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: Minnesota Veterans Home – Minneapolis

Location: 5101 Minnehaha Ave., South Minneapolis, MN 55417

Onsite / Virtual: Onsite

Dates of Survey: 10/21/24 – 10/24/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 300

Census on First Day of Survey: 295

VA Regulation Deficiency	Findings
	Initial Comments A VA Annual Survey was conducted from October 21, 2024, through October 24, 2024, at the Minnesota Veterans Home – Minneapolis. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.100 (b) Self-determination and participation. (b) Self-determination and participation. The resident has the right to— (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care (2) Interact with members of the community both inside and outside the facility; and (3) Make choices about aspects of his or her life in the facility that are significant to the resident. **Level of Harm** – No Actual Harm, with potential for more than minimal harm	Based on observation, interview, clinical record review, and review of facility policy, the facility failed to allow residents to choose activities consistent with their interests, assessments, and Plan of Care. This was observed when two (2) of two (2) residents requested to leave [LOCATION] to attend a Veterans of Foreign War (VFW) picnic hosted by the facility. The findings include: A review of the facility's policy "Standard of Work for Resident COVID Illness," created December 2023, revealed that the purpose was to have a standard practice throughout all floors/buildings for the facility's response to residents with COVID. Resident #44 was admitted to the facility with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Chronic Diastolic Congestive Heart Failure (CHF), and Chronic Kidney Disease. A review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental

Residents Affected – Few	Status (BIMS) score of 14, which indicated no cognitive impairment, and the resident was able to make their own decisions and wishes known. Resident #45 was admitted to the facility with diagnoses that included Hypertension, Chronic Kidney Disease, and Heart Failure. A review of the Quarterly MDS, dated [DATE], revealed a BIMS of 13, which indicated mild cognitive impairment, and they were able to make their own decisions and wishes known. On 10/22/24, at 12:11 p.m., an observation of Licensed Nurse C on [LOCATION] revealed they approached Resident #44 and Resident #45 after they had requested to attend the facility hosted VFW picnic in their building on the first floor. They told them that if they left the floor, they requested the residents to wear surgical masks, due to [LOCATION] having residents who had COVID. Both residents agreed, and masks were provided to each. Licensed Nurse C then left the floor and returned and stated to each of the two (2) residents that they were not allowed to leave the floor because the activities calendar had the event marked out, and that indicated they were not invited to the picnic because they lived on a floor that had COVID positive residents. Both residents expressed a strong desire to attend the event. Licensed Nurse C, after consulting with "them," informed the two (2) residents they were not allowed to leave the floor. Both residents expressed disappointment at not being able to attend a VFW sponsored event. On 10/22/24, at 12:15 p.m., an interview with Licensed Nurse C revealed they had consulted with Licensed Nurse A, and was told that because the activities calendar revealed the event had been marked off, that indicated the residents of that unit were not invited to attend because of COVID. When asked who "them" was, they replied: "the [Licensed Nurse A]." On 10/22/24, at 12:30 p.m., an interview with Licensed Nurse A revealed that the residents were discouraged from leaving the floor where COVID was present, but it was an infringement of their rights to tell them they could not leave the floor. They stated that they were wrong to tell Licensed Nurse C that the residents requesting to attend the picnic could not leave the unit, and it was an infringement of the residents' rights to tell them that. On 10/22/24, at 2:32 p.m., an interview with Consultant Staff A revealed their staff had marked out the VFW picnic activity on the calendar on [LOCATION] because they thought the residents on the floor with COVID were not allowed to leave the floor. They confirmed that any resident that resided in the facility had the right to leave their unit if they desired to do so.

