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: Veterans Community Living Center at Fitzsimons - Aurora

Location: 1919 Quentin St. Aurora, CO 80045

Onsite / Virtual: Onsite

Dates of Survey: 1/31/23 – 2/3/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 180

Census on First Day of Survey: 124

VA Regulation Deficiency	Findings
	An Annual VA Survey was conducted from January 31, 2023 through February 3, 2023 at Veterans Community Living Center at Fitzsimons – Aurora. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes. On February 2, 2023 at 10:40 a.m., a determination was made that a situation in which the facility's noncompliance with one (1) or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment or death to residents. Administrative Staff A and Administrative Nurse A were notified of the Immediate Jeopardy on February 2, 2023 at 3:52 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on October 12, 2022. The Immediate Jeopardy continued through February 2, 2023. The facility implemented a Plan of Removal related to the Immediate Jeopardy on February 2, 2023. The IJ was a result of the facility's failure to 1) Implement lifesaving measures in accordance with established Advance Directives for Resident #8 and Resident #19, and 2) Ensure staff were competent in accessing code status information, and 3) Ensure nursing staff were competent to provide or withhold Basic Life Support, including Cardiopulmonary Resuscitation (CPR), based on the facility's protocol and residents' Advance Directives, and 5) Develop and implement appropriate plans of action to correct identified quality deficiencies. The facility's

	failure contributed to the death of two (2) residents and the system-wide practice remained unchanged at the time of the survey. Any resident with established Advance Directives was at risk. There were 124 residents with Advance Directives as of the date of the survey.
§ 51.70 (c) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on record review, interviews, and facility policy, the facility management failed to convey funds and provide a final accounting of trust fund monies to the resident and/or resident's representative within 90 calendar days following the death or discharge of the resident (Residents #19 and #28). The findings include: Review of the facility policy titled, "Veterans Community Living Center at Fitzsimons Standard Operating Policy & Procedure, Subject: Personal Needs," last revised 10/1/15, and reviewed 5/15/17, revealed: "7. [Administrative Staff B] is the first person assigned to sign checks on the account. If [Administrative Staff B] is not available to sign [Administrative Staff C] or [Administrative Staff A] will sign. This overall procedure will enhance internal controls. In the event a resident is discharged or becomes deceased, the account will be closed in accordance with State and Federal regulations, within 30 days, and appropriate payment of funds will be made to the resident, responsible party or funds will be transferred to the current nursing facility, as appropriate." On 1/31/23, at 2:49 p.m., review of the facility's Trust Fund-Current Account Balances report revealed the following: Resident #19, who expired on [DATE], had a remaining balance of $143.24. Resident #28, who was discharged from the facility on [DATE], had a remaining balance of $20.04. On 2/1/23, at 11:00 a.m., during an interview with the Administrative Staff D and Administrative Staff E, Administrative Staff D was informed of two (2) residents who had remaining account balances. Administrative Staff D stated they were not sure why the funds had not been conveyed, but would provide a response via email as soon as possible. On 2/1/23, at 6:06 p.m., Administrative Staff D revealed Resident #19's funds were not conveyed within 90 calendar days because the facility had not received the small estate form from the family. Administrative Staff D revealed once the facility received the small estate form, the money would be refunded

	right away. Administrative Staff D revealed Resident #28's funds were not conveyed within 90 calendar days due to a Medicaid issue. Administrative Staff D stated once the Medicaid issue was resolved, the money would be refunded right away.
§ 51.90 (b) (1) – (5) Abuse. The resident has the right to be free from mental, physical, sexual, and verbal abuse or neglect, corporal punishment, and involuntary seclusion. (1) Mental abuse includes humiliation, harassment, and threats of punishment or deprivation. (2) Physical abuse includes hitting, slapping, pinching, or kicking. Also includes controlling behavior through corporal punishment. (3) Sexual abuse includes sexual harassment, sexual coercion, and sexual assault. (4) Neglect is any impaired quality of life for an individual because of the absence of minimal services or resources to meet basic needs. Includes withholding or inadequately providing food and hydration (without physician, resident, or surrogate approval), clothing, medical care, and good hygiene. May also include placing the individual in unsafe or unsupervised conditions. (5) Involuntary seclusion is a resident's separation from other residents or from the resident's room against his or her will or the will of his or her legal representative. Level of Harm – Immediate Jeopardy to resident health or safety **Residents Affected** – Many	Based on interviews and record review, the facility failed to protect residents from neglect by failing to implement lifesaving measures, including Cardiopulmonary Resuscitation, in accordance with residents' established Advance Directives and professional standards of practice for two (2) of two (2) residents (Resident #8 and Resident #19) reviewed for compliance. This deficient practice had the potential to affect all 124 residents residing in the facility at the time of the survey. The findings include: According to the American Heart Association (https://cpr.heart.org/en/resources/what-is-cpr accessed February 3, 2023), Cardiopulmonary Resuscitation (CPR) is an emergency, lifesaving procedure performed when the heart stops beating. Immediate CPR can double or triple the changes of survival after cardiac arrest. On 1/31/23, the facility was asked to produce a policy governing processes for CPR. The facility provided a policy titled, "Cardiopulmonary Resuscitation (CPR)," which indicated a last revision date of 1/19/23. The policy read, "The facility will follow current American Heart Association (AHA) guidelines regarding CPR. The facility will confer with the MOST form to determine if CPR should be initiated. If a resident experiences a cardiac arrest, facility staff will provide basic life support, including CPR, prior to the arrival of emergency medical services." 1. Review of the medical record for Resident #8 revealed an initial admission date of [DATE]. Resident #8's primary medical diagnosis was [DIAGNOSIS] with a secondary diagnosis of Dementia. A comprehensive Minimum Data Set (MDS) assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of nine (9), indicating mild cognitive impairment. Resident #8 required extensive assistance with bed mobility and total dependence with transfers. Resident #8 expired in the facility on [DATE]. A nursing Progress Note, dated [DATE], at 12:26 a.m., and authored by Administrative Nurse B indicated Resident #8 was found deceased by a Certified Nurse Aide entering the resident's room to take vital signs. Resident #8 was described as cold to the touch and was "obviously deceased." The note failed to indicate whether Resident #8's Advance Directives were reviewed or whether CPR was initiated.

	A nursing Progress Note, dated [DATE], at 4:08 p.m., and authored by Licensed Nurse A was reviewed. The note indicated a Certified Nurse Aide approached the nurse and asked the nurse to check Resident #8. The nurse attempted to obtain vital signs twice but was unsuccessful. The resident was unresponsive. The nurse described the resident as "cold and stiffed." Administrative Nurse B was notified and "confirmed the resident was long dead upon [their] assessment." A call was made to the medical provider by Licensed Nurse A, and they handed the phone to Administrative Nurse B. Administrative Nurse B told the medical provider that "the patient is dead with cold and stiffness." The note failed to indicate whether Resident #8's Advance Directives were reviewed or whether CPR was initiated. Review of a Colorado Medical Orders for Scope of Treatment (MOST) form, dated [DATE], revealed Resident #8 wished for CPR to be attempted in the event they were found with no pulse and were not breathing. Review of Resident #8's Physician Orders revealed an order, dated [DATE], which read, "Attempt cardiopulmonary resuscitation/CPR See MOST form." The facility's investigative report was reviewed. The report was completed by Consultant Staff A. The report identified two (2) alleged perpetrators (Administrative Nurse B and Licensed Nurse A). The report included a witness statement by Licensed Nurse B, dated [DATE], at 12:10 p.m. Licensed Nurse B recalled speaking with two (2) nurses but was not able to recall their names. Licensed Nurse B allegedly questioned the first nurse about Resident #8's code status and was told Resident #8 was a "full code," indicating CPR should be performed if the resident was found without a pulse. Licensed Nurse B then questioned the nurse as to why they were not performing CPR or calling 911. The nurse stated something along the lines of "[Resident #1]'s gone." The nurse then handed the phone to Administrative Nurse B. Licensed Nurse B asked the supervisor why CPR was not being initiated or why paramedics had not been called. Administrative Nurse B responded with, "No we're not going to do that, [Resident #1]'s dead." Licensed Nurse B confirmed they had not received any calls regarding Resident #1 prior to the report of death. 2. Review of the medical record for Resident #19 revealed an initial admission date of [DATE]. Resident #19's primary medical diagnosis was Chronic Kidney Disease. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Resident #19 required extensive assistance with bed

