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: Nevada State Veterans Home

Location: 100 Veterans Memorial Drive, Boulder City, NV 89005

Onsite / Virtual: Onsite

Dates of Survey: 8/30/2022 - 9/02/2022

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 180

Census on First Day of Survey: 151

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from August 30, 2022, through September 2, 2022, at the Nevada State Veterans Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.70 (c) (6) Assurance of financial security. The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Many	Based on record reviews and interviews, the facility failed to provide a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all the residents' personal funds that were deposited within the facility. Specifically, the facility's lack of having a surety bond or an approval letter from the Under Secretary of Health potentially put all residents with funds deposited within the facility at risk of losing their funds. The findings include: Review of the document titled, "Southern Nevada State Veterans Home Resident Trust Fund General Information," last revised on 12/06/19, revealed: "10. To assure the security of all residents' personal funds deposited with the Resident Trust Fund, funds are deposit in an insured financial institution and the Southern Nevada State Veterans Home is self-insured through the State of Nevada."

	An interview was conducted with Administrative Staff A, on 9/1/22, from 10:40 a.m., to11:06 a.m., and they were questioned as to whether the facility had an approval letter from the Under Secretary of Health of the Veterans Administration (VA) or any documentation that specifically used the term “Surety Bond” when referencing the insurance of the residents' funds. Administrative Staff A stated, “We have always just used the letter from the Under Secretary of Health for the state of Nevada.” An interview was conducted with Administrative Staff B, on 9/1/22, at 11:08 a.m., When asked for clarification if there was any documentation from the VA supporting a letter from the Under Secretary of Health, they mentioned that they had never gone to the Federal VA to get the letter from the Under Secretary of Health, just the state of Nevada. The document the facility provided was a letter from the Nevada Department of Veterans Services, dated 8/30/22, stating that the funds of the residents of Nevada State Veterans Home in Boulder City, NV were protected by the state and the Declaration of Self Insurance for Liability Claims from the State of Nevada Department of Administration Risk Management Division. There was no evidence of a Surety Bond or a letter from the Under Secretary of Health with the Veterans Administration (VA).
§ 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, 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.	Based on observation, interview, record review, and facility policy review, the facility failed to develop a Care Plan for one (1) resident (Resident #9) of 25 residents reviewed for smoking hazard. The findings include: Review of the facility’s “Care Planning” policy, revised 4/24/19, revealed: “Policy: Resident’s electronic Care Plan will be initiated upon admission. Electronic comprehensive care plans will be completed within 21 days of admission. Procedure: 1. c. Comprehensive Care Plans will be completed by the MDS (Minimum Data Set) nurse and members of IDT (Interdisciplinary Team). 2. b. Problems – i. All problems, needs, and risks will be identified under the problem section. When indicated, a narrative problem description of resident history and personal preferences will be done for resident ‘I centered care plan.’ ii. The problem will be personalized and specific to the resident.” Review of the facility’s “Smoking Cessation for Current In-House Smokers” policy, revised on 9/25/19, revealed: “6. During the cessation period nursing staff will assess residents and address

Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	their cognitive and physical abilities to utilize tobacco products and smoking materials quarterly or if there is a significant change. The assessment will be reviewed at the IDT meeting and documented in the care plan." Review of Resident #9's clinical record revealed the resident was admitted to the facility in 2022 and readmitted in 2022 with diagnoses which included: Type 2 Diabetes Mellitus, Fracture of Right Femur, Hypertension and Lower Back Pain. Review of Resident #9's "Smoking – Safety Screen," dated [DATE], revealed a score of 1.0, indicating the resident was safe to smoke without supervision. Review of Resident #9's "Smoking – Safety Screen," dated [DATE], revealed a score of 1.0, indicating the resident was safe to smoke without supervision. Review of Resident #9's Care Plans revealed there was no Care Plan addressing smoking. During an interview, on 9/1/22, at 9:30 a.m., Resident #9 stated they were a smoker. Resident stated that due to the accident and subsequent surgery, the resident had not been able to smoke like they wanted. Resident #9 stated that as soon as they could, they would be out there smoking. During an interview, on 9/2/22, at 12:00 p.m., Administrative Nurse A stated they were responsible for developing Care Plans upon admission, and completion of the Care Area Assessment (CAA). Administrative Nurse A stated that anyone could update a Care Plan. Administrative Nurse A stated major updates were done during the IDT meetings. Administrative Nurse A stated that they were not aware that Resident #9 did not have a smoking Care Plan. Administrative Nurse A stated they thought the resident was no longer smoking. Review of Resident #9's Care Plans revealed that the Care Plan was revised to address the resident's smoking status on [DATE], after the concern was identified by the surveyor.
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care.	Based on observation, interview, record review, and policy review, the facility failed to implement the Plan of Care for one (1) of 24 sampled residents, Resident # 14. The findings include: Review of the policy and procedure titled, "Care Planning," dated 4/24/19, revealed: "b. The resident and their representative will be provided with a care plan that includes but is not limited to iii. Any services and treatments to be

Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	administered by the facility and personnel acting on behalf of the facility." Record review of the Admission Minimum Data Set (MDS), dated [DATE], revealed the Brief Interview Mental Status (BIMS) score to be 11, indicating the resident had moderate cognitive impairment. Continued review of the MDS revealed the resident had the presence of a feeding tube. Review of the Plan of Care for Resident #14 revealed the resident was not able to tolerate medication, fluids, or nutrition orally and had a feeding tube in place. Further review of the Care Plan revealed interventions including assessing feeding tube placement, patency, and residual before and after administration of any fluids or medication. Observation of Resident #14, on 9/1/22, at 8:20 a.m., revealed the resident to be alert, and oriented. The resident's head of the bed (HOB) was elevated approximately 30 degrees. Diabetisource 1.2 via g-tube at 75 milliliters (MLS) per hour via a Kangaroo Pump was observed. Observation of Licensed Nurse A, on 9/1/22, at 8:20 a.m., revealed the administration of medications through Resident #14's gastronomy tube (g-tube); however, the nurse failed to check for residual of gastric contents and failed to auscultate for verification of tube placement. An interview with Licensed Nurse A, on 9/1/22, at 8:30 a.m., revealed that normally they would use their stethoscope to auscultate for proper placement of the tube but did not feel that step to be necessary since the resident already had a continuous tube feeding infusing. An interview with Licensed Nurse A, on 9/1/22, at 8:45 a.m., revealed it was important to check for proper g-tube placement prior to the instillation of medications to ensure that the g-tube was not on the outside of the stomach. An interview with Administrative Nurse A, on 9/2/22, at 12:00 p.m., revealed the Care Plan was a road map which provided all the interdisciplinary team directions based on identified resident issues. The nurse revealed it was important for the staff to follow the Care Plan because not doing so could result in a negative outcome for the resident. An interview with Administrative Nurse B, on 9/2/22, at 12:04 p.m., revealed that it was very important for the nurse to check for placement of a g-tube prior to the administration of medications because the medications should be instilled into the