	On 10/23/24, at 1:35 p.m., an interview with Consultant Staff B revealed that any resident who made a request to leave the floor should be allowed to leave. They stated that it was restrictive of the residents' right to refuse their request to leave their home, even if COVID was present on that unit. They stated that the staff should strongly encourage the residents to wear a surgical mask when they left the unit for their protection, but residents should never be told that they were not allowed to leave. They stated that this refusal was bordering on false imprisonment. On 10/24/24, at 11:15 a.m., an interview with Administrative Nurse A revealed that residents who lived on a unit where the COVID virus was present were encouraged not to leave the unit, but the facility could not force a resident not to leave that unit if they desired to leave. They stated that if the resident left the unit, they strongly encouraged the resident to wear a surgical mask. On 10/24/24, at 11:16 a.m., an interview with Administrative Staff B revealed that residents who lived on any unit where the COVID virus had been detected were encouraged not to leave the unit, but it was the residents' right to leave if they chose. They stated that residents who left the unit for any reason, such as an activity or appointment, were strongly encouraged to wear a surgical mask. On 10/24/24, at 11:20 a.m., an interview with Administrative Staff A revealed that every resident had the right to leave their unit to attend an activity, even if they had COVID. They strongly encouraged them not to leave if they came from a unit where COVID was present, but the residents had the right to leave if they wished.
§ 51.110 (e) (1) Comprehensive care plans. (1) The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following— (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental,	Based on interview, record review, and policy review, the facility failed to revise the comprehensive Care Plans for three (3) residents (Resident #5, Resident #10, and Resident #14) out of three (3) residents with COVID-19. The findings include: Review of the facility policy titled, "Resident Assessment - Care Plan (Skilled Nursing Facility)," revised 1/27/23, revealed: "Policy: Each MVH [Minnesota Veterans Home] will complete a periodic comprehensive assessment, according to the Federal, State, local and agency requirements, for each resident. The assessment process includes discipline-specific assessments, the Minimum Data Set (MDS) and Care Area Assessments. The assessment will be reviewed at least quarterly, and anytime a significant change in status is identified."

and psychosocial well-being as required under §51.120; and (ii) Any services that would otherwise be required under §51.120 of this part but are not provided due to the resident's exercise of rights under §51.70, including the right to refuse treatment under §51.70(b)(4) of this part. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	Resident #5 was admitted to the facility on [DATE], with diagnoses that included Parkinson's Disease, Dementia, Anxiety Disorder, and Depressive Disorder. The MDS, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of one (1), which indicated severe cognitive impairment. Physician Orders, dated [DATE], indicated: "complete COVID Progress Note and Full Set of Vitals every shift for Covid-19 Outbreak-Monitoring for 9 Days." Review of Resident #5's comprehensive Care Plan, initiated [DATE], and with updates that included [DATE], [DATE], and [DATE], found that the Care Plan did not indicate a "Focus area, Outcomes, or Interventions" which addressed COVID-19 monitoring or care. Resident #10 was admitted to the facility on [DATE], with diagnoses that included Vascular Dementia and COVID-19. A review of the Quarterly MDS, dated [DATE], revealed a BIMS of 15, which revealed no cognitive impairment. A review of the comprehensive Care Plan, updated [DATE], revealed the Care Plan did not address COVID-19 monitoring or care. Resident #14 was admitted to the facility on [DATE], with diagnoses which included Dementia, Depression, and Macular Degeneration. Review of the most recent MDS, dated [DATE], revealed a BIMS which coded the residents as eight (8), which indicated moderate cognitive impairment. The Physician Orders, dated [DATE], indicated: "COVID positive, isolation started." The order further documented that the resident would be in isolation until [DATE], and the nursing staff was to "complete COVID Progress Note and Full Set of Vitals every shift for COVID-19 Outbreak." Review of the comprehensive Care Plan, initiated [DATE], and updated [DATE], revealed the Care Plan did not address COVID-19 monitoring or care. On 10/23/24, at 10:00 a.m., Administrative Nurse A presented an updated Care Plan which addressed COVID-19 after it was presented to them that it was not addressed on the previous Care Plan. During an interview with Administrative Nurse A, on 10/23/24, at 10:35 a.m., Administrative Nurse A stated that there was not a Care Plan template for COVID-19 in the facility's Point Click Care system. Administrative Nurse A further stated that a Care Plan for COVID-19 had never been used in the Minnesota facilities.
§ 51.120 (i) Accidents.	Based on observations, interviews, record review, and review of facility policy, the facility failed to provide effective interventions