	mobility, transfers, locomotion, dressing, toileting, and personal hygiene. Resident #19 expired in the facility on [DATE]. Review of Resident #19's Physician Orders revealed an order, dated [DATE], which read, "Do Not Resuscitate See MOST form." Review of a Colorado Medical Orders for Scope of Treatment (MOST) form, dated [DATE], revealed Resident #19 wished for CPR to be attempted in the event they were found with no pulse and were not breathing. Review of Resident #19's Progress Notes revealed an entry, dated [DATE], at 8:50 p.m., and authored by Licensed Nurse C which described Resident #19 as having an episode of emesis. Continued review of Resident #19's Progress Notes revealed an entry, dated [DATE], at 11:13 p.m., and authored by Licensed Nurse C which indicated Resident #19 was found unresponsive. Licensed Nurse C checked for vital signs but was unsuccessful. Administrative Nurse B then was notified. The note failed to indicate whether Resident #19' s Advance Directives were reviewed or whether CPR was initiated. Continued review of Resident #19's Progress Notes revealed an entry, dated [DATE], at 12:08 a.m., and authored by Administrative Nurse B which indicated they were called to Resident #19's room after Resident #19 was found unresponsive. The note failed to indicate whether Resident #19' s Advance Directives were reviewed or whether CPR was initiated. The facility's investigative report was reviewed. The report was completed by Consultant Staff A. The investigation was initiated after the facility identified concerns with Resident #8's care and began reviewing other deaths that had occurred. The facility determined Resident #19's Advance Directives were not followed, and that CPR was not initiated despite Resident #19's wishes. A statement by Licensed Nurse C, dated [DATE], indicated Administrative Nurse B told Licensed Nurse C that doing CPR after discovering Resident #19 deceased "will have no use." Licensed Nurse C also acknowledged confusion between the MOST form and physician code status order in the electronic health record. A performance improvement action plan, dated 10/17/22, was provided by the facility and reviewed. The action plan asserted that education was provided to 100% of nurses regarding CPR. On 2/1/23, the facility provided rosters for Certified Nurse Aides and Licensed Nurses. 21 staff members on the Certified Nurse

	Aide roster had no documented education or mock drill participation. 20 staff members on the Licensed Nurse roster had no documented education or mock drill participation. Continued review of the facility's performance improvement action plan revealed an action step in which the facility asserted that mock codes were to be conducted randomly on all shifts, once per month, and were to begin in [DATE]. Review of a Mock CPR Drill form, dated [DATE], revealed Administrative Staff C required correction to verify code status before CPR was initiated. Review of a Mock CPR Drill form, dated [DATE], revealed a Certified Nurse Aide required instruction to not start CPR until the nurse determined the resident's code status. Review of a Mock CPR Drill Form, dated [DATE], revealed Certified Nurse Aide A required education and a reminder that code status needed to be determined by the nurse prior to initiating CPR. Review of a Mock CPR Drill Form, dated [DATE], revealed Certified Nurse Aide B required instruction to not start CPR initially and that the nurse needed to verify the code status first. Review of a Mock CPR Drill Form, dated [DATE], revealed Licensed Nurse D required education to check the MOST form and not use the computer to verify code status. On 2/1/23, at 11:56 a.m., an interview was conducted with Consultant Staff A. They confirmed that they were responsible for facilitating investigations for abuse, neglect, and exploitation and that they had been in that role for approximately six (6) months due to the facility's change in leadership. Regarding the investigation for Resident #19, Consultant Staff A explained that the facility was not aware of the CPR discrepancy until they began an investigation into Resident #8's death. Consultant Staff A confirmed that, for both investigations, Administrative Nurse B was the Administrative Nurse on duty and was active, to some capacity, in both events. Consultant Staff A also confirmed that Administrative Nurse B failed to implement CPR for Resident #8 and Resident #19. Consultant Staff A added that they were not aware of any ongoing audit activity related to the corrective action plan, aside from the facility continuing education and mock CPR drills. On 2/1/23, at 2:16 p.m., an interview was conducted with Licensed Nurse E. They explained that they had been employed at the facility for approximately seven (7) years, and that they had not attended any mock CPR drills in the past. Licensed

	Nurse E was also unable to recall receiving any education recently regarding the facility's CPR and Advance Directive processes. When asked what their response would be to discovering a resident unresponsive, Licensed Nurse E stated they would "check the resident's code status in the computer" and start CPR accordingly. On 2/1/23, at approximately 3:10 p.m., an interview was conducted with Certified Nurse Aide B. They stated they could not recall receiving any recent training regarding the facility's CPR and Advance Directive processes and could not recall attending any mock CPR drills recently. When asked what their response would be to discovering a resident unresponsive, Certified Nurse Aide B stated they would "notify the nurse and start CPR if needed." When asked whether there were any steps required prior to initiating CPR, Certified Nurse Aide B stated, "I don't think so." On 2/2/23, at 10:03 a.m., an interview was conducted with Consultant Staff B regarding facility's corrective action plan and the education provided to ensure clinical staff were proficient in Advance Directives and CPR. Consultant Staff B explained that the training consisted of providing clinical staff with a copy of the facility's policy, and that return competency was being checked via "mock codes." Consultant Staff B stated they had been working on the training since [DATE] and that they were struggling with completing the training as they were having to complete the process themself. Consultant Staff B repeatedly stated, "It's hard for me to penetrate this training to people. They just don't get it." Consultant Staff B confirmed that some clinical staff had still not received education or participated in a mock drill. On 2/3/23, at 12:47 p.m., an interview was conducted with Administrative Nurse A regarding the incidents involving Resident #8 and Resident #19. Administrative Nurse A acknowledged that they were aware of the incidents and confirmed that CPR was inappropriately withheld from both Resident #8 and Resident #19. Administrative Nurse A explained that Consultant Staff B was overseeing the facility's corrective actions for education and mock drills, and that they were not abreast of the progress of either corrective action.
§ 51.100 (h) (2) Social Services. For each 120 beds, a nursing home must employ one or more qualified social workers who work for a total period that equals at least the work time of one full-time employee (FTE). A State home that has more or less than	Based on record review, staff interviews, and review of the facility policy, the facility failed to employ a qualified Social Worker required to accommodate the proportionate census of the facility. The census was 124 out of a total of 180 authorized beds.

