask staff to reheat the food, without further investigation or attempts to resolve the issue. The resident continued to receive foods that were served cold. The Responsible Party (RP) for Resident #23 voiced a grievance that the resident was transferred to an acute care facility without first receiving proper mouth care. The facility failed to investigate to determine if the resident had received mouth care as required, and resolve the grievance with corrective action, if indicated. The findings include: Review of a facility policy titled, "Grievances: Healthcare Centers," revised 11/21/22, revealed: "Policy Statement: It is the policy of [facility name] and its affiliated healthcare centers to follow an established process whereby patients and/or other customers may have their grievances and complaints resolved

	in a prompt, reasonable and consistent manner." Procedures established included: "If the grievance is taken and a response can be started, complete the *Action Taken and Findings* section of the *Grievance/Complaint Form: Healthcare Centers* and give it to [Administrative Staff A] or designee...2. [Administrative Staff A] will be responsible for overseeing the grievance process: [Administrative Staff A] or designee will track the grievance on the *Grievance/Complaint Log Form: Healthcare Centers*... [Administrative Staff A] or designee will then refer the grievance to the appropriate department for investigation if it has not already been referred. 3. Once the referral is made to the responsible discipline, the responsible discipline will make prompt efforts to resolve the grievance...The action taken should be recorded on the *Grievance/Complaint Form: Healthcare Centers*, then signed and returned to [Administrative Staff A] or designee...for final review. 4. [Administrative Staff A] or designee will be responsible for follow-up with the patient, authorized individual or other representative to determine the grievance has been resolved and to ensure the grievance process is understood...5. The Grievance/Complaint should be resolved within three business days. 6. If the complainant is not satisfied with the resolution or written response of [Administrative Staff A] or designee, the complainant may submit an oral or written grievance to the community Ombudsman" [sic]. 1. Review of a "Grievance/Complaint Log Form: Healthcare Centers," revised 10/29/18, and reviewed 11/3/22, with documented grievances for the year [DATE], revealed on [DATE], Resident #10 filed a grievance through the facility's established grievance procedures. Per the Grievance/Complaint Form: Healthcare Centers (revised 11/28/22), the resident complained the food was cold; they did not receive salt/pepper with meals; and did not receive ice with beverages at meal services. The Grievance/Complaint Log Form specified the grievance had been referred to the Dietary Department on [DATE], (one (1) day before the date the grievance was filed). The Grievance/Complaint Log Form indicated the "Date Staff Action Completed" was on [DATE], the same day the grievance was filed by Resident #10. The action/response to resolve the grievance specified "advised ask nurse to heat it up." No further action in regard to Resident #10's filed grievance was documented. The grievance form had a category that asked, "Is It Resolved?" and the documented response was "Yes." A request for further documentation of the investigation and resolution of the filed grievance revealed there was no further action or follow-up taken. An interview with Resident #10, on 7/11/23, at 12:13 p.m., revealed the resident filed a grievance related to cold food, especially the grits in the morning. The resident stated this had

	been an ongoing complaint of the residents, and the only resolution was to have the staff re-heat the food. The resident stated that staff did not have time to re-heat the food, and the food continued to be cold. An interview was conducted, on 7/13/23, at 11:15 a.m., with Licensed Nurse B. They stated the documentation on the Grievance/Complaint form and log for the grievance filed by Resident #10 was the only investigation that had been done to address the cold food concern. 2. Review of a "Grievance/Complaint Log Form: Healthcare Centers," revised 10/29/18, and reviewed 11/3/22, with documented grievances for the year [DATE], revealed on [DATE], a grievance was filed by Resident #23 in regard to dissatisfaction with oral care. The grievance was referred to nursing on [DATE]. The grievance log documentation indicated the staff's actions to address the grievance were completed on [DATE], with a follow-up on [DATE]. The documented response taken to address the grievance was "staff re-educated." The grievance regarding Resident #23 not receiving proper oral care was also documented on a "Grievance/Complaint Form: Healthcare Centers," revised 11/28/22, and revealed the grievance was taken by Consultant Staff A on [DATE], from Resident #23's RP. Consultant Staff A documented the grievance was referred to Licensed Nurse B. Consultant Staff A noted the grievance was received from Resident #23's RP via telephone, who reported the resident had been transferred to the local hospital the previous [DATE], from the facility, without receiving proper mouth care. The RP reported Resident #23 was sleeping with their mouth wide open and was noted to have teeth "caked with gunk," and it was so thick the RP could "pull it out with their hands." The RP asked the hospital nurse to help clean Resident #23's teeth. The nurse used a suction tube to get some of the debris out of the resident's teeth. The RP stated they felt the resident was not receiving the proper daily oral care needed. Licensed Nurse B documented on the grievance form the steps taken to investigate the grievance were to interview Administrative Nurse A, interview the RP, and conduct a staffing review by Administrative Nurse A. A summary of the grievance investigation was documented that specified "referred to [Administrative Nurse A] for appropriate staffing measures and/or receiving education/reeducation. Confirmed by [Administrative Nurse A]." The documentation regarding the filed grievance contained no evidence of an investigation to determine if the reported grievance was substantiated regarding Resident #23's reported poor oral status. There was no documented evidence to indicate Resident #23's RP, who filed the grievance, had been contacted

	to report the investigative findings to the satisfaction of the complainant. Resident #23 was admitted to the facility on [DATE]. The resident had a diagnosis of Dysphagia. Review of a Significant Change Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #23 was severely impaired in cognitive skills for daily decision making. The assessment indicated the resident had exhibited no behavioral symptoms during the review period. The resident required total assistance of one (1) staff person with personal hygiene. Resident #23 received nothing by mouth, with all caloric intake and fluids received via feeding tube. The Care Area Assessment (CAA) summary for the triggered care area of nutritional status indicated the resident had some natural teeth missing, with some teeth noted to be broken and decayed. Review of Resident #23's Care Plan, to address nutritional status, dated [DATE], revealed the problem deficit included the resident having some natural teeth missing with partial dentures to upper and lower gums. Some teeth were noted to be carious. The established goals included that the resident would have adequate oral care for the next 90 days. Care Plan approaches included to remind and encourage the resident to perform oral hygiene at least twice a day and for staff to assist as needed. An interview was conducted, on 7/13/23, at 11:10 a.m., with the Consultant Staff A. They stated they were not Administrative Staff A's designee to oversee the grievance process. Consultant Staff A stated they did keep a file on grievances, but sometimes it was other department heads who received and investigated grievances. An interview was conducted, on 7/13/23, at 11:15 a.m., with Licensed Nurse B. They stated the documentation on the Grievance/Complaint form and log for the grievance filed by Resident #10's RP was the only investigation that had been done to address the concern. Licensed Nurse B acknowledged that no investigation had been conducted to determine the validity of the grievance filed by the resident's RP. They stated the RP had not been notified of the facility's findings regarding the investigation of the reported grievance.
§ 51.100 (d) Participation in resident and family groups. (1) A resident has the right to organize and participate in resident groups in the facility;	Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure that residents had the right to attend scheduled Resident Council meetings without staff present. Additionally, concerns presented by residents to facility management regarding issues affecting resident care and life in the facility were not acted upon. The findings Include:

(2) A resident's family has the right to meet in the facility with the families of other residents in the facility; (3) The facility management must provide the council and any resident or family group that exists with private space; (4) Staff or visitors may attend meetings at the group's invitation; (5) The facility management must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings; (6) The facility management must listen to the views of any resident or family group, including the council established under paragraph (c) of this section, and act upon the concerns of residents, families, and the council regarding policy and operational decisions affecting resident care and life in the facility **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	Review of a facility policy titled, "Patient/Resident Council," revised 10/20/17, and reviewed 11/29/22, revealed: "Policy Statement: A Patient/Resident Council will be developed and supported by the administration. Recreation Services staff will provide coordination and support assistance as needed to assure patients/residents are provided with the opportunity to have and participate in an active Patient/Resident Council. The Council will serve as a vehicle for patients/residents to exercise their rights and protect their interests by participating in decisions which affect their lives. It is intended to promote patient/resident interest and involvement in healthcare center policies and day to day activities." Procedures identified included: "1. The Patient/Resident Council will meet as a group…2. Issues raised/discussed, and recommendations made by the Patient/Resident Council will be communicated to the healthcare center administration, considered in center planning, and responded to promptly…5. The Council will be provided with a private place to meet. 6. All patients/ residents are automatically a member of the Patient/Resident Council when admitted to the healthcare center…7. The Patient/Resident Council Meetings will be held according to a planned agenda developed in advance by the Council officers with the assistance of the designated staff person liaison…8. Minutes will be taken by the Council Secretary or designated staff liaison (at the request of the Council) …10. Issues, concerns, ideas, or complaints of the Council will be transferred to the Patient/Resident Council/Family Council Department Response Form by the staff liaison person and given to [Administrative Staff A] for distribution and response by the appropriate department. The response/action will be documented on this form, returned to the Council staff liaison for communication back to the Council Presiding Officer and presentation at the next council meeting…15. [Administrative Staff A, Administrative Staff B,, Dietary Staff A, and other department heads may be invited when issues involve their respective departments. This will be done with the approval of group members." A review of Resident Council meeting minutes revealed a meeting was conducted on [DATE]. Old business from the previous council meeting was read and included the residents wanted better food. Additionally, the minutes indicated the Resident Council members had reported the food substitutes for menu items were unacceptable. Dietary Staff B was present and responded that the dietary department would order more food so the facility wouldn't run out. Dietary Staff B reported new menus were coming from "Corporate." The meeting minutes contained documentation the residents' voiced concerns regarding activities, and stated they would like to return to having more tournament style activities, have the

	canteen open more than two (2) days each week, and have the apparel shop reopened. Consultant Staff C responded to the residents that they would check into getting more volunteers to come to the facility to staff the canteen and apparel shop so they could be open more often. Consultant Staff D, who served as the designated staff liaison, acknowledged that the activity program, in the past, had provided a variety of tournaments and planned to implement the activity again, now that COVID restrictions had been lifted. The Resident Council meeting minutes ended with a list of names that indicated 14 staff persons attended the Resident Council meeting. Review of the Resident Council meeting minutes revealed a Resident Council meeting was held on [DATE]. Consultant Staff C addressed changes to the apparel shop, which indicated Administrative Staff A had approved moving it to the pavilion area. Meeting minute documentation revealed residents continued to complain regarding the food, and indicated food was being served cold. The residents indicated they were not happy with the food. One (1) resident stated they would like to be served coffee with their meals. Dietary Staff C responded that food trays could be reheated on the unit and coffee could be ordered anytime. Dietary Staff C stated they would find out when the new menus would be arriving and would ensure snacks were delivered to the units. A resident asked when they could start going to the [LOCATION] again. Consultant Staff E told the residents no one was allowed to use the [LOCATION], residents or staff. One (1) resident commented that staff should identify themselves before addressing the council. The meeting minutes ended with a list of 14 names of staff who were present at the meeting. A group meeting was held with the surveyor present on 7/12/23, at 1:15 p.m., with eight (8) members of the Resident Council (Residents #5, #22, #24, #25, #26, #27, #28, and #29). When questioned about the food service, the residents unanimously voiced that food was being served cold. The residents stated that two (2) of three (3) meals served each day contained cold food. The residents complained that grits served for breakfast were always so cold they could “stick a fork in them and it would stand up.” The residents stated the cold food concerns had been mentioned in numerous Resident Council meetings and the response was always that the residents should ask staff on the unit to heat it up for them. But the Certified Nurse Aides did not want to heat it. Sometimes ice cream bars would be served on the meal tray as a dessert. The ice cream would be so melted by the time the residents opened it, the paper wrapper would be wet and shredded into the ice cream to the point it couldn’t be eaten. The residents stated another concern was that food items would be missing when the meal trays arrived. An example given was that a few mornings previously residents

	were served cereal without milk on the meal tray. The residents indicated a Resident Council meeting had been held the previous day, [DATE], and it "got heated in there." Dietary Staff B asked the residents to raise their hand if anyone liked the food served. Nobody raised their hand. Dietary Staff B stated they had a menu and had to follow it. The residents stated they felt breakfast was being served cold because the meal service was scheduled to start at 7:00 a.m. However, the shift change for staff was also at 7:00 a.m., which caused a delay in the meal being served so the food sat without being served. This was because there were no staff in the dining room to serve the meal. The facility required a nurse to be in the dining room before the meal could be served. Sometimes the nurse came into the dining room late and acted like they were "doing us a favor by coming." The residents stated they had brought these and other concerns forward in the Resident Council meetings and that it did no good. The residents felt the facility did not care what they had to say and didn't do anything about their concerns. The residents indicated there was always a large group of staff in the Resident Council meetings. The residents did not know who all of the staff were that attended, and indicated the residents did not invite staff, they just always showed up to attend. The residents were not aware they could meet without staff, and/or they could invite the staff they wanted to have in their Resident Council meetings. An interview was conducted on 7/14/23, at 12:35 p.m., with Consultant Staff C. They stated residents did complain about food during the Resident Council meetings. The dietary department staff discussed the concerns with the residents. When concerns were brought up by the residents, the department staff responsible for the area of concern usually talked to the residents. Consultant Staff C stated the Resident Council President always called the Resident Council meeting to order. Staff pretty much just went in before the meeting started and sat down without being invited. No one had ever asked the staff to leave. Consultant Staff C stated they had been thinking about that, although no resident had complained to them about staff attending without invitation. An interview was conducted on 7/13/23, at 4:00 p.m., with Administrative Staff A, during the daily debrief. Administrative Staff A stated the Resident Council meeting was the residents' meeting. Staff should not attend without first being invited by the Resident Council members.
§ 51.100 (g) (1) Patient Activities. (1) The facility management must provide for an ongoing program of activities designed to meet, in	Based on interview, record review, and review of facility policy, it was determined the facility failed for three (3) of four (4) Units to provide an on-going activities program to meet the interests and needs of the residents. Individual and group interviews with residents revealed the residents complained there were no

accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	activities provided in the evenings and on weekends. A review of the activity calendar for [DATE] and [DATE] revealed a lack of consistently planned activities in the evenings and on weekends. The resident census was 142 and 125 residents resided on the three (3) Units affected by the deficient practice. The findings include: 1. Review of a facility policy titled, "Recreation Programming," revised 11/30/22, revealed: "Policy Statement: It is the policy of the Healthcare Center to provide a wide variety of recreation programs and opportunities for involvement in life according to an established schedule and spontaneously on a daily basis. Group and individual programming will be organized and designed to meet recreational interests and needs of each patient/resident with the objective of eliminating loneliness, helplessness, and boredom among the population of the healthcare center." Procedures established included: "Scheduling: 1. Group activity programming will be provided daily, seven days a week. 2. Group activities will be provided at hours convenient for, and/or desired by patients/residents, including every morning and afternoon and at least two [2] evenings per week." Review of a [DATE] activity calendar revealed a fish fry dinner activity at the Elks Lodge was planned for 5:00 to 9:00 p.m., on [DATE]. There were no further activities planned after 3:00 p.m., for the month of [DATE]. The [DATE] activity calendar had no activities planned for Thursdays ([DATES]) and no activities planned for Sundays ([DATES]). There were no activities planned for two (2) Saturdays ([DATE] and [DATE]). Review of a [DATE] activity calendar revealed there were no activities planned after 3:00 p.m., for the entire month. There were no activities planned for four (4) Saturdays ([DATES]) and five (5) Sundays ([DATES]). Review of Resident Council meeting minutes revealed residents voiced concerns regarding the provision of activities. Resident Council meetings were conducted on [DATE], and [DATE]. During both meetings, the residents reported they wanted to have more tournament style activities, and to be able to go to the [LOCATION] located on campus. A group meeting was conducted on 7/12/23, at 1:15 p.m., with eight (8) members of the Resident Council (Residents #5, #22, #24, #25, #26, #27, #28, and #29). The residents complained the facility did not provide activities on the weekends, and stated they would like to have something to do. Furthermore, the residents stated there was nothing to do after 5:00 p.m., in the evenings during the week. The residents stated there was a

	[LOCATION] on campus that contained pool tables and other activities. The [LOCATION] used to be open, and the residents could go there whenever they wanted to for entertainment. However, the [LOCATION] was now closed and not available to the residents. The residents indicated the recreation center had closed during the COVID pandemic and had not reopened. An interview was conducted, on 7/13/23, at 4:00 p.m., with Administrative Staff A, during the daily debrief. Administrative Staff A stated the previous Consultant Staff had recently retired, and Consultant Staff C was new to the position. Administrative Staff A stated Consultant Staff C was working hard to make changes and improvements to the activity program. Administrative Staff A acknowledged consultant staff were not scheduled to work and provide activities to residents on the weekends. An interview was conducted, on 7/14/23, at 12:35 p.m., with Consultant Staff C. They stated they were not aware there needed to be continuous activities provided on the weekends. Consultant Staff C confirmed that no consultant staff worked on the weekends and the calendar did not always include planned weekend activities. Consultant Staff C stated the activity calendars were developed based on resident input. However, Consultant Staff C did not know the residents wanted activities to be provided in the evenings. 2. An interview with Resident #10, on 7/11/23, at 12:13 p.m., revealed that activities were canceled without notice and there were no activities on the weekends. The facility offered bingo sometimes, which everyone enjoyed, although there was not enough to do. An interview with Resident #8, on 7/11/23, at 1:35 p.m., revealed that the facility had not offered activities on the weekends in a long time. There was not much to do on the weekends. Sometimes the activity calendar showed an activity, but it did not happen. An interview with Licensed Nurse C, on 7/12/23, at 1:45 p.m., revealed that Consultant Staff F was not in the building at this time due to having to drive residents to appointments. Consultant Staff F served as a driver in addition to being a Consultant Staff on the [LOCATION]. An interview with Consultant Staff F, on 7/13/23, at 1:15 p.m., revealed they were collecting needed items from several residents who could not shop for themselves. They had several envelopes with residents' names, the amount of money from their accounts, and the items they would like Consultant Staff F

	to purchase for them. The list included Resident #6's requested Diet Cokes and Little Debbie snacks. Consultant Staff F then explained that the facility had an appointment calendar for residents, who sometimes traveled to three (3) different locations for appointments. The facility did not have enough drivers every day, so they also served as a van driver on those days. Consultant Staff F produced an appointment calendar, which showed on [DATE], they were assigned to drive residents to their appointments. An interview, on 7/14/23, at 11:50 p.m., with Consultant Staff C revealed that they accompanied residents on their shopping trip that morning and was not certain if the 10:00 a.m., activity occurred. They revealed that Consultant Staff F was a van driver today, and the second consultant staff for the [LOCATION] served as a Certified Nurse Aide for the resident's appointments that day.
§ 51.110 (e) (2) Comprehensive care plans. A comprehensive care plan must be— (i) Developed within 7 calendar days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, record review, and staff interviews, the facility failed to revise the Care Plan for two (2) of 29 sampled residents, who began to have behaviors related to anxiety (Resident #6) and catheter placement (Resident #9). The findings include: Review of the policy titled, "Care Plans," effective 12/31/96, revealed: "Care Plan Review and Update: …4. Care plans will be updated by nurses, Case Mix Directors (CMD), or any other interdisciplinary team member so that the care plan will reflect the patient/resident's needs at any given moment." 1. Resident #6 was admitted to the facility on [DATE], with the following diagnoses: Depression, Dementia, and Anxiety. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident was not cognitively intact. The resident was assessed for having no behaviors or depressed moods, and was not assessed for taking any anti-anxiety medication. Review of the resident's Care Plan revealed they were at risk of social isolation and that they had a Wanderguard. An observation and interview with the resident, on 7/11/23, at 11:50 a.m., revealed the resident sitting in their room, in a wheelchair. The resident was alert with some confusion. The resident kept repeating that their family put the resident in the facility to get rid of them. The resident wanted to go back home and hire someone to take care of them.