	stomach. They stated that it was their expectation that each resident's Care Plan would be followed by the staff.
§ 51.120 (h) Enteral Feedings. Based on the comprehensive assessment of a resident, the facility management must ensure that— (1) A resident who has been able to adequately eat or take fluids alone or with assistance is not fed by enteral feedings unless the resident's clinical condition demonstrates that use of enteral feedings was unavoidable; and (2) A resident who is fed by enteral feedings receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, nasal pharyngeal ulcers, and other skin breakdowns, and to restore, if possible, normal eating skills. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on observation, interview, record review, and policy review, the facility failed to assess proper gastrostomy tube placement prior to administering medications for one (1) of one (1) sampled residents (Resident #14). The findings include: Review of the policy and procedure titled, "Gastrostomy Tube (G-Tube) Feeding and Medication Administration," dated 03/13/14, documented that the purpose of the policy was to document assessment of G-Tubes for proper placement prior to use. It noted, "How completed: 10. Check feeding tube for placement by aspiration of gastric contents and by auscultation." Record review of the Admission Minimum Data Set (MDS), dated [DATE], revealed the Brief Interview Mental Status (BIMS) score to be 11, which indicated that the resident had moderate cognitive impairment. Continued review of the MDS revealed the resident had the presence of a feeding tube. Review of the Plan of Care for Resident #14 revealed that the resident was not able to tolerate medication, fluids, or nutrition orally and had a feeding tube in place. Further review of the Care Plan stated to assess feeding tube placement, patency, and residuals before and after administration of any fluids or medication. Observation of Resident #14, on 9/1/22, at 8:20 a.m., revealed the resident to be alert and oriented. The resident's head of the bed (HOB) was elevated approximately 30 degrees. Diabetisource 1.2 via g-tube at 75 MLS per hour via a Kangaroo Pump was observed. Observation of Licensed Nurse A, on 9/1/22, at 8:20 a.m., revealed the administration of medications through Resident #14's g-tube; however, the nurse failed to check for residuals of gastric contents and failed to auscultate for verification of tube placement. An interview with Licensed Nurse A, on 9/1/22, at 8:30 a.m., revealed they would use their stethoscope to auscultate for proper placement of the tube but did not feel that step was necessary since the resident already had a continuous tube feeding infusing. Licensed Nurse A stated it was important to check for proper g-tube placement prior to the instillation of medications to ensure that the g-tube was not on the outside of the stomach.

	An interview with Licensed Nurse B, on 9/1/22, at 2:00 p.m., revealed that when medications were administered through a g-tube, the tube should be flushed with 60 MLS of water, aspirated, and auscultated to ensure proper placement of the tube. An interview with Administrative Nurse B, on 9/2/22, at 12:04 p.m., revealed it was very important for the nurse to check for placement of a g-tube prior to the administration of medications, because the medications should be instilled into the stomach.
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Many	Based on facility observations, record review, and staff interviews, the facility failed to ensure that food was stored, prepared, distributed, and served under sanitary conditions. Specifically, the facility failed to ensure: -food was dated, labeled, and stored appropriately -food temperatures were properly monitored -proper sanitation was maintained during food preparation and service for residents on three (3) of three (3) units. The findings include: Review of the facility's policy, "Food and Nutrition Services," which was provided on 9/1/22, and had an effective date of 3/29/02, and was last revised 6/14/17, found stated in pertinent part: "PROCEDURE: 2. Menus and Nutrition… c. Food and drink items are prepared to meet individual needs by methods that conserve nutritional value, accommodate resident allergies, intolerances, and preferences, are flavorful and attractive in appearance and served at a safe and appetizing temperature… 5. Sanitary Conditions… b. Food will be handled, prepared, distributed, and served under sanitary conditions to prevent the outbreak of food borne illness. c. Hot food will be served at or above 140 degrees F [Fahrenheit], cold food at or below 41 degrees F. Kitchen staff will monitor food temperatures daily… g. Food, including those brought to residents by family and other visitors will be stored in labeled, closed, and dated containers according to policy FN-1255 Food Brought in by Visitors… j. All procedures will be in compliance with Federal, State and local health codes."