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	for the prevention of falls, and failed to provide interventions as planned for the prevention of falls for one (1) of nine (9) residents reviewed for falls (Resident #19). The findings include: Review of the facility policy titled, "Fall Management," dated 10/13/23, revealed: "Policy: Each MVH's [Minnesota Veterans Homes] fall prevention and management program will provide guidelines for resident fall risk assessment and post-fall follow-up procedures so residents are able to maintain the highest level of independence. Procedures: A. Skilled nursing facilities will conduct a fall risk assessment on each resident upon admission, quarterly, annually, and on a change of condition review in accordance with the Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS). Assessments will focus on the areas of environmental, cognition, continence, mobility, typical patterns, medications, and overall physical limitations…B. Each facility will have a method of identifying residents with a high fall risk. A resident identified as having a high fall risk will have safety interventions included in their care plan, and in place as appropriate, to include therapy consults, restorative nursing, use of assistive devices, and injury prevention interventions such as mats, hip protectors, and padded clothing." Review of Resident #19's clinical record revealed the admission date of [DATE], and diagnoses included Alzheimer's Disease, Anxiety Disorder, Repeated Falls, Heart Failure, and Flaccid Neuropathic Bladder. Review of Resident #19's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was three (3), which indicated severe cognitive impairment, and they rejected care one (1) to three (3) days of the seven (7) day observation period. The resident was dependent on staff with upper and lower dressing, personal hygiene, and required substantial/maximal assistance with toileting. Resident #19's walking up to 10 feet was not attempted due to medical condition or safety concern. The resident utilized a walker or wheelchair and had a catheter. The resident had two (2) or more no injury falls, and one (1) fall with nonmajor injury. The MDS revealed the resident did not receive therapy or restorative services. Review of Resident #19's Care Plan, in place on [DATE], found that it listed the fall interventions: staff to check on the resident at the beginning of the shift and ask if they needed help and reminded the resident to use the call light; the resident had poor insight into what they could do for themselves, assist the resident as needed; remind the resident to ask for help from

	staff when conflict arose; keep the bed at knee high level for safety and place a sign at the appropriate bed height; ensure the bed was locked after repositioning/night rounds; walker to be kept at bedside whenever the resident was in bed or next to the recliner in the [LOCATION]; staff to ensure the call light was accessible before leaving the room; frequent checks while in the room; keep the room door open; use non-skid socks at night; the resident may prefer to stay up into the nighttime hours; if the resident was awake, offer to assist the resident to their wheelchair or recliner in [LOCATION] and assist the resident to bed per their indication or when they appeared tired; encourage the resident to ask for help when getting items from the floor; housekeeping to clean the bathroom floor frequently and staff to report if floor was sticky; the resident needed reminders to use the walker and to keep it within reach; brightly colored tape on the walker for a visual reminder; anticipate needs and assist with mobility as needed; offer participation in activities throughout the day; provide encouragement and assist the resident to their wheelchair to activities of their interest; refer to elimination Care Plan for catheter care/frequency; check in with the resident during mealtime to identify needs and minimize the amount of times the resident got up/left the [LOCATION] during mealtimes; offer water with routine rounds; put visual reminders in the bathroom to use the call light for assistance; the resident enjoyed spending time in the [LOCATION] recliner, encourage the resident to spend time there when they were awake on any shift; the resident enjoyed doing crossword puzzles, reading magazines and watching TV in the recliner, offer those when they were in the recliner. Review of Resident #19's Physician Orders revealed: [DATE] – okay for bilateral grab bars/repositioning bars to bed to aid in bed mobility. [DATE] – Fitness Gym Program per therapy recommendation to maintain functional mobility. [DATE] – Restorative Nursing Program Fitness exercise, standing toe/heel raises two (2) times per week per Physical Therapy (PT) parameters. Review of the Fall Risk Assessments revealed: [DATE] – score of 18, which indicated the resident was at a high risk for falls. [DATE] – score of 22, which indicated the resident was at a high risk for falls. [DATE] – score of 20, which indicated the resident was at a high risk for falls. [DATE] – score of 14, which indicated the resident was at a moderate risk for falls.