	During an interview with the resident, on 7/12/23, at 9:42 a.m., while they sat outside of their room in a wheelchair, they stated they had memory problems. The resident stated they wished staff would take them outside from time to time. The resident stated that they felt "trapped like an animal." An interview with Licensed Nurse C, on 7/13/23, 10:15 a.m., revealed that they offered to take the resident outside, but the resident always said, "maybe later." They had asked the resident earlier in the day, and they said, "maybe later." Licensed Nurse D joined the conversation and revealed the resident was seen by Consultant Staff G weekly and was monitored for behaviors. Licensed Nurse D revealed the resident could be referred to the Counseling workload, and they would review the resident's medications. The resident was currently on Xanax 0.25 milligrams (mg) at 4:00 p.m., daily as needed for anxiety since the resident "Sundowns" and became confused, agitated, and anxious around that time. Licensed Nurse D stated they would have Consultant Staff E perform a depression screen on the resident. An observation, on 7/13/23, at 10:46 a.m., was made of the resident as they got on the elevator to go outside with Certified Nurse Aide A. An interview with Consultant Staff E, on 7/13/23, at 11:35 a.m., revealed they performed a "Depression Assessment" while the resident was outside, and the resident scored a four (4). A score of five (5) indicated the resident was depressed. An interview was conducted with Licensed Nurse C and Administrative Nurse B, on 7/13/23, at 1:50 p.m., regarding Resident #6's behavior that was documented in the record. Administrative Nurse B was not aware the resident was on a behavior management plan and should have a behavior Care Plan. Licensed Nurse C stated that nursing did not complete a behavior packet, which would have alerted Administrative Nurse B to update the Care Plan. 2. Record review revealed that Resident #9 was re-admitted to the facility on [DATE], with multiple diagnoses including: Cerebral Vascular Accident (CVA), Left Sided Hemiplegia, Dysphagia, Gastrostomy Tube, Hospice, and a Urinary Catheter. Review of the Quarterly MDS, dated [DATE], revealed a BIMS score of four (4), which indicated the resident was not cognitively intact. The resident was not assessed as having behaviors.

	Review of the resident's current Care Plan revealed they had a urinary catheter that was to be checked every shift for proper position of tubing and bag. There was not a Care Plan revision for behaviors of pulling on the catheter or maintaining the catheter bag and tubing off of the floor. Record review revealed the resident was hospitalized, on [DATE], after a urine culture revealed a urinary tract infection on [DATE]. Observation, on 7/11/23, at 10:28 a.m., revealed the resident was in a low bed with the catheter tubing lying on the floor with the catheter bag attached to the bed. Observation, on 7/12/23, at 9:23 a.m., revealed the resident in a low bed with the catheter bag touching the floor. Observation of catheter care, on 7/13/23, at 11:10 a.m., with Licensed Nurse E and Licensed Nurse C revealed the resident's leg strap was not attached to the leg, but rather attached to the tubing. There were green clamps attached to the tubing which were not attached to the bed sheets, which allowed the tubing to lay on the floor. During catheter care, a new leg strap was placed, and the green clamps were adjusted and placed on the bed sheets to keep the tubing off the floor. Both Licensed Nurse E and Licensed Nurse C stated the resident constantly picked at the catheter, tubing, and clamps, which was difficult to manage. Both Licensed Nurse E and Licensed Nurse C revealed that neither the catheter bag nor tubing should touch the floor. An observation of Resident #9 and an interview with Certified Nurse Aide B, on 7/14/23, at 9:52 a.m., revealed that they were assigned to care for the resident that day. Observation revealed the catheter tubing was lying on the floor. Certified Nurse Aide B stated that neither the catheter bag nor tubing should be lying on the floor, as that could lead to a urinary tract infection. Certified Nurse Aide B could not remember when the bag and tubing were last checked.
§ 51.120 (b) (3) Activities of daily living. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination.	Based on observations, interviews, and record review, the facility failed to provide necessary services to maintain good grooming, personal hygiene, and mobility to a resident unable to carry out activities of daily living (ADLs) independently. This deficient practice affected one (1) of three (3) residents reviewed for ADLs from a total of 29 residents sampled. The findings include: A review of Resident #15's medical record revealed an initial admission date of [DATE]. Resident #15's medical diagnoses

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	included: Paraplegia, Post-Traumatic Stress Disorder, Depression, and Anxiety. A Significant Change Minimum Data Set (MDS) assessment, dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #15 required extensive assistance with most activities of daily living to include shaving and bathing. During observations of Resident #15, on 7/11/23, at 11:40 a.m., and 7/12/23, at 11:00 a.m., Resident #15 presented with unkempt hair and unshaven facial hair. On 7/12/23, at approximately 11:00 a.m., an interview was attempted with Resident #15. They were lying in bed with their eyes open. When asked how they were doing, Resident #15 stated, "I'm not in a good mood. Please come back later. I've been trying to get up since early this morning and no one will help me." Resident #15's hair was unkempt and facial hair was unshaven. On 7/12/23, at 12:48 p.m., a follow up observation of Resident #15 was conducted. They were lying in bed conversing with a visitor who was sitting at the bedside. Resident #15's hair was unkempt and facial hair was unshaven. On 7/13/23, at 10:22 a.m., an interview was conducted with Resident #15 in their room. Resident #15 was laying in the bed with both legs draped over the side of the bed. Resident #15 had the bed remote in their hand raising the bed up and down repeatedly. Resident #15's nurse call light was tied around the left bed rail and was resting on the floor out of the resident's reach. Resident #15 explained that they had been requesting assistance out of bed since "early morning," and could not get any staff to assist them. Resident #15 went on to state, "very rarely will they get me up. I spend 98% of my time in here alone. My pastor came in yesterday and sat with me for a long time. I couldn't even get help to get up for that." When asked about bathing and shaving, Resident #15 stated, "It takes me a week or two (2) to get shaved and even longer for a bath. I used to shave once sometimes twice a day, but I can't do it anymore because my vision is so bad." On 7/13/23, at 11:45 a.m., an interview was conducted with Certified Nurse Aide C. They confirmed that they were assigned to care for Resident #15 and was familiar with their care. Certified Nurse Aide C explained that they were not sure when Resident #15 had last been offered assistance with a shower or to shave. Certified Nurse Aide C explained that bathing and shaving records would be documented in the Certified Nurse Aide ADL documentation. Certified Nurse Aide C confirmed that Resident #15 had asked for assistance to get out of bed, but that they "hadn't made it back to the room yet."