	Observations on 8/30/22, beginning at 9:50 a.m., at the facility's main kitchen, were made with Dietary Staff A. Observations included: 1. Walk-in Freezer -A storage container of Mexican rice and chicken with a label that stated 2/27/22-8/2 (no year). Dietary Staff A said that they kept frozen items six (6) months. -A metal container of meatballs dated 8/25, covered in torn plastic wrap. -An undated storage container of chili. -A storage container of chicken soup dated 8/22. The lid had lifted off the container. -An opened and undated bag of chocolate chip cookie dough was not properly tied or secured. 2. Walk-in Refrigerator -A storage container of chicken soup dated 8/26. The lid had lifted off the container. -A storage container of undated cranberry mix had a lid that had lifted off the container. -A storage container of a brown liquid, dated 8/30, had a lid that had lifted off the container. -A storage container of sliced cheese, dated 8/30, had a lid that had lifted off the container. 3. Pantry -An opened and undated bag of thick, sliced bread was not properly tied or secured. Observations on 9/1/22, at 9:31 a.m., at the facility's [LOCATION] nourishment room revealed there was a sign posted on the cupboard that read, "All juices and drinks must be dated once opened." Three (3) Mighty Shakes were observed thawed in the refrigerator: one (1) 6-ounce (oz.) vanilla with a use by date of 8/17/23, and two (2) 6 oz. strawberry cartons with a use by date of 8/3/23. The cartons stated: "Store frozen. Thaw at/or below 40 F. Use thawed product within 14 days. Keep refrigerated." There was no thaw date on the cartons.

	Three (3) opened, 32 oz. cartons of vanilla MedPass 2.0 Fortified Nutritional Shakes were in the refrigerator. All had “use by” dates of 7/30/23. The cartons stated: “After open, consume product within 4 days if properly refrigerated. After open, consume product within 4 hours if not refrigerated.” One (1) opened carton was marked “8/25” on it. The other two (2) were not dated. One (1) Hormel Thick and Easy Clear Cranberry Juice, nectar consistency, was observed opened and undated. The use by date was 4/29/23. The carton stated: “Refrigerate unused portion. Discard if not used within 10 days of opening.” There was no thaw date observed on the container. One (1) dated and opened bag of sliced bread on top of the microwave, not properly tied or secured. -One (1) dated and opened bag with a single bagel, not properly tied or secured. Certified Nurse Aide A said the drinks should be dated by staff when they were opened, and then stored in the nourishment room refrigerator. Certified Nurse Aide A said they had not been educated or made aware that Mighty Shakes should be dated when thawed. Observations on 9/1/22, at 9:45 a.m., at the facility’s [LOCATION] nourishment room revealed that there were two (2) large, open top containers filled with ice. There were paper plates covering the top of the containers, as improvised lids. Certified Nurse Aide B and Certified Nurse Aide C were observed in the nourishment room. They both said that this was the way ice was currently being provided to the residents, since the ice-machine in the [LOCATION] nourishment room was not working. They both said it was not a sanitary process. Observations on 9/1/22, at 9:51 a.m., at the facility’s main kitchen were made with Dietary Staff A. There were eight (8) Mighty Shakes thawed in the refrigerator, with no thaw dates. Dietary Staff A said they were not aware that the drinks needed to have the thaw date recorded. A storage container of cookie crumbs, with a label dated “6/13/21-use 12/21,” was observed in the pantry with the lid lifted off the container. Lunch service was observed on 9/1/22, at 10:27 a.m., with Dietary Staff A. Dietary Staff C was observed placing the thermometer approximately an inch deep into the food items being recorded. After each food item, Dietary Staff C used the tea towel tucked into their apron belt to clean the thermometer off. At 10:44 a.m. Dietary Staff C was observed dropping a tea