120 beds must provide qualified social worker services on a proportionate basis (for example, a nursing home with 60 beds must employ one or more qualified social workers who work for a total period equaling at least one-half FTE and a nursing home with 180 beds must employ qualified social workers who work for a total period equaling at least one and one-half FTE). Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Review of the facility documents revealed 180 recognized beds. Review of the facility's staff credentials revealed that no qualified Social Worker was employed by the facility. On 2/1/23, at 11:55 a.m., during an interview with Consultant Staff A, they revealed they did not have a full time Social Worker with a Bachelor of Social Work (BSW) or Master of Social Work (MSW) degree. Consultant Staff A stated the facility contracted with an outside agency, and the Social Worker was a consultant. Consultant Staff A further revealed the consulting Social Worker was not a full-time employee of the facility.
§ 51.120 (i) Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. Level of Harm – Immediate Jeopardy to resident health or safety **Residents Affected** – Few	Based on observation, record reviews, interviews, and review of the facility's policy, the facility failed to provide adequate supervision for one (1) of three (3) sampled residents reviewed for accidents (Resident #9). The findings include: Review of the facility policy titled, "Elopements and Wandering Residents Policy," initiated on 1/1/04, and last revised on 2/1/23, revealed: "Policy: The Veterans Community Living Centers (VCLCs) ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk…Definitions: Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so…2. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner…4. D. Adequate supervision will be provided to help prevent accidents or elopements." Review of the facility policy titled, "Secure Memory Care Policy," initiated 6/03, and last revised 2/23, revealed: "Purpose: It is the policy of the VCLCs to provide the appropriate treatment and services to every resident who displays signs of, or diagnosed with dementia, to meet [their] highest practicable physical, mental, and psychosocial well-being. When appropriate, residents may reside on a secured memory care neighborhood…Policy: Individuals diagnosed by a physician, as having Alzheimer's disease or another dementia diagnosis will be considered appropriate for secured memory care placement."

	On 1/31/23, at 1:47 p.m., review of the Occurrence & Issue Brief Tracking for 2023 revealed Resident #9 was a "missing person" on [DATE]. Further review of Resident #9's Progress Notes revealed they were found in the employee parking lot by a maintenance worker. On 2/1/23, at 2:03 p.m., during an interview with Maintenance Staff A, they revealed on [DATE], they assisted Resident #9 back into the facility. Maintenance Staff A stated they did not witness the incident; however, Resident #9 was in the employee parking lot. Maintenance Staff A revealed contractors were onsite; however, they had exited the facility and keys were returned by the time Resident #9 was in the employee parking lot. Maintenance Staff A stated the [LOCATION] door had to be unsecured if Resident #9 was able to exit through the rear exit doors. Maintenance Staff A stated their contractors did not enter the building through the [LOCATION], and did not leave the [LOCATION] unsecured. On 2/1/23, at 2:12 p.m., during an interview with Consultant Staff C and Maintenance Staff A, Consultant Staff C revealed they conducted the investigation into Resident #9's elopement. Consultant Staff C stated on [DATE], at approximately 3:43 p.m., Resident #9 exited the facility through the [LOCATION]. Consultant Staff A stated a maintenance staff worker observed Resident #9 in the employee parking lot and assisted them back into the facility around 3:52 p.m. Consultant Staff C revealed staff did not witness Resident #9 exiting the facility, and that they reviewed the security footage to determine the timeframe of Resident #9's elopement. Consultant Staff C stated Resident #9 was assessed by a nurse and did not have any injuries. Consultant Staff C and Maintenance Staff A revealed on [DATE], at approximately 3:43 p.m., the temperature was around 20-30 degrees Fahrenheit (F) and Resident #9 was wearing a sweatshirt, sweatpants, and hospital-like slippers. Resident #9 was admitted to the facility on [DATE], with diagnoses including, but not limited to, Parkinson's Disease, Post-Traumatic Stress Disorder (PTSD), Other Specified Depressive Episodes, Anxiety Disorder, Dementia, Difficulty in Walking, and History of Falling. Review of the Minimum Data Set (MDS), with an Assessment Reference date (ARD) of [DATE], revealed Resident #9 had a Brief Interview of Mental Status (BIMS) score of 4, which indicated they were severely cognitively impaired. Review of the activities of daily living (ADLs) section of the MDS revealed Resident #9 required supervision with locomotion on and off the unit.

	Review of Resident #9's Comprehensive Care Plan, with a start date of [DATE], revealed: "Elopement: Resident has cont. [continued] to express frustration with being in a nursing facility. Not oriented to time, place, situation. Not a candidate for secure placement d/t [due to] hx [history] of physical bxs {sic}. Has impaired safety awareness. Has left facility to get "exercise," has delusions of family passing/needing to go to a funeral, demanding POA [Power of Attorney] come to visit/take [them] out. Wander guard placed on R [right] wrist. POA said it would be beneficial for [them] to believe it's a heart monitor." Review of Resident #9's quarterly Elopement Risk Scale assessment, dated [DATE], revealed a score of 14, which indicated resident was at risk to elope. The Risk Scale indicated resident had verbalized or attempted to leave the building one to two (1- 2) times per week, and was at high risk for elopement. There were no elopement risk assessments completed between [DATE], and [DATE]. Review of the quarterly Fall Risk Assessment, dated [DATE], revealed the resident had a score of 16, indicating they were at a high risk for falls. Review of Resident #9's Progress Notes, dated [DATE], at 3:30 p.m., revealed: "Resident continues to ask about the door to the stairs located next to [their] room and asking if the stairs lead to out of the facility. Resident was told it does not lead to outside and did not attempt to leave. Resident continued to ask about a bus and saying [they wanted] to leave the facility through the morning shift. Resident also was weighed post lasix weight has not gone down, BMP labs drawn today. Physician saw resident and gave an order for day boarding in [LOCATION]. No other orders given at this time. Resident will continue to be monitored and re-directed." Review of Resident #9's Progress Notes, dated [DATE], at 5:30 p.m., revealed: "Note Text: SS completed a check-in with resident regarding [their] request to have [their] [family member] call [them]. SS communicated to resident that they messaged [their] [family member], to give [them] a call at [their] earliest convenience. SS also called [family member] with [resident] present; [family member] was unable to answer the call. SS also explained to the resident that they would begin a day-boarding program on a different unit starting Monday the following week. SS explained that it would only be for a few hours during the weekdays to begin with and that they would plan to attend lunch back on the [LOCATION] during those days. SS also messaged resident's [family member] to communicate the information regarding resident's day-boarding plan to [them] as well."

	Review of Resident #9's Progress Notes, dated [DATE], at 3:35 p.m., revealed, "Resident started day boarding at [LOCATION], and was there for two hours today. Staff reported no issues noted and everything went smooth." [sic] Review of Resident #9's Progress Notes, dated [DATE], at 10:55 a.m., revealed: "Progress note/Day Boarding-resident was brought down this morning for day boarding. Resident immediately became distressed stating that, "this is trickery on how I was brought here, I want to leave, I am my own person and you people are running Alcatraz for the looney." Resident stated that there were only old people here when they were invited to get to know others. They would not accept anything to drink alleging that it could be poisonous. Resident would not accept their dog, "Polly", calling [them] "brain-dead". They stay parked in [their] wheelchair by the main doors and blocked the door with [their] foot when opened from the other side by Staff who escorted another Resident onto the unit. They started arguing with Staff and this staff was called for back-up to avoid an altercation with the Resident that was returning to the unit. Resident was returned to [their] unit by this staff with resident commenting that they were tricked and they will not be a prisoner." Review of Resident #9's Progress Notes, dated [DATE], at 6:15 p.m., revealed: "[Administrative Nurse C] notified this [Administrative Nurse D] that maintenance staff found resident in wheelchair outside in employee parking lot and was assisted back into the building. Resident verbalize they were going to [family member's] restaurant to assist [them]. Resident appeared to be in no distress and was assisted back to [LOCATION]. No S/S [signs/symptoms] of pain noted. [Administrative Staff A], [Consultant Staff A] notified. Message left for resident [family member] and MD.1:1 [one-to-one] monitoring to start when resident return to unit. Skin observation done by floor nurse and is intact no apparent injury noted." Review of the facility's Video Surveillance Review form, dated [DATE], revealed: "R#9 was observed exiting the facility by pushing the fire exit door. The fire alarm sounded, and security responded to the door alarm. Security reported looking out in area but did not see resident. A member of maintenance was observed getting into their car and the resident appears in camera view and knocks on car door. The member of maintenance assists resident back into the building." Review of the facility's Investigation Summary, dated [DATE], revealed: "On [DATE], Police, APS [Adult Protective Services], and Ombudsman were notified of the allegation. Staff interviews were conducted. Documentation reviewed. Video surveillance reviewed. Resident was placed on 1:1. The following day they