	Review of the Post Fall Notes and Progress Notes revealed the following 15 falls: [DATE], at 10:50 p.m. – staff found the resident on the floor in front of the recliner. Staff documented the resident should be monitored at all times when in the recliner. [DATE], at 4:00 a.m. – staff found the resident on the floor in front of the recliner. Staff again documented that the resident would be monitored at all times when in the recliner. [DATE], at midnight – staff found the resident on the floor near their bathroom. Staff, after bedtime toileting, would offer to keep the resident up in the wheelchair in the [LOCATION] until they verbalized that they were ready for bed. [DATE], at 2:25 p.m. – staff found the resident on the floor in the [LOCATION], in front of their recliner. Staff to offer activities (word searches, coloring) of interest when in the recliner. [DATE], at 4:40 p.m. – staff found the resident on the floor in the [LOCATION]. Staff would offer and assist the resident to the recliner when unit activities were completed. [DATE], at 2:45 p.m. – staff observed the resident sliding from the recliner onto the floor. Staff added a non-skid pad (did not specify if it was for the recliner or the wheelchair). [DATE], at 4:47 p.m. – staff observed the resident stand up from the recliner and the resident lost their balance and fell. Staff added the intervention for an afternoon snack. [DATE], at 5:15 a.m. – the resident was at the dining room table and “staff had to do cares for other [residents] for approximately 15 minutes.” When they returned, staff found the resident on the floor in the [LOCATION]. Staff added the intervention for Occupational Therapy (OT) evaluation and treatment for wheelchair modifications/positioning, as the resident may benefit from an autolocking device. Review of the OT Discharge Summary, dated [DATE], revealed the recommendation for a wheelchair with an autolocking device. [DATE], at 3:00 a.m. – staff found the resident on their bedroom floor. PT to evaluate and treat for ambulation training/strengthening. Review of the PT Discharge Summary, dated [DATE], revealed a restorative ambulation program and range of motion program were established. [DATE], at midnight – staff found the resident on their bedroom floor. [DATE], at 8:15 a.m. – staff were transferring the resident, and the resident began to sit down, and staff lowered the resident to the floor. Staff were to offer the resident the chance to rest in the recliner after breakfast. [DATE], at 4:30 a.m. – staff observed the resident transferring from their bed to the wheelchair, and the resident began to lose their balance, and staff assisted the resident to the floor. Resident was started on antibiotics for a urinary tract infection (UTI).

	[DATE], at 8:00 a.m. – while staff were preparing to toilet the resident, the resident stood up from the chair and attempted to transfer to the toilet and fell. Resident was on antibiotics for a UTI. [DATE], at 4:15 a.m. – staff found the resident on the floor in the [LOCATION] and pushing their wheelchair across the floor. Staff were to continue with frequent checks when in the [LOCATION] at night and engage the resident in activities of preference. [DATE], at 3:22 p.m. – staff found the resident on the floor in front of their recliner. Staff were to provide more assistance with observations and mobility as needed during acute illness, and review any ongoing weakness with the rehabilitation /Interdisciplinary Team. Observation, on 10/21/24, at 2:03 p.m., revealed Resident #19 sat in a wheelchair at the dining room table, and anti-tip and anti-lock brakes were on the wheelchair. Observation, on 10/22/24, at 12:08 p.m., revealed Resident #19 sat in the wheelchair at the dining room table, with their head hanging down. Observation, on 10/23/24, at 9:27 a.m., revealed Resident #19 sat in a recliner in the [LOCATION] with their eyes closed. Observation, on 10/23/24, at 11:30 a.m., revealed Resident #19 sat at the dining room table in a wheelchair with their eyes closed and head hanging down. Observation, on 10/23/24, at 1:22 p.m., revealed the sign to call for assistance located behind the commode where the resident could not see it if sitting on the commode. Observation revealed no sign was on the wall by the bed noting what height the bed should be at, as was planned. Observation, on 10/23/24, at 1:50 p.m., of the resident's recliner revealed no nonslip pad above or below the pressure relieving cushion, as planned. Observation, on 10/24/24, at 9:18 a.m., revealed the nonslip pad on top of the cushion in the recliner instead of below the cushion. Observation, on 10/24/24, at 9:36 a.m., revealed the nonslip pad on top of the cushion in the wheelchair instead of below the cushion. In an interview with Certified Nurse Aide C, on 10/23/24, at 1:22 p.m., they stated that fall interventions included observing the