	A review of the Certified Nurse Aide ADL Care Flow Sheets for [DATE] revealed no documented showers, bathing, or shaving for [DATES].
§ 51.120 (d) Pressure sores. Based on the comprehensive assessment of a resident, the facility management must ensure that— (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to provide necessary services to promote healing of pressure injuries by failing to ensure therapeutic support surfaces were properly functioning for one (1) of three (3) residents reviewed for pressure injuries from a total of 29 residents sampled. The findings include: A review of Resident #15's medical record revealed an initial admission date of [DATE]. Resident #15's medical diagnoses included: Paraplegia, Post-Traumatic Stress Disorder, Depression, and Anxiety. A Significant Change Minimum Data Set (MDS) assessment, dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Resident #15 required extensive assistance with most activities of daily living. The assessment identified the presence of two (2) Stage Four (4) pressure injuries that were present on admission. A review of Resident #15's Care Plan revealed a focus area for pressure injuries. An intervention on the Care Plan indicated Resident #15 would have an air mattress in place for wound healing. On 7/12/23, at 11:00 a.m., an observation of the air mattress pump on Resident #15's bed was conducted. The lighted indicators on the pump were not working and there was no audible air flow. On 7/12/23, at 12:48 p.m., an observation of the air mattress pump on Resident #15's bed was conducted. The lighted indicators on the pump were not working and there was no audible air flow. On 7/13/23, at 10:22 a.m., an observation of the air mattress pump on Resident #15's bed was conducted. The lighted indicators on the pump were not working and there was no audible air flow. A review of Resident #15's Medication and Treatment Administration Records for [DATE] revealed an order directing staff to check the air mattress daily for proper function. There were signatures noted for [DATES]. There were no additional notes on the records indicating the air mattress pump was not functioning properly.

	A review of Resident #15's nursing progress notes for July, 2023 revealed no entries indicating the air mattress was not functioning properly. On 7/13/23, at 11:00 a.m., an observation of wound care was conducted for Resident #15 with Licensed Nurse F. Following the observation, Licensed Nurse F was asked to check the air mattress pump to ensure it was functioning properly. Licensed Nurse F replied, "What's wrong with it?" Licensed Nurse F was asked how staff would know what level of air support the mattress was providing if none of the lighted indicators were working on the pump. Licensed Nurse F checked to ensure the pump was plugged into an electrical source and then turned the pump on and off. Licensed Nurse F then stated, "I don't know why the lights aren't working, but I guess the pump is working." On 7/13/23, at 11:30 a.m., an interview was conducted with Maintenance Staff A. They were asked to check Resident #15's air mattress pump. Maintenance Staff A confirmed the pump was not working and stated it would be switched out with a new one. Maintenance Staff A confirmed that no requests had been received to check the pump's function prior to the survey.
§ 51.140 (d) Food. Each resident receives and the facility provides— (1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (2) Food that is palatable, attractive, and at the proper temperature; (3) Food prepared in a form designed to meet individual needs; and (4) Substitutes offered of similar nutritive value to residents. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on observations, interviews, record review, and review of the facility policy, the dietary staff failed to maintain the recommended temperatures for hot and cold foods. Additionally, the facility failed to store, label, and date potentially hazardous foods appropriately. This failure placed all residents in the facility at risk for foodborne illness, as well as decreased food intake by the residents when food was not served at the proper temperatures and was not palatable. The census was 142. Review of the facility policy titled, "Food Temperatures," last revised 2/24/23, revealed: "Procedure: 1. All hot foods served from the steam table must be held at or above 135 degrees. 2. All potentially hazardous cold foods must be held at 41 degrees or less…8. Once heated to the appropriate temperature, hot food may be transferred to the heated steam table for serving. Food should be transferred to the steam table no more than 30 minutes prior to patient/resident serving time." The findings include: On 7/11/23, at 10:37 a.m., during the initial tour of the [LOCATION], Dietary Staff D revealed the lunch meal was prepared at the [LOCATION] and transported to the [LOCATION] for meal service. Dietary Staff D further revealed the lunch meal, on 7/11/23, which was to be served at 12:00 p.m., had been transported to the [LOCATION] at 10:45 a.m.

	Dietary Staff D stated the meals usually arrived 1-1.5 hours prior to meal service. The following interviews were conducted with residents regarding the quality of the food at the facility: Record review of the Quarterly Minimum Data Set (MDS), dated [DATE], for Resident #8, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. An interview with Resident #8, on 7/11/23, at 1:35 p.m., revealed that the food served was always cold, especially breakfast. The grits were always cold and solid, which had been brought up to the staff and in Resident Council meetings multiple times. The dietary staff's response was that staff could heat the food in the microwave, but staff did not have time to re-heat the food. The resident stated they ate meals on the unit, and this had been an ongoing problem. Record review of the Quarterly MDS, dated [DATE], for Resident #10, revealed a BIMS assessment of 15, which indicated the resident was cognitively intact. An interview with Resident #10, on 7/11/23, at 12:13 p.m., revealed that the resident was involved with Resident Council, which met that morning. The resident stated the food was always cold and looked better than it tasted. The resident stated breakfast was always cold, especially the grits. This was brought up at most Resident Council meetings with the resolution to have staff reheat the food. They stated staff did not have time to reheat the food due to there were so many residents who were required to be fed. The Resident Council was aware the facility was building a new [LOCATION] onsite, but it would be months before it was ready. They stated this was an ongoing issue and they would like the facility to adequately address the concern. Review of the quarterly MDS, with an Assessment Reference Date (ARD) of [DATE], revealed Resident #5 had a BIMS score of 15, which indicated the resident was cognitively intact. An interview with Resident #5, on 7/13/23, at 10:54 a.m., revealed they had a concern with the food. The resident stated the food was served cold. The Resident stated they had brought up the concern of cold food in the Resident Council meetings, however they felt like the facility staff did not care. Resident #5 stated they hoped the new [LOCATION] would open soon so the residents would get warmer food.

	On 7/12/23, at 9:01 a.m., in the presence of Dietary Staff D and Dietary Staff C, the following temperatures were recorded at the [LOCATION]: Okra - 192.6 degrees Fahrenheit (F) Fried chicken - 176 degrees F Baked chicken - 209 degrees F Pureed vegetables - 195 degrees F Okra and tomatoes - 204 degrees F Black eyed peas - 185 degrees F Chopped chicken - 207 degrees F Pureed chicken - 170 degrees F Pureed black eyed peas - 203 degrees F On 7/12/23, at 12:15 p.m., during meal service in the [LOCATION], the following temperatures were recorded: Two (2) pans of fried chicken: 108 degrees F and 126 degrees F. On 7/12/23, at 1:15 p.m., a Resident Council meeting was held with several residents to discuss the food concerns. Several of the residents voiced concerns ranging from the food being consistently served late to the food consistently being served cold. On 7/13/23, at 11:30 a.m., in the presence of Dietary Staff B and Dietary Staff C, the following temperatures were recorded in the [LOCATION]: Sloppy Joes - 190 degrees F French fries - 148 degrees F Squash - 157 degrees F Mashed potatoes - 146.2 degrees F Pureed sloppy joes - 158.7 degrees F Chicken tenders - 117.8 degrees F On 7/13/23, at 11:40 a.m., Dietary Staff B stated the chicken tenders needed to be reheated before meal service at 12:00 p.m. Dietary Staff B revealed some of the resident trays had been made and were on the cart to be delivered to the units. At this time, Dietary Staff B revealed they were preparing the trays for the [LOCATION]. The surveyor did not observe any dietary staff reheating any of the trays that had chicken tenders for lunch. On 7/13/23, at 11:50 a.m., in the presence of Dietary Staff C, the surveyor observed staff pass out trays on the [LOCATION]. At 11:59 a.m., all the trays were delivered, and the surveyor asked the staff for the test tray. The items on the test tray included: a sloppy joe sandwich, yellow squash, French fries,

	canned pineapples, and 1% low-fat chocolate milk. The surveyor observed the test tray and concluded that the sloppy joe sandwich and the French fries were not warm. The hot plate (which was used to serve residents) was not warm to the touch. Dietary Staff C confirmed the food items may have needed to be reheated. The following temperatures were recorded from the test tray: Sloppy Joe sandwich: 133 degrees F Yellow Squash: 131.9 degrees F Fries: 89.1 degrees F Canned Pineapples: 64.6 degrees F (cold item) 1% low-fat chocolate milk- 48.6 degrees F (cold item) On 7/13/23, at 1:40 p.m., during an interview with Dietary Staff C, they confirmed the temperatures on the steam table were not in range of recommended holding temperatures. Dietary Staff C stated it was their expectations that hot foods should be held at 135 degrees F or higher and cold foods should be kept at 41 degrees F or lower. Dietary Staff C stated there were some repairs done on the steam table a while back, and they would have to get maintenance to take a look at it again. Dietary Staff C also stated they should have replaced the food warmer in the main dining hall to ensure the temperatures were within the recommended temperature ranges. On 7/14/23, at 6:59 am., during meal service in the [LOCATION] hall, the following temperatures were recorded: Grits - 169 degrees F Sausage gravy - 159.6 degrees F Scramble eggs - 163.6 degrees F Pork sausage links - 127.6 degrees F Pureed eggs: 127 degrees F Boiled eggs: 131.6 degrees F Oatmeal: 163 degrees F On 7/14/23, at 7:15 a.m., during an interview with Dietary Staff B, they stated some of the foods needed to be reheated to 165 degrees F before they were served. Dietary Staff B stated they expected the steam table to hold hot foods at least 135 degrees F.
§ 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	Based on observations, interviews, and review of the facility policy, the dietary staff failed to store foods in a sanitary manner. This failure placed all residents who received food from the [LOCATION] at risk for foodborne illnesses. The findings include:

(3) Dispose of garbage and refuse properly. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Review of the facility policy titled, "Labeling, Dating, and Storage," last revised 11/11/22, revealed: "Procedure: 1. Food and beverage items will have an identifying label as well as a received date and opened date, as applicable; for items prepared onsite, a 'use by' date will also be indicated. 2. Foods will be stored in their original or approved container and, if opened, shall be wrapped tightly with film, foil, etc." On 7/11/23, at 10:30 a.m., during the initial tour of the [LOCATION], an observation of two (2) clear, gallon containers of raw chicken were observed in the walk-in refrigerator, partially uncovered, unlabeled, and undated. There were several additional deep, half metal pans that were undated, and unlabeled. Dietary Staff D confirmed the food was uncooked vegetables in the pans, and they were going to be used for dinner on 7/11/23. An interview with Dietary Staff D and Dietary Staff C, on 7/11/23, at 10:45 a.m., revealed the containers of raw chicken were prepared that morning by dietary staff. Dietary Staff D stated the dietary staff probably forgot to label and date the chicken. Dietary Staff D was also observed re-wrapping the containers of raw chicken. Dietary Staff D further revealed the metal pans were vegetables that were prepared that morning, and confirmed they should have been labeled and dated before being stored in the walk-in refrigerator. Dietary Staff C stated they expected all items to be labeled and dated and that they would have to do an in-service with the dietary staff.
§ 51.190 Infection control. The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interviews, and record review, the facility failed to ensure that proper technique was utilized during pressure sore treatment for one (1) resident (Resident #8) and for one (1) resident (Resident #4) during incontinent care of 29 sampled residents. The findings include: Review of the policy titled, "Wound Observation and Assessment Documentation," with a revised date of 3/10/21, did not cover the wound treatment preparation. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including: Diabetes Type 2, Cerebral Vascular Accident (CVA) with Right Sided Weakness, Right Below the Knee Amputation, and a History of Deep Vein Thrombus. An observation, on 7/11/23, at 12:00 p.m., revealed the resident was in a motorized wheelchair in the common area eating lunch. The resident had a gauze dressing around their left foot.

	An observation in the resident's room, on 7/11/23, at 2:00 p.m., revealed Certified Nurse Aide A came in to give the resident a bed bath. Certified Nurse Aide A noted the resident had a large amount of clear drainage on the pillowcase below the resident's left foot. They notified the wound team to come and change the dressing due to the heavy drainage. On the same day, at 2:15 p.m., Licensed Nurse G and Licensed Nurse H entered Resident #8's room to check the dressing and determine if the dressing should be changed. Licensed Nurse H gathered the needed supplies on the treatment cart outside the resident's room, and placed them on a clean, plastic tray, covered with a plastic bag. Certified Nurse Aide A had set up one (1) bedside table for the bathing and a second bedside table contained the resident's personal belongings. Licensed Nurse H then moved some personal items on the second bedside table and placed the tray on it. An interview with Licensed Nurse H following the treatment revealed the table was not cleaned prior to putting the tray on the table. An interview with Licensed Nurse I, on 7/14/23, at 10:20 a.m., revealed that the bedside table should have been cleaned prior to placing the wound tray down. Review of the "Skills Competency Checklist Form: Treatment Nurse/Treatment Procedure Wound and Skin Checklist," for Licensed Nurse G, dated [DATE], revealed: "6. Prepare clean area for treatment cart…8. Place all needed items on clean area." Review of the "Skills Competency Checklist Form: Treatment Nurse/Treatment Procedure Wound and Skin Checklist," for Licensed Nurse H, dated [DATE], revealed: "6. Prepare clean area for treatment cart…8. Place all needed items on clean area."
§ 51.200 (a) Life safety from fire. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Veterans Affected** – Many	**<u>Electrical Systems</u>** 1. Based on records review, observation, and interview, the facility failed to maintain documentation of inspections on all Patient-Care Related Electrical Equipment (PCREE). The deficient practice affected one (1) of four (4) smoke compartments in the Wheeler Building and four (4) of eight (8) smoke compartments in the [LOCATION], staff, and all residents. The facility had a capacity for 375 beds with a census of 142 on the day of the survey. The findings include:

	Observations during the building inspection tour, on 7/11/23, at 11:47 a.m., of the vitals monitoring machines on the [LOCATION] revealed the machines were not equipped with any sort of label or tag to indicate when the vitals monitoring machines had last been electrically tested, or when they were due for re-testing. Records review, on 7/11/23, at 3:30 p.m., of testing and inspection records of PCREE revealed that all of the PCREE was being inspected by an outside vendor, except for the vitals monitoring machines. The facility failed to perform electrical testing on the vitals monitoring machines throughout patient care areas of the facility as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. An interview, on 7/11/23, at 3:30 p.m., with Maintenance Staff A revealed the facility was not aware the vitals monitoring machines were required to be electrically tested in accordance with the code. The census of 142 was verified by Administrative Staff A on 7/11/23, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 7/12/23, at 4:00 p.m. **Actual NFPA Standard: NFPA 99, Health Care Facilities Code (2012)** **3.3.137 Patient-Care-Related Electrical Equipment.** Electrical equipment appliance that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care vicinity. **10.3 Testing Requirements — Fixed and Portable.** **10.3.1* Physical Integrity.** The physical integrity of the power cord assembly composed of the power cord, attachment plug, and cord-strain relief shall be confirmed by visual inspection. **10.3.2* Resistance.** **10.3.2.1** For appliances that are used in the patient care vicinity, the resistance between the appliance chassis, or any exposed conductive surface of the appliance, and the ground pin of the attachment plug shall be less than 0.50 ohm under the following conditions: **(1)** The cord shall be flexed at its connection to the attachment plug or connector. **(2)** The cord shall be flexed at its connection to the strain relief on the chassis. **10.3.2.2** The requirement of 10.3.2.1 shall not apply to accessible metal parts that achieve separation from main parts by double insulation or metallic screening or that are unlikely to

	become energized (e.g., escutcheons or nameplates, small screws). **10.3.3* Leakage Current Tests.** **10.3.3.1 General.** **10.3.3.1.1** The requirements in 10.3.3.2 through 10.3.3.4 shall apply to all tests. **10.3.3.1.2** Tests shall be performed with the power switch ON and OFF. **10.3.3.2 Resistance Test**. The resistance tests of 10.3.3.3 shall be conducted before undertaking any leakage current measurements. **10.3.3.3*** Techniques of Measurement. The test shall not be made on the load side of an isolated power system or separable isolation transformer. **10.3.3.4* Leakage Current Limits.** The leakage current limits in 10.3.4 and 10.3.5 shall be followed. **10.3.4 Leakage Current — Fixed Equipment.** **10.3.4.1** Permanently wired appliances in the patient care vicinity shall be tested prior to installation while the equipment is temporarily insulated from ground. **10.3.4.2** The leakage current flowing through the ground conductor of the power supply connection to ground of permanently wired appliances installed in general or critical care areas shall not exceed 10.0 mA (ac or dc) with all grounds lifted. **10.3.5 Touch Current — Portable Equipment.** **10.3.5.1* Touch Current Limits.** The touch current for cord connected equipment shall not exceed 100 µA with the ground wire intact (if a ground wire is provided) with normal polarity and shall not exceed 500 µA with the ground wire disconnected. **10.3.5.2** If multiple devices are connected together and one power cord supplies power, the leakage current shall be measured as an assembly. **10.3.5.3** When multiple devices are connected together and more than one power cord supplies power, the devices shall be separated into groups according to their power supply cord, and the leakage current shall be measured independently for each group as an assembly. **10.3.5.4** Touch Leakage Test Procedure. Measurements shall be made using the circuit, as illustrated in Figure 10.3.5.4, with the appliance ground broken in two modes of appliance operation as follows: **(1)** Power plug connected normally with the appliance on **(2)** Power plug connected normally with the appliance off (if equipped with an on/off switch) **10.3.5.4.1** If the appliance has fixed redundant grounding (e.g., permanently fastened to the grounding system), the touch leakage current test shall be conducted with the redundant grounding intact. **10.3.5.4.2** Test shall be made with Switch A in Figure 10.3.5.4 closed.

	10.3.6* Lead Leakage Current Tests and Limits — Portable Equipment. **10.3.6.1** The leakage current between all patient leads connected together and ground shall be measured with the power plug connected normally and the device on. **10.3.6.2** An acceptable test configuration shall be as illustrated in Figure 10.3.5.4. **10.3.6.3** The leakage current shall not exceed 100 µA for ground wire closed and 500 µA ac for ground wire open. **10.5.2.1 Testing Intervals.** **10.5.2.1.1** The facility shall establish policies and protocols for the type of test and intervals of testing for patient care–related electrical equipment. **10.5.2.1.2** All patient care–related electrical equipment used in patient care rooms shall be tested in accordance with 10.3.5.4 or 10.3.6 before being put into service for the first time and after any repair or modification that might have compromised electrical safety. **10.5.2.5* System Demonstration.** Any system consisting of several electric appliances shall be demonstrated to comply with this code as a complete system. **10.5.3 Servicing and Maintenance of Equipment.** **10.5.3.1** The manufacturer of the appliance shall furnish documents containing at least a technical description, instructions for use, and a means of contacting the manufacturer. **10.5.3.1.1** The documents specified in 10.5.3.1 shall include the following, where applicable: **(1)** Illustrations that show the location of controls **(2)** Explanation of the function of each control **(3)** Illustrations of proper connection to the patient or other equipment, or both **(4)** Step-by-step procedures for testing and proper use of the appliance **(5)** Safety considerations in use and servicing of the appliance **(6)** Precautions to be taken if the appliance is used on a patient simultaneously with other electric appliances **(7)** Schematics, wiring diagrams, mechanical layouts, parts lists, and other pertinent data for the appliance **(8)** Instructions for cleaning, disinfection, or sterilization **(9)** Utility supply requirements (electrical, gas, ventilation, heating, cooling, and so forth) **(10)** Explanation of figures, symbols, and abbreviations on the appliance **(11)** Technical performance specifications **(12)** Instructions for unpacking, inspection, installation, adjustment, and alignment **(13)** Preventive and corrective maintenance and repair procedures

	10.5.3.1.2 Service manuals, instructions, and procedures provided by the manufacturer shall be considered in the development of a program for maintenance of equipment. **10.5.6 Record Keeping — Patient Care Appliances.** **10.5.6.1 Instruction Manuals.** **10.5.6.1.1** A permanent file of instruction and maintenance manuals shall be maintained and be accessible. **10.5.6.1.2** The file of manuals shall be in the custody of the engineering group responsible for the maintenance of the appliance. **10.5.6.1.3** Duplicate instruction and maintenance manuals shall be available to the user. **10.5.6.1.4** Any safety labels and condensed operating instructions on an appliance shall be maintained in legible condition. **10.5.6.2* Documentation.** **10.5.6.2.1** A record shall be maintained of the tests required by this chapter and associated repairs or modifications. **10.5.6.2.2** At a minimum, the record shall contain all of the following: **(1)** Date **(2)** Unique identification of the equipment tested **(3)** Indication of which items have met or have failed to meet the performance requirements of 10.5.6.2 **10.5.6.3 Test Logs.** A log of test results and repairs shall be maintained and kept for a period of time in accordance with a health care facility's record retention policy. **10.5.8 Qualification and Training of Personnel.** **10.5.8.1*** Personnel concerned for the application or maintenance of electric appliances shall be trained on the risks associated with their use. **10.5.8.1.1** The health care facilities shall provide programs of continuing education for its personnel. **10.5.8.1.2** Continuing education programs shall include periodic review of manufacturers' safety guidelines and usage requirements for electrosurgical units and similar appliances. **10.5.8.2** Personnel involved in the use of energy-delivering devices including, but not limited to, electrosurgical, surgical laser, and fiberoptic devices shall receive periodic training in fire suppression. **10.5.8.3** Equipment shall be serviced by qualified personnel only. **<u>Smoke Barriers and Sprinklers</u>** 2. Based on observation and interview, the facility failed to properly maintain the sprinkler system. The deficient practice affected one (1) of 23 smoke compartments, staff, and four (4) residents. The facility had a capacity for 375 beds with a census of 142 on the day of the survey.

	The findings include: Observation during the building inspection tour, on 7/12/23, at 12:10 p.m., of the two (2) sprinkler heads inside the cooler in the [LOCATION] on the [LOCATION] revealed the sprinkler heads were stamped with a manufacturer date of "1988." Records review, on 7/12/23, at 3:00 p.m., of the sprinkler inspection records revealed there was no documentation of the two (2) sprinkler heads located in the cooler being replaced after 10 years in service, or a representative sampling being sent in for UL testing. The facility failed to replace the sprinklers at 10-year intervals or send in a representative sampling being sent in for Underwriters Laboratories (UL) testing as required by section of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems An interview with Maintenance Staff A, on 7/12/23, at 3:00 p.m., revealed the facility was not aware of the requirement to replace the sprinklers at 10-year intervals or send in a representative sampling to be sent in for UL testing. The census of 142 was verified by Administrative Staff A on 7/11/23, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 7/12/23, at 4:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.5 Extinguishment Requirements.** **19.3.5.1** Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. **19.3.5.2** High-rise buildings shall comply with 19.4.2. **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. **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 **9.7.5 Maintenance and Testing.** All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.

	Actual NFPA Standard: NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011) **5.3 Testing.** **5.3.1* Sprinklers.** **5.3.1.1*** Where required by this section, sample sprinklers shall be submitted to a recognized testing laboratory acceptable to the **5.3.1.1.1.6*** Dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals.
§ 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 properly inspect and test all components of the facility's emergency generators. The deficient practice affected 23 of 23 smoke compartments, staff, and all residents. The facility had a capacity for 375 beds with a census of 142 on the first day of the survey. The findings include: Observation, on 7/11/23, from 10:43 a.m., until 11:26 a.m., revealed the batteries for each of the facility's four (4) emergency generators were sealed lead acid maintenance free type batteries. Records review, on 7/11/23, at 3:30 p.m., of the generator inspection and testing records dating back 12 months prior to the survey, revealed the row titled "Battery Water Level" had "N/A" written in on each space on their generator inspection form where the battery specific gravity levels or conductance testing readings should have been recorded. The facility failed to perform specific gravity testing or conductance testing for the lead-acid batteries, as required by section 8.3.7.1 of NFPA 110, Standard for Emergency and Standby Power Systems. An interview, on 7/11/23, at 3:30 p.m., with Maintenance Staff A confirmed the batteries for the generator were maintenance free type batteries and the facility was unaware of the requirement to perform conductance testing in lieu of specific gravity testing for maintenance free type generator batteries. The census of 142 was verified by Administrative Staff A on 7/11/23, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 7/12/23, at 4:00 p.m. **Actual NFPA Standard: NFPA 101, (2012) Life Safety Code** **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** 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted.
§ 51.210 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on observation, interview, record review, and review of facility policy it was determined the facility was not administered in a manner to use its resources to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Quality deficiencies were identified that demonstrate the operation and management of the facility was not being administered effectively. The findings include: The survey conducted from 7/11/23 through 7/14/23 revealed the facility demonstrated on-going non-compliance with implementing policies and procedures to ensure residents received quality care and services. The Administration failed to assume responsibility for oversight of facility systems to maintain compliance. Interviews with staff and residents, observations of resident care, services, environmental conditions, record review, and policy review provided evidence of failed facility practice being identified in the following areas: • **§ 51.70 (a) (1) – (5) Exercise of rights.** The facility failed to protect Resident #15's right to be free from physical restraints by failing to disengage their wheelchair brakes upon the resident's request and in accordance with facility policy. This was evidenced by observations, interviews and record reviews. • **§ 51.70 (f) (1) – (2) Grievances.** The facility failed for two (2) of 29 residents (Resident #10 and Resident #23) to make prompt efforts to resolve grievances when residents and/or a responsible party (RP) voiced concerns with treatment not received, in accordance with facility policy. This was evidenced by interviews, and record reviews.

	• **§ 51.100 (d) Participation in resident and family groups.** The facility failed to ensure that residents had the right to attend scheduled Resident Council meetings without staff present. Additionally, concerns presented by residents to facility management regarding issues affecting resident care and life in the facility were not acted upon, in accordance with facility policy. This was evidenced by interviews and record reviews. • **§ 51.100 (g) (1) Patient Activities.** The facility failed for three (3) of four (4) Units to provide an on-going activities program to meet the interests and needs of the residents, in accordance with facility policy. • **§ 51.110 (e) (2) Comprehensive care plans.** The facility failed to revise the Care Plan for two (2) of 29 (Resident #6 and Resident #9) sampled residents, in accordance with facility policy. This was evidenced by observations, interviews, and record reviews. • **§ 51.120 (b) (3) Activities of daily living.** The facility failed for one (1) of 29 residents (Resident #15) to provide necessary services to maintain good grooming, personal hygiene, and mobility to a resident unable to carry out activities of daily living (ADLs) independently. This was evidenced by observations, interviews, and record reviews. • **§ 51.120 (d) Pressure sores.** The facility failed to provide necessary services to promote healing of pressure injuries for one (1) of three (3) residents reviewed for pressure injuries from a total of 29 residents sampled. This was evidenced by observations, interviews, and record reviews. • **§ 51.140 (d) Food.** The dietary staff failed to maintain the recommended temperatures for hot and cold foods. Additionally, the facility failed to store, label, and date potentially hazardous foods appropriately, in accordance with facility policy. This was evidenced by observations, interviews, and record reviews. • **§ 51.140 (h) Sanitary conditions.** The dietary staff failed to store foods in a sanitary manner, in accordance with facility policy. This failure placed all residents who received food from the kitchen at risk for foodborne illnesses. • **§ 51.190 Infection control.** The facility failed to ensure that proper technique was utilized during pressure sore

	treatment for one (1) resident (Resident #8) and for one (1) resident (Resident #4) during incontinent care of 29 sampled residents, in accordance with facility policy. This was evidenced by observations, interviews, and record reviews. • **§ 51.200 (a) Life safety from fire.** The facility failed to maintain documentation of inspections on all Patient-Care Related Electrical Equipment (PCREE). • **§ 51.200 (b) Emergency power.** The facility failed to properly inspect and test all components of the facilities emergency generators.