	went to [LOCATION] for day boarding program, which they started on [DATE]. On [DATE] order was received from physician for permanent placement on [LOCATION]. [Family Member]/MPOA gave consent to move. Room moves completed [DATE]. Skin assessment completed [DATE], no sign of injury or exposure to the elements noted." Further review of the Investigation Summary revealed, "Staff did not witness resident exit the facility. However, staff who were present during the incident stated that they observed resident in the back parking lot and that staff were able to safely assist resident back inside the facility. Typically, the [LOCATION] door was locked when it is not in use. Contracted workers were present on [DATE], and were noted to require access to the [LOCATION] in addition to Activities staff." Review of the facility's Conclusion Summary, dated [DATE], revealed: "The conclusion of the internal investigation is substantiated secondary to resident's history of exit seeking behavior and patterns, which have resulted in a revision of the care plan to place resident in a [LOCATION] within the community after obtaining consent and approval of the MD and Resident responsible party." On 1/31/23, at 11:09 a.m., Resident #9 was observed in the [LOCATION] in their wheelchair. During the observation, an attempt to interview Resident #9 was unsuccessful. On 1/31/23, at 2:33 p.m., Resident #9 was observed in their room in bed. Resident #9's eyes were closed, and they appeared to be sleeping. A second attempt to interview Resident #9 was unsuccessful. On 1/31/23, at 2:40 p.m., an attempt to interview Resident #9's family member via telephone was unsuccessful. A voicemail was left to return the call. On 2/1/23, at 8:18 a.m., Resident #9's family member returned the phone call, and an interview was conducted. Resident #9's family member stated they were made aware of the elopement on [DATE]. Resident #9's family member stated staff seemed very concerned on the phone and was not sure how Resident #9 got to the employee parking lot unsupervised. Resident #9's family member stated facility staff revealed that Resident #9 may have been let outside by contractors who were onsite. Resident #9's family member stated sometimes Resident #9 liked to play tricks on people to get what they wanted. On 2/3/23, at 10:33 a.m., during an interview with Consultant Staff D, they stated they were not made aware of Resident #9's elopement until today (2/3/23). Consultant Staff D stated they were not Resident #9's primary care physician (PCP); however, they should have been notified or made aware of the elopement. Consultant Staff D stated it was their responsibility

	to help assist the facility with incidents so appropriate corrective actions could be put into place. Consultant Staff D stated they believed there was no continuity between themself and the facility.
§ 51.120 (l) Special needs. The facility management must ensure that residents receive proper treatment and care for the following special services: (1) Injections; (2) Parenteral and enteral fluids; (3) Colostomy, ureterostomy, or ileostomy care; (4) Tracheostomy care; (5) Tracheal suctioning; (6) Respiratory care; (7) Foot care; and (8) Prostheses. Level of Harm – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	Based on observations, interviews, policy review, and record review, the facility failed to ensure that one (1) of one (1) resident reviewed for oxygen therapy (Resident #21) received humidified oxygen via nasal cannula at all times as ordered by the physician. This may have caused harm to Resident #21 by exacerbating the resident's dry nares by continuous oxygen therapy without humidification. The findings include: Review of the facility policy for "Oxygen Therapy," that was revised 2/3/23, revealed: "It is the policy of the Veterans Community Living Centers (VCLCs) that oxygen is administered consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. "Oxygen is administered under orders of a physician, except in the case of an emergency." An interview of Resident #21 and their family member, on 2/1/23, at 3:00 p.m., revealed that they visited two (2) to three (3) times a week. The family member stated that their oxygen had not been connected to the humidifier cannister for greater than a month. An observation at this time revealed Resident #21 was out of bed and in their wheelchair with a portable oxygen tank that was not attached to a humidifier. Resident #21 was observed blowing their nose with bloody mucus from both nostrils onto the tissue. The dry water cannister for the oxygen concentrator was observed on top of the wardrobe in the bedroom. The oxygen concentrator was observed without a cannister for water attached. Additionally, the portable oxygen concentrator that was on the back of Resident #21's wheelchair had no humidifier attached. Further observation and interview of Resident #21 and their family member, on 2/1/23, revealed that they had purchased a room humidifier to place in their room because of their nosebleeds and their need for humified air. Health record review for Resident #21 revealed diagnoses that included: End Stage Renal Disease, Atherosclerotic Heart Disease, Type Two Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Acute and Chronic Respiratory Failure with Hypoxia, Malignant Neoplasm of Kidney Renal Pelvis and Presence of a Cardiac Pacemaker.

	Review of the Physician Orders for Resident #21 revealed an order, dated [DATE], for oxygen via nasal cannula or simple mask: "HUMIDIFIER ON 02 [oxygen] @ ALL TIMES *every shift for Prophylaxis Prevention of Hypoxia/Respiratory distress."* Further review of the Physician Orders revealed additional orders to address their dry nares that included: "Saline Gel one application to both nostrils two times a day for dry nares related to oxygen use in AM [morning] and HS [hour of sleep]." "Saline Spray solution one spray both nostrils three times a day AM, midday, and HS." Review of the Care Plan for Resident #21, dated [DATE], and [DATE], revealed a plan for "Epistaxis" (bleeding from the nose) which revealed a goal that nose bleeds would resolve without complication through the review date. An interview with Consultant Staff D, on 2/2/23, at 1:35 p.m., revealed that it was their expectation for Resident #21's oxygen via nasal cannula to be humidified at all times, as indicated in the Physician Orders. An inquiry was made to Licensed Nurse F regarding Consultant Staff D's instructions that Resident #21's oxygen should be humidified at all times. Licensed Nurse F stated understanding, but stated they must contact Consultant Staff D to confirm the intent of the order. Licensed Nurse F also stated that there were no connectors available to connect the portable oxygen to the humidifier cannister or to the oxygen concentrator. A follow-up interview, on 2/3/23, at 10:35 a.m., with Administrative Nurse D revealed that Resident #21's humidifier had been reconnected to the oxygen concentrator and a second cannister connected to the portable oxygen container.
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly.	Based on observation and interview, the facility failed to dispose of garbage and refuse properly as evidenced by trash and food substances on the ground around the dumpster. The findings include: During an observation, on 2/1/23, at 11:35 a.m., with Dietary Staff A, it was noted that the garbage disposal located in the [LOCATION] was broken, and staff was scraping food scraps into a lined trash can. Dietary Staff A stated since the garbage disposal was broken,