	resident, and if they got restless, the staff would take the resident to the bathroom. In an interview with Administrative Nurse C, on 10/23/24, at 1:50 p.m., they stated fall interventions for Resident #19 included OT/PT referrals, medication review, engaging the resident in coloring or word searches, keep them in the [LOCATION] after they woke up in the morning, placing a nonskid pad under the cushion in the wheelchair and in their recliner, and placing the resident on a walking program which was completed by the certified nurse aids. During a further interview with Administrative Nurse C, on 10/24/24, at 8:30 a.m., they stated that the fall program consisted of an initial assessment of the resident was completed after a fall, then a post fall assessment was completed where everyone who was present went over what happened, and an intervention was then put into place. The Interdisciplinary Team (IDT) met weekly, reviewed the fall, and evaluated the intervention put in place for appropriateness. During an observation and interview with Licensed Nurse B, on 10/24/24, at 10:25 a.m., they confirmed that the sign to notify staff of where the height the bed should be, was not present. Licensed Nurse B also confirmed the sign to instruct the resident to call for assistance was not visible to the resident when they sat on the commode.
§ 51.190 (b) Preventing spread of infection. **(**1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident. (2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease. (3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. **Level of Harm** – No Actual Harm, with potential for more than minimal harm	Based on observation, interview, clinical record review, and review of facility policy, the facility failed to ensure the prevention of the spread of infection on three (3) of three (3) units ([LOCATIONS]) where residents had tested positive for COVID-19 and had been placed in Contact/Droplet Precaution Isolation. Facility staff did not follow the transmission-based precautions as stated in the facility's document titled, "Standard of Work Resident COVID Illness," to prevent the residents from the potential spread of infection. The findings include: Review of the facility's document titled, "Standard of Work Resident COVID Illness," created December 2023, revealed the purpose was to have a standard practice throughout all floors/buildings for the facility's response to residents with COVID. It further revealed: "When a Resident Tests Positive for COVID: 1. The Positive Resident will be: (a) Placed on Contact/Droplet Isolation in their Room i. Duration to be Determined by Infection Preventionist (IP) based on Current Guidelines…3. The Floor the Positive Resident Resides on will: …b. If the Positive Resident is NOT Complying with Isolation in their Room. (i). Staff on the Floor will wear N95 Mask and Eye

Residents Affected – Many	Protection or PAPR (Powered Air Purifying Respirator) (determined based on Fit Testing) (ii). Residents will be Encouraged to Wear Surgical Masks when Outside their Rooms" [sic]. A review of the facility's document "Units on Isolation Precautions," updated daily on 10/21/24, through 10/24/24, revealed units [LOCATIONS] were identified as units where residents were in COVID isolation, and staff were to always wear an N95 mask and eye protections or PAPR while on the unit. On 10/21/24, at 1:15 p.m., an observation was made on [LOCATION] where COVID positive residents lived and revealed Licensed Nurse D and Certified Nurse Aide A were both stationed at the [LOCATION] wearing surgical masks and no eye protection. There was one (1) resident seated in the [LOCATION], approximately 100 feet from the staff, who was not wearing a surgical mask. On 10/21/24, at 1:35 p.m., an interview with Licensed Nurse D revealed they were required to wear a surgical mask while on the resident floor. If required to enter a resident room who was COVID positive, they were to wear an N95 mask with gown and gloves, and remove that PPE when they exited the room, replace their N95 mask with a surgical mask only, and they did not have to use eye protection. They stated that the unit had some residents who would come out of their rooms who were COVID positive. They stated this did not change the PPE requirements. On 10/21/24, at 1:39 p.m., an interview with Certified Nurse Aide A revealed they were only required to wear a surgical mask while on the unit unless they entered a resident's room who had COVID. On 10/21/24, at 1:43 p.m., an interview with Consultant Staff B revealed they were required to wear an N95 isolation mask and eye protection/face shield anytime they were on [LOCATIONS]. They stated that staff were never allowed on the units without an N95 mask and protective eye wear. On 10/21/24, at 1:54 p.m., an interview with Administrative Nurse B revealed [LOCATIONS] were under a COVID mandate for the use of PPE. They stated that all staff were always required to wear N95 masks and eye protection while on the units when COVID illness was present. They confirmed this was required for all staff on the [LOCATIONS], because the staff were shared from each unit. They stated that if a staff member entered a resident room where the resident was COVID positive, the staff were to wear eye protection, N95 mask, gown,