	towel onto the kitchen floor. It was picked up and lightly tossed onto the rack holding plate lids. Dietary Staff A picked it up and removed it from the food preparation area. Food Temperature Log documentation was provided by Dietary Staff A on 9/1/22, at 12:25 p.m., for review. The Food Temperature Log provided a place to identify hot foods and cold foods, the food item, and the temperatures of those items. The first available date the facility had documented food temperatures was 8/26/22. The food temperatures were not logged prior to 8/26/22. The items logged from 8/26/22 until 9/1/22 did not specify temperatures for alternate meal items, for any altered food textures, or recorded specifically repetitive temperatures. On 8/26/22, at 6 a.m., only a cheese omelet, oatmeal, and bacon were documented at 165 degrees (deg.) Fahrenheit (F). At 10 a.m., beef tips in gravy were noted at 169 deg. F; garlic mashed potatoes and fresh asparagus were both documented at 165 deg. F; and brownies were noted at 38 deg. F. At 2 p.m., spaghetti and meat sauce, and zucchini, were both noted at 165 deg. F; and cherry pie was noted at 38 deg. F. No altered textures or alternatives were identified or documented. On 8/27/22, at 6 a.m., ham and cheese frittata, and hash brown patty, were both noted at 165F; and fresh fruit was documented at 38F. At 10 a.m., marinara chicken penne pasta was noted at 169F; sauteed vegetables were noted at 165F; and chocolate pudding was noted at 38F. At 2 p.m., the buttermilk fried chicken, macaroni and cheese, and corn on the cob were all noted at 165F; and “assorted desserts” were noted at 38F. No altered textures or alternatives were identified or documented. On 8/28/22, at 6 a.m., sausage, country gravy, and biscuits were all documented at 165F; and peanut butter cookies were recorded at 40F. At 10:20 a.m., chicken tenders, curly fries and corn O’Brian were all noted at 165F. At 2 p.m., BBQ chicken breast, macaroni and cheese, and corn on the cob were all recorded at 165F; and yellow cake was noted at 38F at 1 p.m. No altered textures or alternatives were identified or documented. On 8/29/22, at 7 a.m., French toast and bacon were logged at 165F; and fresh fruit was logged at 38F. At 10 a.m., sweet potato tots were noted at 165F. At 2 p.m., pasta carbonara and grilled asparagus were documented at 165F; and brownies, cranberry turkey wrap, and banana pudding were recorded as 38F at 1 p.m. No altered textures or alternatives were identified or documented.

	On 8/30/22, at 6:20 a.m., egg Denver was logged at 167F and at 6:40 a.m., was noted at 163F. At 6:30 a.m., hash browns were at 183F, and at 6:40 a.m. were 180F. At 10 a.m., the tacos were recorded at 160F, and a second temperature at the same 10 a.m., time was noted at 150F. At 10 a.m., the refried beans were 160F, and at the same 10 a.m., time were also noted at 155F. At 10 a.m., the corn was noted at 160F, and again at the same 10 a.m., time were also noted at 150F. At 2 p.m., the pie was noted at 38F. At 4 p.m., the chicken was noted as172F, the mashed potatoes were at 165F, and the capri vegetable blend was recorded at 167F. At 4 p.m., the cherry pie was 37F. No altered textures or alternatives were identified or documented. On 8/31/22, at 6:30 a.m., the oatmeal was logged at 166F, the pancakes were noted at 168F, and the eggs were recorded as 171F. The fresh fruit was noted at 36F at 6:30 a.m. At 10 a.m., the chicken alfredo and zucchini were both recorded at 165F, and the chocolate cake was at 32F. At 3:30 p.m., the beef tips were noted at 170F, the wild rice was 155F, and the cauliflower was 148F. No cold foods were logged. No altered textures or alternatives were identified or documented. On 9/1/22, at 10:33 a.m., the “puree” was at 163F, and at 10:45 a.m., was 153F. At 10:33 a.m., the “veg” was 133F (out of acceptable range), and the gravy was recorded at 182F. At 10 a.m., the mashed potatoes were noted at 165F. At 10:50 a.m., the chicken and fries were both recorded at 164F. At 10:30 a.m., the M&M bread had no temperature noted, and at 10 a.m. the peaches were 38F. No altered textures or alternatives were identified or documented. Dietary Staff A said that the kitchen steamtable had been broken for about a year. Dietary Staff A said the facility had tried to order a new one last year, but had had supply issues. Dietary Staff A said the facility ended up having to order a different unit this February. Dietary Staff A stated that the facility anticipated putting in new kitchen floors this month, and then the facility would put in the new steamtable that arrived in July, 2022. During the renovation Dietary Staff A said the dietary department would use a catering or detached food preparation process for the resident meals. Dietary Staff A stated that the dietary department had been told that they should start taking food temperatures during the renovation to ensure that they were holding well. Dietary Staff A said no one, including Dietary Staff B or other outside agencies, had told them that they needed to take food temperatures for each meal regularly. Dietary Staff A said that in order to prepare for the renovation, they had started their staff on getting used to taking food temperatures. Dietary Staff A said that Dietary Staff C should not have used their tea towel to wipe off the thermometer when they took food temperatures. Dietary Staff A also stated that

	because the steamtable had been broken, the kitchen had been using Sterno four (4) hour burner cans during meal service. Dietary Staff A said they used two (2) per well. On 9/2/22, at 12:01 p.m., Maintenance Staff A was interviewed. Maintenance Staff A said that the facility was preparing to renovate the kitchen. Maintenance Staff A said that the originally ordered steam table was backordered, but they had one (1) ready now for installation since July. Maintenance Staff A said that the Sternos had been used in the kitchen for over six (6) months, as a work-around. Maintenance Staff A said they had been informed that the use of Sternos was appropriate according to commercial practice, and was meeting catering standards. Maintenance Staff A was not aware that food temperatures were not being done until last week. Maintenance Staff A said that the steamtable in the unused dining room worked, but had not been used due to COVID outbreaks that had prevented regular access to the dining room for resident use. Because residents were not using the dining room, the facility had not considered using the working steamtable in that area while they waited to install the new steamtable. Dietary Staff A was interviewed on 9/2/22, at 12:28 p.m. Dietary Staff A said that they just started having staff document food temperatures on 8/26/22. They said that Dietary Staff B was surprised that Food Temperature Logs needed to be done for resident food. Dietary Staff A said that they looked into the storage containers that had the lids coming off in the kitchen and tested them to find out why the lids came off. Dietary Staff A stated the excess moisture in the cooler/freezer caused the lids to come off the containers. Dietary Staff A further stated it was important to let hot food items cool down first before the lids go on. Dietary Staff B was interviewed on 9/2/22, at 12:56 p.m. Dietary Staff B said that they provided oversight for Dietary Staff A. Dietary Staff B said that until it was discussed during the current investigation, they were not aware of the need to take food temperatures, and record them, on the steam table. Dietary Staff B said that during the past five (5) surveys, no one had ever asked about food temperatures before. Dietary Staff B said that they had dated drinks in the past, but had never been aware of the need to date thawing Mighty Shakes. Dietary Staff B was not sure where the MedPass in the nourishment rooms had come from, and that they should not be in use at all now.
§ 51.190 (a) Infection control program. The facility management must establish and maintain an infection control program designed to provide a safe,	Based on observation, interview, record review, and policy review, the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection for two (2) of 24 sampled

sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection control program. The facility management must establish an infection control program under which it— (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	residents, Resident #23, and Resident #24. The facility also failed to ensure that staff were serving food under sanitary conditions. Specifically, staff were observed not sanitizing and/or using proper hand washing techniques while delivering food trays to multiple residents. The findings include: Review of the Policy and Procedure titled, "Southern Nevada State Veterans Home Infection Prevention and Control Policy and Procedure," last revised on 3/14/2020, stated: "Policy: All healthcare workers including team members, physicians, physician extenders, contracted services, and volunteers shall practice effective hand hygiene when providing care to residents. Procedure: 1.When to Utilize Effective Hand Hygiene a. BEFORE and AFTER all of the following: …iv. Handling medication or food" On 8/30/22, Certified Nurse Aide D was observed during lunch delivering trays to residents on the [LOCATION] section of the [LOCATION] unit, and they did not sanitize or wash their hands throughout the entire process. The total number of rooms that could have potentially been affected on that section of the unit were 16. Some of the rooms had two (2) residents and some had just one (1) resident. Observation on [LOCATION], on 8/30/22, at 2:10 p.m., revealed Certified Nurse Aide E take a soiled napkin from Resident # 23's hands, which was soiled from ice cream the resident had wiped off resident's face. Certified Nurse Aide E was not wearing gloves. Continued observation on the unit revealed Certified Nurse Aide F reposition Resident #23's facial mask, touch the resident on the shoulders, and proceeded to pat Resident #24's shoulders. No hand sanitization or glove changes were observed. An interview with Certified Nurse Aide E, on 8/30/22, at 2:15 p.m., revealed that they had picked up the soiled napkin without wearing gloves, and they stated that because of possible secretions from the resident, they should have worn gloves. An interview with Certified Nurse Aide F, on 8/30/22, at 2:30 p.m., revealed they kept hand sanitizer in their pocket but just forgot to use it between caring for the two residents. An interview was conducted with Consultant Staff A, on 8/30/22, at 2:36 p.m. When asked if there was a policy in place for hand hygiene, specifically in relation to meal tray delivery, it was said

	that there wasn't one, but there were expectations. The expectation of the Certified Nurse Aides was to sanitize their hands in between each tray being delivered. It was also mentioned that the staff member in question had been trained in hand hygiene, for which there was documentation. An interview, on 9/1/22, at 2:00 p.m., with Licensed Nurse C, revealed that they expected the staff members to wash their hands after having touched any potentially soiled or contaminated surfaces and to sanitize between meal setups. An interview with Administrative Staff B, on 9/2/22, at 12:04 p.m., revealed it was their expectation hand hygiene was completed between each resident, and that they would expect staff to wash their hands with soap and water after having touched soiled contaminants.
§ 51.200 (a) Life safety from fire. The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (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>Electrical Systems</u>** Based on observation and interview, the facility failed to ensure that an emergency remote stop switch was installed for the emergency generator. The deficient practice affected nine (9) of nine (9) smoke compartments, staff, and all residents. The facility had a capacity for 180 beds with a census of 151 on the day of the survey. The findings include: Observation during the building inspection tour, on 8/31/22, at 9:39 a.m., revealed the facility's emergency generator was not provided with a remote manual stop station located elsewhere on the premises, as required by section 5.6.5.6 and 5.6.5.6.1 of NFPA 110, Standard for Emergency and Standby Power Systems. An interview with Maintenance Staff B at that time revealed the facility was told to put the stop switch on the generator and was not aware of the requirement and that it would be expensive to do. The census of 151 was verified by Administrative Staff A on 8/30/22. The findings were acknowledged by Administrative Staff A and Maintenance Staff B during the exit interview on 8/31/22, at 4:00 pm. **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)** 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.
§ 51.210 (h) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section. (2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. (3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed services and will notify the veteran or the authorized representative of the veteran.	Based on record reviews and interviews the facility failed to provide a written agreement for services provided to residents by outside resources. Specifically, the facility did not have a sharing or written agreement with a dental provider that provided dental services to the residents. The findings include: Several interviews were conducted with multiple staff members stating that when it came to the residents receiving dental care, most of the residents went to a dentist that they had an established patient status with. The facility made the appointments and provided transportation for the residents. An interview was conducted with Administrative Staff A, on 9/1/22, at 10:40 a.m., to 11:06 a.m. When the surveyor asked about having a written agreement, invoices, or Memorandum of Understanding with any of the dental offices or specific Dentist in the area, they stated that they did not have any. Administrative Staff A mentioned that since the residents went to multiple, different dentist offices, by their own choice, throughout the surrounding area, it would be difficult to get a written agreement with all of them. They also mentioned that, due to the location, it would be difficult to have just one (1) Dentist come to offer services to the residents. When asked how the dental visits were paid for, Administrative Staff A mentioned that the residents' own insurance handled all the billing.

Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Many	