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** –Many	they had to scape all the scraps of food from the plates into a lined garbage can and dispose of it outside. During an observation on 2/1/23, at 3:45 p.m., loose trash and food scraps were observed on the ground around the outside dumpster. On 2/2/23, at 9:23 a.m., in an interview with the Maintenance Staff B, they said that the garbage disposal had been broken for a while, and that it needed to be replaced. They stated that there had been several work orders received from the dietary department. They stated that they would not be able to produce all the previous work orders, because the previous Maintenance Staff would close out orders that the Maintenance Department was unable to fix, and the work order disappeared from the system once it was closed. They stated that the garbage disposal had been looked at by an outside vendor, and it was determined that it needed to be replaced. On 2/2/23, at 10:30 a.m., Dietary Staff B stated that they were aware that they had multiple pieces of broken equipment in the [LOCATION]. They stated that the previous Maintenance Staff would just close out the work orders without resolving the issues, and that the [LOCATION] would continue to submit new work orders for the same issues. They stated the broken equipment included: a hot service line (steam table), dishwasher heat booster, food garbage disposal, and a dish machine. Dietary Staff B further stated that it was very difficult to keep the dumpster area clean because of the extra refuse that was accumulated due to the garbage disposal being broken, and the garbage sacks were wet and heavy and sometimes broke when being thrown into the dumpster. Review, on 2/2/23, at 2:30 p.m., of the maintenance work orders related to the [LOCATION] revealed: “6. Garbage Disposal. 7/7/22 Garbage disposal is broken. e. 11/7/22 Garbage disposal not working. f. 2/1/23 Garbage disposal not working.” Review on 2/2/23, at 3:15 p.m., of the dietary department’s documents that could be found from an outside vendor [vendor name] revealed: “6. Garbage Disposal b. 8/18/22 Installed new garbage disposer and drain, recommendations given to facility.” The policy on maintenance of equipment was requested on 2/1/23,and Administrative Staff A stated that they would have to

	see what they could find. The policy had not been received by the end of the survey.
§ 51.160 (a) Provision of services If specialized rehabilitative services such as but not limited to physical therapy, speech therapy, occupational therapy, and mental health services for mental illness are required in the resident's comprehensive plan of care, facility management must— (1) Provide the required services; or (2) Obtain the required services from an outside resource, in accordance with §51.210(h) of this part, from a provider of specialized rehabilitative services. Level of Harm – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to provide physical therapy services to address functional decline for one (1) (Resident #1) of one (1) residents reviewed for compliance with rehabilitative services from a total of 27 sampled residents. The findings include: Review of Resident #1's medical record revealed an admission date of [DATE]. Resident #1's medical history included Chronic Pain Syndrome and a History of Falls. A quarterly minimum data set (MDS) assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. Resident #1 required extensive assistance of one person for transfers and limited assistance of one person for toilet use. The assessment identified Resident #1 as being continent of bowel and bladder. On 1/31/23, at 11:35 a.m., an employee was observed pushing Resident #1 to their room in a wheelchair. While pushing Resident #1 in the hallway, the employee stated to Certified Nurse Aide C, "[Resident #1] needs to use the bathroom." The employee then pushed Resident #1 into the room and asked Resident #1, "Can you do it by yourself?" Resident #1 replied, "I guess so" and the employee left the room. Certified Nurse Aide C did not stop to assist Resident #1, and continued walking down the hallway. On 1/31/23, at 11:49 a.m., Resident #1 activated the restroom call light. Certified Nurse Aide C responded to the room at 11:52 a.m. After assisting Resident #1 with transferring back to their wheelchair, the staff member asked Resident #1 whether they wanted to go back to the dining room for lunch. Resident #1 stated, "I don't think so. I'm too tired now. Just tell them to bring my soup to the room." On 1/31/23, at approximately 12:01 p.m., an interview was conducted with Resident #1 in their room. Resident #1 stated they did not want to return to the dining room because they were tired after having to transfer themself on and off the toilet. Resident #1 went on to explain that they felt light, and their strength was declining, and that they seemed to "feel tired all the time." A Physician Progress Note, dated [DATE], at 10:45 a.m., indicated Physical Therapy (PT) was to evaluate and treat Resident #1 to increase strength and mobility. Review of Resident #1's Physician Orders revealed no order on, or around

	[DATE], for Physical Therapy to evaluate and/or treat Resident #1. A Physician Progress Note, dated [DATE], at 10:20 a.m., indicated staff had noticed a physical decline, with the resident "struggling more than in past to propel w/c [wheelchair] to dining room." The note read, "We planned on PT [physical therapy] at last visit to work on strength and mobility, I cannot see that order placed so entered same today. I also proceeded with lab orders [Medical Provider] had planned to help r/o [rule out] medical factor in functional decline." Review of Resident #1's Physician Orders revealed an order, dated [DATE], for PT evaluation and treatment for functional decline. On 2/1/23, at approximately 10:30 a.m., an interview was conducted with Consultant Staff E regarding Resident #1's Physician Order for physical therapy evaluation and treatment. Consultant Staff E explained that they would need to look into whether Resident #1 was being treated and would provide additional information. On 2/1/23, at 1:03 p.m., a follow up interview was conducted with Consultant Staff E who explained that the therapy department did not receive communication of the order for evaluation/treatment on [DATE], or [DATE]. Consultant Staff E confirmed Resident #1 had not yet been evaluated for therapy, as they were unaware of the order until it was brought to their attention by the surveyor on [DATE].
§ 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 **Residents Affected** – Many	**<u>Means of Egress</u>** 1. Based on observation and interview, the facility failed to ensure exit pathways were free of obstructions. The deficient practice affected one (1) of 16 smoke compartments, staff, and 122 residents. The facility had a capacity for 180 beds with a census of 122 on the day of the survey. The findings include: Observation during the inspection tour, on 2/2/23, at 8:00 a.m., revealed two (2) scaffolds stored at the [LOCATION] which blocked the path of egress, as prohibited by section 7.1.10.1 of NFPA 101, Life Safety Code. An interview at that time with Maintenance Staff B, on 2/2/23, at 8:00 a.m., revealed the facility had been undergoing a repair at the [LOCATION] for three (3) months.

	Observation upon leaving the building, on 2/3/23, at 7:34 p.m., revealed two (2) scaffolds stored at the [LOCATION] which blocked the path of egress. Further observation revealed a maintenance staff member was stuck in the [LOCATION] as they drove a drivable lift, preventing access to exiting the [LOCATION]. During an interview at that time with Maintenance Staff B, on 2/2/23, at 7:34 p.m., they indicated, "the scaffolds were in the way." The census of 122 was verified by Administrative Staff A on 2/2/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff B, and verified by Maintenance Staff C during the exit interview on 2/3/23. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** 19.2 Means of Egress Requirements. **19.2.1** General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. **7.1.10** Means of Egress Reliability. **7.1.10.1*** General. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. **7.1.10.2** Furnishings and Decorations in Means of Egress. **7.1.10.2.1** No furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. **Smoke Barriers and Sprinklers** 2. Based on record review and interview, the facility failed to maintain the kitchen hood ventilation system in accordance with the code. The deficient practice affected one (1) of 16 smoke compartments, staff, and 122 residents. The facility had the capacity for 180 beds with a census of 122 on the day of survey. Observation during the inspection tour, on 2/2/23, at 10:56 a.m., revealed one (1) of six (6) grease filters located in the kitchen range hood was bent or leaving gaps between the filters as prohibited by section 6.2.3.3 of NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. During an interview, on 2/2/23, at 10:56 p.m., with the Dietary Staff C, they stated that wasn't their job, and understood the

	grease filters needed to fit tightly. Maintenance Staff B stated they would replace the grease filter immediately. The census of 122 was verified by Administrative Staff A on 2/2/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff B, and verified by Maintenance Staff C during the exit interview on 2/3/23. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.3.2.5 Cooking Facilities.** **19.3.2.5.1** Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4. **19.3.2.5.2*** Where residential cooking equipment is used for food warming or limited cooking, the equipment shall not be required to be protected in accordance with 9.2.3, and the presence of the equipment shall not require the area to be protected as a hazardous area. **9.2.3 Commercial Cooking Equipment.** Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service. **Actual NFPA Standard: NFPA 96, Standard for Ventilation Control and Fire Protections of Commercial Cooking Operations (2011)** **Chapter 6 Grease Removal Devices in Hoods** **6.2** Installation. **6.2.3** Grease Filters. **6.2.3.3** Grease filters shall be arranged so that all exhaust air passes through the grease filters. 3. Based on records review and interview, the facility failed to inspect the sprinkler system in accordance with the code. The deficient practice affected 16 of 16 smoke compartments, staff, and 122 residents. The facility had a capacity for 180 beds with a census of 122 on the day of the survey. The findings include: Records review on 2/3/23, at 8:18 a.m., revealed the last inspections for the sprinkler system were [DATE], and [DATE], not quarterly as required by sections 5.2.5 and 5.3.3.1 of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. An interview with Maintenance Staff B, on 2/3/23, at 8:18 a.m., revealed the facility was not aware of the requirement.

	The census of 122 was verified by Administrative Staff A on 2/2/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff B, and verified by Maintenance Staff C during the exit interview on 2/3/23. **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. **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. **9.7.6** Sprinkler System Impairments. Sprinkler impairment procedures shall comply with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. **9.7.7** Documentation. All required documentation regarding the design of the fire protection system and the procedures for maintenance, inspection, and testing of the fire protection system shall be maintained at an approved, secured location for the life of the fire protection system. **9.7.8** Record Keeping. Testing and maintenance records required by NFPA25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, shall be maintained at an approved, secured location. **Actual NFPA Standard: NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011)** **4.3** Records. **4.3.1*** Records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. **4.3.2** Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. **4.3.3*** Records shall be maintained by the property owner. **4.3.4** As-built system installation drawings, hydraulic calculations, original acceptance test records, and device manufacturer's data sheets shall be retained for the life of the system. **4.3.5** Subsequent records shall be retained for a period of 1 year after the next inspection, test, or maintenance of that type required by the standard.

	5.2.5 Waterflow Alarm and Supervisory Devices. Waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. **5.2.6*** Hydraulic Design Information Sign. The hydraulic design information sign for hydraulically designed systems shall be inspected quarterly to verify that it is attached securely to the sprinkler riser and is legible. **5.3.3** Waterflow Alarm Devices. **5.3.3.1** Mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 4. Based on observation and interview, the facility failed to maintain the smoke barriers. The deficient practice affected two (2) of 16 smoke compartments, staff, and 30 residents. The facility had a capacity for 180 beds with a census of 122 on the day of the survey. The findings include: Observation during the building inspection tour, on 2/2/23, at 11:56 a.m., of the smoke barrier above the lay-in ceiling tile at the cross-corridor doors outside of [LOCATION] near the [LOCATION] revealed an unsealed, four (4) inch circumference conduit, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code. An interview with Maintenance Staff B, on 2/2/23, at 11:58 a.m., revealed the facility was not aware of the unsealed opening. Observation during the building inspection tour, on 2/2/23, at 11:58 a.m., of the smoke barrier above the lay-in ceiling tile at the cross-corridor doors [LOCATION] near the [LOCATION] revealed a 4 x 4 inch unsealed square opening, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code. The census of 122 was verified by Administrative Staff A on 2/2/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff B, and verified by Maintenance Staff C during the exit interview on 2/3/23. **Actual NFPA Standard: NFPA 101 (2012) Life Safety Code** **19.3.7.3** Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1⁄2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply:

	(a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2)*Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. **8.5 Smoke Barriers.** **8.5.6 Penetrations.** **8.5.6.1** The provisions of 8.5.6 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations of smoke barriers. **8.5.6.2** Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke **<u>Fire and Operations</u>** 5. Based on records review and interview, the facility failed to conduct all required fire drills. The deficient practice affected 16 of 16 smoke compartments, staff, and all residents. The facility had the capacity for 180 beds with a census of 122 on the day of survey. The findings include: Records review on 2/2/23, at 8:46 a.m., of the facility's fire drill records for the 12-month period prior to the survey revealed there was no fire drill conducted on the first, second and third shift from [DATE] through [DATE]; [DATE]; [DATE] and [DATE], or quarterly on each shift to familiarize facility personnel as required by section 19.7.1.6 of NFPA 101, Life Safety Code. An interview, on 2/2/23, at 8:46 a.m., with Administrative Staff A and Maintenance Staff B revealed that the facility knew they had no fire drills due to the previous Maintenance Staff B. The census of 122 was verified by Administrative Staff A on 2/2/23. The findings were acknowledged by Administrative Staff

	A and Maintenance Staff B, and verified by Maintenance Staff C during the exit interview on 2/3/23. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.7.1** Evacuation and Relocation Plan and Fire Drills. **19.7.1.6** Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. 6. Based on observation and interview, the facility failed to provide the designated smoking areas with the required equipment. The deficient practice affected zero (0) of 16 smoke compartments, staff, and no residents. The facility had the capacity for 180 beds with a census of 122 on the day of survey. The findings include: Observation during the exterior building inspection tour, on 2/2/23, at 2:38 p.m., of the designated smoking area revealed the area was not provided with a metal container with self-closing cover devices into which ashtrays can be emptied, as required by section 19.7.4 (6) of NFPA 101, Life Safety Code. An interview, on 2/2/23, at 2:38 p.m., with Maintenance Staff B revealed the facility did not have a metal container with a self-closing device and indicated that a metal container with a self-closing cover device was not on premises. The census of 122 was verified by Administrative Staff A on 2/2/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff B, and verified by Maintenance Staff C during the exit interview on 2/3/23. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.7.4*** Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited.

	(4) The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 7. Based on observation and interview, the facility failed to prohibit the use of portable space heaters that do not meet the requirements of the code. The deficient practice affected one (1) of 16 smoke compartments, staff, and no residents. The facility had the capacity for 180 beds with a census of 122 on the day of survey. The findings include: Observation during the building inspection tour, on 2/2/23, at 1:42 p.m., revealed a portable space heater in use in the [LOCATION]. Additional observation revealed the temperature of the heating element was 250 degrees Fahrenheit when Maintenance Staff B tested the space heater with an infrared thermometer. An interview, on 2/2/23, at 1:42 p.m., with Maintenance Staff B revealed the facility was not aware the space heater was in use in [LOCATION] and the heating element would exceed 212°F (100°C), as prohibited by section 19.7.8 of NFPA 101, Life Safety Code. The census of 122 was verified by Administrative Staff A on 2/2/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff B and verified by Maintenance Staff C during the exit interview on 2/3/23. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.7.8 Portable Space-Heating Devices.** Portable space-heating devices shall be prohibited in all health care occupancies, unless both of the following criteria are met: (1) Such devices are used only in nonsleeping staff and employee areas. (2) The heating elements of such devices do not exceed 212°F (100°C). **Electrical Systems** 8. Based on observation and interview, the facility failed to prohibit the improper use of electrical equipment. The deficient practice affected three (3) of 16 smoke compartments, staff, and

	zero (0) residents. The facility had a capacity for 180 beds with a census of 122 on the day of the survey. The findings include: Observation during the building inspection tour, on 2/2/23, at 12:10 p.m., revealed a power strip used in lieu of fixed wiring to power a mini refrigerator in the [LOCATION], as prohibited by sections 400.8 and 590.3 of NFPA 70, National Electric Code. An interview, on 2/2/23, at 12:10 p.m., with Maintenance Staff B revealed the facility was not aware that a power strip was used in lieu of fixed wiring to power a mini refrigerator in the [LOCATION]. Observation during the building inspection tour, on 2/2/23, at 1:37 p.m., revealed a power strip used in lieu of fixed wiring to power a mini refrigerator in the [LOCATION], as prohibited by sections 400.8 and 590.3 of NFPA 70, National Electric Code. An interview, on 2/2/23, at 1:37 p.m., with Maintenance Staff B revealed the facility was not aware that a power strip was used in lieu of fixed wiring to power a mini refrigerator in the [LOCATION]. Observation during the building inspection tour, on 2/2/23, at 1:42 p.m., revealed a power strip used in lieu of fixed wiring powering a microwave, mini refrigerator, and space heater, in the [LOCATION], as prohibited by sections 400.8 and 590.3 of NFPA 70, National Electric Code. An interview, on 2/2/23, at 1:42 p.m., with Maintenance Staff B revealed the facility was not aware that a power strip was used in lieu of fixed wiring to power a microwave, mini refrigerator, and space heater in [LOCATION]. The census of 122 was verified by Administrative Staff A on 2/2/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff B, and verified by Maintenance Staff C during the exit interview on 2/3/23. **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 Utilities.** **9.1.2 Electrical Systems**. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service.