	and gloves while in the room and the PPE was to be removed as they exited the resident's room. They were required to always continue the use of the N95 mask and eye protection while on the unit. They confirmed that all residents and families were encouraged to use a surgical mask; however, the facility could not force the residents or family to comply because of the residents' rights. They stated that the staff who worked on the [LOCATIONS] units on [DATE], had been educated at 10:00 a.m., on that date, of the importance of always wearing the N95 mask and eye protection. Their concerns included the staff becoming sick, and the staff transmitting the COVID virus to a resident who was not infected. On 10/22/24, at 10:15 a.m., upon entrance into the second floor of [LOCATION], the [LOCATION], it was noted that there was a sign on the door which read: "Surgical masks and eye protection must be worn." On 10/22/24, at 10:30 a.m., in Resident #15's room, on the [LOCATION] in [LOCATION], Maintenance Staff B was observed cleaning the floor in the resident's room. Maintenance Staff B was wearing a surgical mask. When asked why they weren't wearing eye goggles and an N95mask, they commented that they wore them yesterday, and they could wear them again today. Maintenance Staff B then put eye goggles on and continued to clean Resident #15's room. On 10/22/24, at 12:11 p.m., an observation was made of Certified Nurse Aide A, who was escorting three (3) separate residents by wheelchair from their room to the [LOCATION], and failed to have any eye protection in place. When questioned about the requirement for proper personal protective equipment (PPE) to be worn, they quickly tried to get their protective eyewear off their head and onto their face. On 10/22/24, at 12:18 p.m., an observation of Certified Nurse Aide B revealed they were working on both [LOCATIONS], and were observed to have an N95 mask on, but their face shield was on top of their head. When questioned about what they were required to wear, they stated: "this," and continued their duties and did not pull their shield down in place. On 10/22/24, at 12:22 p.m., in an interview with Dietary Staff A, they stated that they were not required to use an N95 mask unless they were in the direct patient care area. If they were in the care area, they were supposed to wear an N95 mask and eye protection. On 10/22/24, at 12:30 p.m., an interview with Licensed Nurse A revealed that all staff who were working [LOCATIONS] were always supposed to wear an N95 mask and eye protection while

	on the units because the COVID positive residents on those units were not compliant with using a mask when they exited their rooms. They stated that this was why the mandate was required for the continuous use of the N95 mask and eye protection while on the units. They stated there were no exceptions, and staff were not to wear surgical masks on [LOCATIONS]. They stated their concerns about the staff not wearing proper PPE was their exposure to the virus, and it being spread to other residents and families who were not ill, and/or transmission of the virus to themselves or other staff. On 10/23/24, at 1:45 p.m., an interview with Administrative Nurse B for [LOCATIONS] revealed they had witnessed the staff on these units failing to follow the PPE "Standard of Work for Resident COVID Illness" protocol by failing to wear proper PPE, such as N95 masks and eye protection. They stated that the staff who worked [DATE], were the same staff who worked on [DATE], and each of them had received education on [DATE], on the proper use of PPE. On 10/24/24, at 11:15 a.m., an interview with Administrative Nurse A revealed they expected the staff to follow the PPE "Standard of Work for Resident COVID Illness" protocol. Failure to follow this mandate included the risk that the staff would become ill and transmit the virus to other staff or a resident/family. They stated that the staff had been educated on the proper use of PPE on a unit where there were COVID positive residents. On 10/24/24, at 11:16 a.m., an interview with Administrative Staff B revealed they required proper education on the use of PPE with COVID positive residents, and they expected the staff to follow the "Standard of Work" practice. The failure to comply with this standard could lead to staff becoming ill, and the transmission of the virus to staff, residents, and families who were not ill. On 10/24/24, at 11:15 a.m., an interview with Administrative Staff A revealed they expected all staff to follow the "Standard of Work" to prevent the spread of the COVID virus.
§ 51.200 (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	**<u>Means Of Egress</u>** 1. Based on record review, observation, and interview, the facility failed to test and inspect illuminated exit signs as required by the code. The deficient practice affected zero (0) of seven (7) smoke compartments in [LOCATION], zero (0) of 10 smoke compartments in [LOCATION], 11 of 11 smoke compartments in [LOCATION], staff, and 100 residents. The facility had

Residents Affected – Many	the capacity for 300 beds with a census of 295 on the first day of the survey. The findings include: Record review, on 10/21/24, at 11:30 a.m., revealed for the 12-month period prior to the survey, the facility had no documentation indicating the required testing and inspection of illuminated exit signs was completed, as required by sections 7.10.9.1 and 7.10.9.2 of NFPA 101, Life Safety Code. An interview, on 10/21/24, at 11:35 a.m., with Maintenance Staff A revealed that the facility was unaware that the battery backup, illuminated exit signs were present in the facility. Observation during the facility tour, on 10/22/24, at 11:00 a.m., revealed 16 battery backup, illuminated exit signs throughout the first floor of [LOCATION]. Observation during the facility tour, on 10/22/24, at 11:15 a.m., revealed 12 battery backup, illuminated exit signs throughout the second floor of [LOCATION]. Observation during the facility tour, on 10/22/24, at 11:30 a.m., revealed 12 battery backup, illuminated exit signs throughout the third floor of [LOCATION]. Observation during the facility tour, on 10/22/24, at 11:45 a.m., revealed 12 battery backup, illuminated exit signs throughout the fourth floor of [LOCATION]. Observation during the facility tour, on 10/22/24, at 12:00 p.m., revealed 12 battery backup, illuminated exit signs throughout the fifth floor of [LOCATION]. The census of 295 was verified by Administrative Staff B on 10/21/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff A during the exit interview on 10/24/24, at 12:00 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012) 19.2.10 Marking of Means of Egress.** **19.2.10.1** Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4. **19.2.10.2** Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons. **19.2.10.3** Where the path of egress travel is obvious, signs shall not be required at gates in outside secured areas.

	19.2.10.4 Access to exits within rooms or sleeping suites shall not be required to be marked where staff is responsible for relocating or evacuating occupants. **7.10.9 Testing and Maintenance.** **7.10.9.1 Inspection.** Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days or shall be periodically monitored in accordance with 7.9.3.1.3. **7.10.9.2 Testing.** Exit signs connected to, or provided with, a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3. **7.9.3 Periodic Testing of Emergency Lighting Equipment.** **7.9.3.1** Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. **7.9.3.1.1** Testing of required emergency lighting systems shall be permitted to be conducted as follows: **(1)** Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). **(2)*** The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. **(3)** Functional testing shall be conducted annually for a minimum of 1½ hours if the emergency lighting system is battery powered. **(4)** The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). **(5)** Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. **7.9.3.1.2** Testing of required emergency lighting systems shall be permitted to be conducted as follows: **(1)** Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided. **(2)** Not less than once every 30 days, self-testing/self-diagnostic battery-operated emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine. **(3)** Self-testing/self-diagnostic battery-operated emergency lighting equipment shall indicate failures by a status indicator. **(4)** A visual inspection shall be performed at intervals not exceeding 30 days. **(5)** Functional testing shall be conducted annually for a minimum of 1½ hours. **(6)** Self-testing/self-diagnostic battery-operated emergency lighting equipment shall be fully operational for the duration of the 1½-hour test. **(7)** Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.

7.9.3.1.3 Testing of required emergency lighting systems shall be permitted to be conducted as follows:
(1) Computer-based, self-testing/self-diagnostic battery-operated emergency lighting equipment shall be provided.
(2) Not less than once every 30 days, emergency lighting equipment shall automatically perform a test with a duration of a minimum of 30 seconds and a diagnostic routine.
(3) The emergency lighting equipment shall automatically perform annually a test for a minimum of 1½ hours.
(4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.3(2) and (3).
(5) The computer-based system shall be capable of providing a report of the history of tests and failures at all times.

Smoke Barriers and Sprinklers

2. Based on record review and interview, the facility failed to properly maintain the alarm system in accordance with the code. The deficient practice affected seven (7) of seven (7) smoke compartments in [LOCATION], 10 of 10 smoke compartments in [LOCATION], 11 of 11 smoke compartments in [LOCATION], staff, and all residents. The facility had the capacity for 300 beds with a census of 295 on the first day of the survey.