	Actual NFPA Standard: NFPA 70 (2011) National Electric Code **400.8 Uses Not Permitted.** Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure **590.3 Time Constraints.** (A) During the Period of Construction. Temporary electric power and lighting installations shall be permitted during the period of construction, remodeling, maintenance, repair, or demolition of buildings, structures, equipment, or similar activities. (B) 90 Days. Temporary electric power and lighting installations shall be permitted for a period not to exceed 90 days for holiday decorative lighting and similar purposes. (C) Emergencies and Tests. Temporary electric power and lighting installations shall be permitted during emergencies and for tests, experiments, and developmental work. (D) Removal. Temporary wiring shall be removed immediately upon completion of construction or purpose for which the wiring was installed. 9. Based on observation and interview, the facility failed to properly store oxygen cylinders. The deficient practice affected one (1) of 16 smoke compartments, staff, and no residents. The facility had a capacity for 180 beds with a census of 122 on the day of the survey. The findings include: Observation during the building inspection tour, on 2/2/23, at 1:05 p.m., revealed the cylinders stored in the [LOCATION] were a mix of full and empty cylinders. The empty cylinders were observed to not be segregated from the full and not marked to avoid confusion, as required by sections 11.6.5.2 and 11.6.5.3 of NFPA 99, Health Care Facilities Code. An interview at that time with Maintenance Staff B revealed that empty and full cylinders were stored together, and the facility was aware of the requirements to segregate and place the empty cylinders on the full side. The census of 122 was verified by Administrative Staff A on 2/2/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff B and verified by Maintenance Staff C during the exit interview on 2/3/23. **Actual NFPA Standard: NFPA 99, Health Care Facilities Code (2012)** **11.6.5** Special Precautions — Storage of Cylinders and Containers. **11.6.5.1** Storage shall be planned so that cylinders can be

	used in the order in which they are received from the supplier. **11.6.5.2** If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. **11.6.5.2.1** When the facility employs cylinders with integral pressure gauge, it shall establish the threshold pressure at which a cylinder is considered empty. **11.6.5.3** Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.
§ 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 of 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 onsite 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 emergency generator. The deficient practice affected 16 of 16 smoke compartments, staff, and all residents. The facility had a capacity for 180 beds with a census of 122 on the day of the survey. The findings include: Records review, on 2/2/23, at 9:12 a.m., of the monthly emergency generator inspection and testing records dating back 12 months prior to the survey revealed there was no documentation of monthly 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. During an interview, on 2/2/23, at 9:12 a.m., with Maintenance Staff B, they stated that they could not locate or confirm documentation of monthly specific gravity testing or conductance testing for the lead-acid batteries on the generator. Records review, on 2/2/23, at 9:12 a.m., revealed there was no documentation of an annual fuel quality test in the 12 months preceding the survey, as required by section 8.3.8 of NFPA 110, Standard for Emergency and Standby Power Systems. An interview with Maintenance Staff B, on 2/2/23, at 9:12 a.m., revealed they were working on getting the fuel quality test but could not locate or confirm documentation due to a previous Maintenance Staff B. Records review, on 2/2/23, at 9:12 a.m., revealed there were missing weekly inspection tests from [DATE] – [DATE] and from [DATE] – [DATE]. Further review of the reports revealed there was no monthly load test for [DATE], [DATE], and [DATE] as required by sections 8.3.4, 8.4.2, and 8.4.2.3 of NFPA 110, Standard for Emergency and Standby Power Systems.

	An interview with Administrative Staff A, on 2/2/23, at 9:12 a.m., revealed the last Maintenance Staff B was not organized and they could not find generator inspection and testing logs since they left. The census of 122 was verified by Administrative Staff A on 2/2/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff B and verified by Maintenance Staff C during the exit interview on 2/3/23. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.5 Building Services.** **19.5.1 Utilities.** **19.5.1.1** Utilities shall comply with the provisions of Section 9.1. **9.1.3 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)** **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. 8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards. 8.4.2* Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating **8.4.2.3** Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours.
§ 51.200 (c) Space and equipment.	Based on observation, interview, and record review, the facility

Facility management must— (1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and (2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	failed to maintain the steam table, plate warmer, garbage disposer, dish machine, and dish machine heat booster in safe operating condition on one (1) of three (3) [LOCATIONS], and failed to maintain one (1) of two (2) emergency crash carts. The findings include: On 1/31/23, at 11:00 a.m., Dietary Staff D explained that dietary staff take temperatures of the food in the [LOCATION] when it was placed in the hot box, and before it was sent to the neighborhood. Temperatures were taken again when food was transferred from the hot box and placed on the steam table, and again 30 minutes after the meal service began. On 1/31/23, at 11:35 a.m., dietary staff were observed placing food on the steam tables and taking the food temperatures to serve the [LOCATIONS]. On 1/31/23, at 11:36 a.m., there was no water observed in the right side of the steam table for the [LOCATIONS]. In an interview with Dietary Staff A, on 1/31/23, at 11:40 a.m., they reported that one (1) part affecting three areas that hold hot food was not working due to the inability to hold water in that area of the steam table. This steam table was used for the [LOCATIONS]. When asked how long the steam tables had been broken, Dietary Staff A responded by stating, “I am not sure, a long time. That is why we must use smaller pans to fit into the area that are working to keep the food within safe food serving temperatures.” On 1/312/23, at 11:40 a.m., Dietary Staff D stated that the [LOCATION] had several issues such as, the dish machine sometimes had to be run two (2) to three (3) times to get the rinse water well to fill up with water. This caused the dishes to come out of the machine with food particles still present on the dishes, and they must rerun the dishes through the machine. They further stated that they were not sure how long the heat booster for the dish machine had been broken, since it was setting to the side of the room all rusted out. They also stated that they must put food in smaller pans because three (3) of the four (4) wells for the hot serving line have been broken for a long time. They further stated since the garbage disposal was broken, they had to scape all the scraps of food from the plates into a garbage can and dispose of it outside. On 2/2/23, at 9:23 a.m., in an interview with Maintenance Staff B, they said that the garbage disposal had been broken for six (6) months or longer, and that they had attempted to fix it, but it needed to be replaced and they were not aware when that was going to occur. During the same interview Maintenance Staff B,

	they stated the dish machine's heat booster had been out of service for two (2) years, and that the previous administration had ordered a replacement, but it was the wrong part and never got returned to the company. They further stated that a second heat booster was ordered after they had received a citation from the state, and it also was the wrong part, and the facility was now awaiting the correct part. They further stated that the three (3) wells (areas that hold hot food trays) in the steam table had been out of service for a while because they had holes in the bottom of the wells, and they would not hold water. They stated that the facility had been trying to get a contract with an outside vendor to repair the line. Maintenance Staff B stated that plate warmer was not in service and that they had an outside vendor come in to look at the machine, and it was determined that it would cost more to repair it than it would to buy another one (1), but to their knowledge no decisions had been made to replace the broken equipment. On 2/2/23, at 10:30 a.m., Dietary Staff B stated that they were aware that they had multiple pieces of broken equipment in the [LOCATION]. They stated the previous Maintenance Staff B would just close out the work orders without resolving the issues, and that the [LOCATION] would continue to submit new work orders for the same issues. They stated the broken equipment included: The hot service line (steam table), dishwasher heat booster, food garbage disposal and problems with correct functioning of the dish machine. Dietary Staff B stated that it was very difficult to keep the dumpster area clean because of the extra refuse that was accumulated due to the food garbage disposal being broken, and the garbage sacks were wet and heavy and sometimes broke when being thrown into the dumpster. Review, on 2/2/23, at 2:30 p.m., of the maintenance work orders related to the [LOCATION] revealed: "1. Dishwasher. a. 7/28/22 Drain clogged in dishwasher. b. 11/2/22 Dishwasher temp low and final rinse is not working. c. 1/25/23 Dish machine not draining during cycle float, inside machine not working. d. 1/29/23 Dish machine does not hold water to wash dishes also we are washing with cold water. 2. Plate Warmer a. 7/26/22 Plate warmer not working. 3. Garbage Disposal a. 7/7/22 Garbage disposal is broken. b. 11/7/22 Garbage disposal not working. c. 2/1/23 Garbage disposal not working. 4. Steam Table a. 5/13/22 Steam table pipe is leaking.

	b. 7/7/22 Steam table is broken and leaking. 5. Dish Booster Heater a. No maintenance documents were received." Review, on 2/2/23, at 3:15 p.m., of the dietary department's documents that could be found from an outside vendor revealed: "1. Dish Machine a. serviced 2. Plate Warmer a. 6/22/22 Capacitor exploded; parts ordered. b. 6/24/22 Blower motor, blower wheel, temp probe and control panel replaced. c. 7/26/22 Replaced burnt electrical connections and wire. d. 8/12/22 Power supply board replaced. e. 12/15/22 Replaced GFCI and burnt cords. 3. Garbage Disposal a. 8/18/22 Installed new garbage disposer and drain, recommendations given to facility. 4. Steam Table a. 7/12/22 fixed cracked shut valve 5. Booster Heater. 7/27/22 PRV and T Stat connections replaced." The policy on maintenance of equipment was requested on 2/1/23. Administrative Staff A stated that they would have to see what they could find. The policy had not been received by the end of the survey. Based on observation, interview, and record review, the facility failed to maintain one (1) of two (2) emergency crash carts. The findings include: Review of Colorado Department of Human Services, Veterans Community Living Center policy titled, "Emergency Crash Cart Policy," dated 11/1/02, with revisions on 10/8/03, and 2/1/23, stated it was the policy of the Veteran's Community Living Centers to ensure that the facility maintained at least one (1) emergency cart per nursing care floor. Compliance Guidelines indicated: "The emergency cart is checked every 24 hours and after each use. Missing or expired items are replaced when applicable." Observation, on 1/31/23, revealed that one (1) of two (2)

	emergency crash carts, located on the [LOCATION] held two (2) bottles of sterile, normal saline with expiration dates of 1/26/22, and sterile tongue blades with an expiration date of 9/2019. Observation, on 1/31/23, revealed a "Daily Crash Cart Check List" on a clipboard on top of the emergency crash cart that contained missing documentation. [DATE] was missing 27 days of initials confirming that the emergency crash cart was checked daily; and [DATE] was missing documentation for 22 days. In an interview, on 1/31/23, at 1:15 p.m., Licensed Nurse G stated, "the crash carts should be checked nightly." They stated that the cart was checked nightly and documented on the appropriate checklist with the nurses' initials. Licensed Nurse G further stated that expired items were removed from the cart and replaced during the checking of the cart. Licensed Nurse G confirmed the expired dates on two (2) bottles of normal saline and four (4) sterile tongue blades. In an interview, on 2/3/23, at 10:30 a.m., Administrative Nurse A stated that the facility's expectations were that the night shift nurse would check the emergency crash cart nightly and replace all damaged or expired items. They further stated that the checking of the emergency crash cart was extremely important to ensure that all items, including oxygen and supplies, were present in the event of an emergency.
§ 51.210 (p) (2) Quality assessment and assurance. The quality assessment and assurance committee— (i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develops and implements appropriate plans of action to correct identified quality deficiencies; and **Level of Harm – No Actual Harm, with potential for more than minimal harm** **Residents Affected** – Many	Based on record review, interviews, and review of the facility policy, the facility failed to assure that the quality assurance committee maintained an effective program that focused on the outcomes of resident care and quality of life. The findings include: Review of the facility policy titled, "Quality Assurance and Performance Improvement (QAPI)," last revised 11/7/22, revealed: "Purpose: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life… Policy: 2. C. Develop and implement appropriate plans of action to correct identified quality deficiencies…3. The QAPI plan will address the following elements: a. Design and scope of the facility's QAPI program and QAA Committee responsibilities and actions. B. Policies and procedures for feedback, data collection systems, and monitoring. C. Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: i. Tracking and measuring performance…ii. Establishing goals and thresholds for

	performance improvements…iii. Identifying and prioritizing quality deficiencies…iv. Systematically analyzing underlying causes of systemic quality deficiencies…v. developing and implementing corrective action or performance improvement activities…vi. Monitoring and evaluating the effectiveness of corrective action/ performance improvement activities and revising as needed." On 2/3/23, at 8:39 a.m., review of the facility's QAPI agendas, dated [DATE], [DATE], [DATE], and [DATE], revealed there were no plans of action regarding the cardiopulmonary resuscitation (CPR) incidents in [DATE]. The facility management identified two (2) occasions where nursing staff failed to implement CPR. Review of the occurrence logs identified the facility management was able to substantiate the incidents and, as a result, the nursing staff were terminated. On 2/3/23, at 10:33 a.m., during an interview with Consultant Staff D, they stated they were not made aware of the CPR incidents in [DATE]. Consultant Staff D stated they expected to made aware of incidents involving residents and staff so that they could help the facility implement appropriate plans of action. Consultant Staff D stated that it was important for facility administration and themself to communicate areas of concern so that incidents involving staff could be addressed in a timely way. Consultant Staff D stated they believed there was no continuity between facility administration and themself. On 2/3/23, at 12:50 p.m., during an interview with Administrative Staff A and Administrative Nurse A, Administrative Nurse A stated they were unaware the Consultant Staff D was not notified of the CPR incidents in [DATE]. Administrative Staff A stated they were not in the building at the time of the occurrences and was not aware Consultant Staff D wasn't notified. Neither Administrative Staff A nor Administrative Nurse A could confirm if the previous Administrative Staff A had any contact with Consultant Staff D regarding the incidents. On 2/3/23, at 3:06 p.m., Administrative Staff A provided the survey team the Minutes for [DATE] QAPI meeting, which was held virtually. Administrative Staff A revealed Consultant Staff D was in attendance and Consultant Staff A discussed the substantiated neglect case of both residents regarding CPR. The facility did not provide any additional documentation of quality assurance plans of action to correct the identified quality deficiencies.
§ 51.210 (7) Annual State Fire Marshall's report.	Based on record review and interview, the facility failed to obtain an Annual State Fire Marshal's report. The deficient practice affected 16 of 16 compartments, staff, and all residents. The

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	facility had a capacity for 180 beds with a census of 122 on the day of the survey. The findings include: Record review, on 2/2/23, at 9:12 a.m., revealed there was no documentation to indicate that the facility had an inspection by the State Fire Marshal, or had obtained an inspection report from the State Fire Marshal, as required by section 51.210 (7). An interview, on 2/2/23, at 9:12 a.m., with Maintenance Staff B, revealed the facility could not schedule a Fire Marshal report due to the area of the facility's location. The census of 122 was verified by Administrative Staff A on 2/2/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff B and verified by the Maintenance Staff C during the exit interview on 2/3/23.