The findings include:

Record review, on 10/21/24, at 10:15 a.m., of the fire alarm testing and inspection records for the 12-month period prior to the survey, revealed there was no documentation of semiannual testing of the alarm system battery charger or discharge test for the back-up batteries, as required by table 14.4.5 of NFPA 72, National Fire Alarm and Signaling Code.

An interview, on 10/21/24, at 10:20 a.m., with Maintenance Staff A revealed that the facility was unaware of the requirement for semi-annual testing of the alarm panel backup batteries. An additional interview with the Maintenance Staff C revealed that the facility only had charger and discharge testing completed during annual fire alarm testing.

Record review, on 10/21/24, at 10:30 a.m., of the fire alarm testing and inspection records for the 12-month period prior to the survey, revealed there was no documentation of semiannual, visual inspections of the alarm system smoke detectors, as required by table 14.3.1 of NFPA 72, National Fire Alarm and Signaling Code.

	An interview, on 10/21/24, at 10:35 a.m., with Maintenance Staff A revealed that the facility was unaware of the requirement for semi-annual, visual inspections of the alarm system smoke detectors. The census of 295 was verified by Administrative Staff B on 10/21/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff A during the exit interview on 10/24/24, at 12:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.4.1 General.** Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. **9.6 Fire Detection, Alarm, and Communications Systems.** **9.6.1* General.** **9.6.1.1** The provisions of Section 9.6 shall apply only where specifically required by another section of this Code. **9.6.1.2** Fire detection, alarm, and communications systems installed to make use of an alternative permitted by this Code shall be considered required systems and shall meet the provisions of this Code applicable to required systems. **9.6.1.3** A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. **9.6.1.4** All systems and components shall be approved for the purpose for which they are installed. **9.6.1.5*** To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. **4.6.12 Maintenance, Inspection, and Testing.** **4.6.12.1** Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. **4.6.12.2** No existing life safety feature shall be removed or reduced where such feature is a requirement for new construction. **4.6.12.3*** Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed.

	4.6.12.4 Any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. **10.2 Purpose.** The purpose of fire alarm and signaling systems shall be primarily to provide notification of alarm, supervisory, and trouble conditions; to alert the occupants; to summon aid; and to control emergency control functions. **10.3 Equipment.** **10.3.1** Equipment constructed and installed in conformity with this Code shall be listed for the purpose for which it is used. **Actual NFPA Standard: NFPA 72, National Fire Alarm and Signaling Code (2010)** **14.4.2* Test Methods.** **14.4.2.1*** At the request of the authority having jurisdiction, the central station facility installation shall be inspected for complete information regarding the central station system, including specifications, wiring diagrams, and floor plans that have been submitted for approval prior to installation of equipment and wiring. **14.4.2.2*** Systems and associated equipment shall be tested according to Table 14.4.2.2. **14.3 Inspection.** **14.3.1*** Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. **14.4.5* Testing Frequency.** Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. **Table 14.3.1 Visual Inspection Frequencies** **Table 14.4.5 Testing Schedule Frequencies**
§ 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	Based on observations and interviews, the facility failed to provide emergency stop stations for the emergency generators as required by the code. The deficient practice affected seven (7) of seven (7) smoke compartments in [LOCATION], 10 of 10 smoke compartments in [LOCATION], 11 of 11 smoke compartments in [LOCATION], staff, and all residents. The facility had the capacity for 300 beds with a census of 295 on the first day of the survey. Observation during the building inspection tour, on 10/22/24, at 1:25 p.m., revealed the facility failed to provide a remote manual stop for the 2000Kw primary generator and the 1600Kw secondary generator that provided emergency power to the entire campus, as required by section 5.6.5.6 of NFPA 110

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	(2010) Standard for Emergency and Standby Power Systems. An additional observation, on 10/22/24, at 1:30 p.m., revealed that the 1600kw generator was installed and operational in 1999. The 2000Kw Generator was installed and operational in 2012. An interview, on 10/22/24, at 1:30 p.m., with Maintenance Staff A revealed the facility was aware of the requirement for remote manual stops to be provided for emergency generators, but was unaware that the facility did not have the required remote manual stops installed on their generators. The census of 295 was verified by Administrative Staff B on 10/21/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff A during the exit interview on 10/24/24, at 12:00 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 (2010)** 5.6.5.6* All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled