# 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:** Illinois Veterans Home – Chicago

**Location:** 4250 N. Oak Park Ave., Chicago, IL 60634

**Onsite / Virtual:** Onsite

**Dates of Survey:** 6/25/24 – 6/27/24

**NH / DOM / ADHC:** NH

**Survey Class:** Annual

**Total Available Beds:** 200

**Census on First Day of Survey:** 53

| VA Regulation Deficiency | Findings |
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| | Initial Comments:<br><br>A VA Annual Survey was conducted from June 25, 2024, through June 27, 2024, at the Illinois Veterans Home – Chicago. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes. |
| **§ 51.43(a) (1)-(2) Drugs and medicines for certain veterans**<br>(a) In addition to the per diem payments under §51.40 of this part, the Secretary will furnish drugs and medicines to a State home as may be ordered by prescription of a duly licensed physician as specific therapy in the treatment of illness or injury for a veteran receiving nursing home care in a State home if—<br><br>(1) The veteran:<br><br>(i) Has a singular or combined rating of less than 50 percent based on one or more service-connected disabilities and needs the drugs and medicines for a service-connected disability; and | The facility was unable to demonstrate they received only drugs and medicines for Veterans who were eligible to receive such medications.<br><br>The findings include:<br><br>Based on record review, one (1) of eight (8) sampled Veterans was eligible to receive medications only for those service-connected disabilities that were at a singular or combined rating of less than 50 percent.<br><br>Based on record review, the facility listed the VA Medical Center (VAMC) of jurisdiction as the Veteran's pharmacy in documentation provided for review. The facility had no mechanism in place to determine whether the VAMC pharmacy or the facility's contracted vendor is supplying some or all medications.<br><br>In interview with Administrative Staff A, it was identified that the facility failed to ensure only eligible Veterans received |

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| (ii) Needs nursing home care for reasons that do not include care for a VA adjudicated service-connected disability; or<br><br>(2) The veteran:<br><br>(i) Has a singular or combined rating of 50 or 60 percent based on one or more service-connected disabilities and needs the drugs and medicines; and<br><br>(ii) Needs nursing home care for reasons that do not include care for a VA adjudicated service-connected disability.<br><br>**Level of Harm** – No Actual Harm, with potential for minimal harm<br>**Residents Affected** – Many | medications from the VAMC of jurisdiction. The facility confirmed they do not reimburse the VAMC of jurisdiction for medications received for ineligible Veterans. |
| **§ 51.43(b) Drugs and medicines for certain veterans**<br>VA will also furnish drugs and medicines to a State home for a veteran receiving nursing home, domiciliary, or adult day health care in a State home pursuant to 38 U.S.C. 1712(d), as implemented by §17.96 of this chapter, subject to the limitation in §51.41(c)(2).<br><br>**Level of Harm** – No Actual Harm, with potential for minimal harm<br>**Residents Affected** – Many | The facility was unable to demonstrate that medications are only furnished subject to the limitations in § 51.41(c)(2).<br><br>The findings include:<br><br>1. The facility failed to ensure that the insurance of Veterans for who the facility receives the prevailing rate of VA Per Diem (Prevailing Rate Veterans) was not billed by the SVH's contracted Pharmacy.<br><br>Based on interviews and record reviews, it was identified that the facility did not ensure that medication costs for Prevailing Rate Veterans are covered in full by the facility. Review of records for September 2023 and December 2023, revealed insurance was billed for two (2) prevailing rate Residents.<br><br>2. The facility was unable to demonstrate receipt of drugs and medicines for only Veterans who were eligible to receive such medications.<br><br>Based on record review, five (5) of eight (8) sampled Veterans were ineligible to have medications furnished by the VA. It was identified that the facility received medications from the VA Medical Center of jurisdiction for an unknown number of Veterans for whom the facility is being paid at either the VA Prevailing or VA Basic Rate of Per Diem. |
| **§ 51.43(d) Drugs and medicines for certain veterans** | The facility failed to have a valid written pharmacy sharing agreement in place with the VA Medical Center (VAMC) of |

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| VA may furnish a drug or medicine under this section and under §17.96 of this chapter by having the drug or medicine delivered to the State home in which the veteran resides by mail or other means and packaged in a form that is mutually acceptable to the State home and to VA set forth in a written agreement.<br><br>**Level of Harm** – No Actual Harm, with potential for minimal harm<br>**Residents Affected** – Many | jurisdiction to include the pharmacy providing medications for the ineligible Veterans of the Illinois Veterans Home - Chicago.<br><br>The findings include:<br><br>Based on interviews and record reviews, the facility does not have a valid Pharmacy Sharing Agreement in place with the VAMC of jurisdiction to provide medications for ineligible residents. During interviews and record reviews, it was identified the facility received medications from the VAMC of jurisdiction for an unknown number of Veterans for whom the facility is being paid at either the VA Prevailing or VA Basic Rate of Per Diem. |
| **§ 51.43(e) Drugs and medicines for certain veterans**<br>As a condition for receiving drugs or medicine under this section or under §17.96 of this chapter, the State must submit to the VA medical center of jurisdiction a completed VA Form 10-0460 with the corresponding prescription(s) for each eligible veteran.<br><br>**Level of Harm** – No Actual Harm, with potential for minimal harm<br>**Residents Affected** – Many | The facility was unable to demonstrate submission of VA Form 10-0460 for Veterans who are be eligible to have medications provided by the VA of jurisdiction.<br><br>The findings include:<br><br>Based on interviews and record reviews, the facility obtained medications from the VA Medical Center of jurisdiction for Veterans who meet eligibility under 38 CFR §51.43. During interviews and record reviews, it was identified the facility failed to complete and submit VA Form 10-0460 as required for each eligible Veteran. The SVH did not have on file VA Form 10-0460 for three (3) of eight (8) sampled Veterans who were eligible to receive medications. The facility did not have a mechanism in place to validate eligibility. |
| **§ 51.140 (c) Menus and nutritional adequacy.**<br>Menus must—<br>(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;<br>(2) Be prepared in advance; and<br>(3) Be followed<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Many | Based on observation, interview, and record review, the facility failed to serve bread items and soup listed on the menus for pureed diets. This omission led to residents who received a pureed diet not receiving a nutritionally adequate diet, as the menu was not followed. This omission had the potential to affect all three (3) residents who received a pureed diet.<br><br>The findings include:<br><br>Review of the facility's lunch menus for Tuesday and Wednesday of the week of the survey revealed the residents who received a pureed diet were to receive garlic bread with margarine and bread with margarine, respectively. Tuesday's menu showed a six (6) ounce serving of Minestrone soup was to be served as well.<br><br>During observations of the lunch meal service, on 6/25/24, from 12:00 p.m., to 1:13 p.m., Dietary Staff A obtained the temperatures of all food items, which included the pureed foods. When asked about the pureed diet, no pureed bread or soup |

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| | were observed, and Dietary Staff A confirmed they were not available during this serving time. |
| **§ 51.140 (h) Sanitary conditions.**<br>The facility must:<br>(1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities;<br>(2) Store, prepare, distribute, and serve food under sanitary conditions; and<br>(3) Dispose of garbage and refuse properly.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Many | Based on observation, interview, record review, and facility policy review, the facility staff failed to maintain clean and sanitary conditions in the [LOCATION] by not discarding food with mold on it, not obtaining food temperatures in an accurate manner, and not taking some food temperatures prior to service; not documenting cooked food temperatures, not covering beverages that were transported from the [LOCATION] to the floors, not maintaining hand hygiene when serving food; and having expired food in the nourishment refrigerators and not maintaining a cleaning schedule in the [LOCATION]. These failures had the potential to affect all 53 residents in the facility who received their meals from the [LOCATION].<br><br>The findings include:<br><br>Review of the facility's policy, "#5.125, Food Temperature Expectations," revised 5/13/21, revealed: "1. Policy – The Dietary Department will follow the guidelines set by IDPH [Illinois Department of Public Health] and ADA [formerly known as American Dietetic Association] when cooking or preparing all foods…3. Procedures… J. Fruits, desserts, salads, and cold beverages must be served between 38-40°F [degrees Fahrenheit]… L. No cold foods shall exceed 60°F prior to service."<br><br>Review of the facility's policy, "Food Temperatures Correct Use of the Thermometer," dated 2021, by Cynthia Chow & Associates, LLC., revealed: "Policy: To ensure food safety, food temperatures are taken and recorded. Procedure: Food temperatures are taken and recorded on the temperature monitoring log which indicates the correct temperature for each item. Hot food temperatures are recorded in the final cooking temperature column on the log at the time the food is taken from the oven…Cold food temperatures are taken and recorded prior to the cold food leaving the [LOCATION] and again in the [LOCATIONS]. Hot foods will be plated at 135° F or higher and cold foods will be plated at 41° F or lower. A calibrated stem-type thermometer is inserted into the thickest part of the food. The sensing area of the thermometer (the part of the probe that is below the indentation or 'dimple') is checked to determine if the indentation or 'dimple' is all the way in the food…Corrective action is taken for foods not meeting the temperature standard."<br><br>Review of the facility's policy, "Food & Nutrition Services Sanitation & Food Safety," dated2021, by Cynthia Chow & Associates, LLC., revealed: "Procedure: Refrigerated Food – Refrigerated food prepared in the healthcare community is labeled with the date to discard or to use by. This includes |

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| | leftovers. The discard/use by date will be a maximum of six [6] days after preparation. The day of preparation is counted as Day 1 [one]…Refrigerated Potentially Hazardous Food (PHF) or Time/Temperature Controlled for Safety (TCS) foods are labeled with the date received and if not opened, are discarded by the manufacturer's expiration date. If opened, the cold food item is labeled with the date opened and the date by which to discard or use by. Refer to the following chart for use by recommendations…Use by Date Recommendations – American cheese, sliced, Unopened – Expiration date per manufacturer, Recommended Maximum Storage Period if Opened and Expiration Date Not Exceeded – 2 [two] weeks refrigerated (wrapped tightly in plastic film wrap or foil." Some of the foods in question were not listed on the "Suggested Guide for Dating Fresh Fruits & Vegetables" chart, such as blueberries and sweet potatoes.<br><br>Observations and interview, on 6/25/24, from 9:38 a.m., to approximately 11:00 a.m., with Dietary Staff B, revealed one (1) gallon of whole milk, unopened, with an expiration date of 6/19/24, in [LOCATION], as well as 20 one (1) pound (lb.) blocks of unsalted margarine without dates; 22 one (1) lb. blocks of salted margarine with one (1) that was opened at the end and had plastic film wrapped around it, all without dates. The wrappers on several of the one (1) lb. blocks of margarine were loose, and exposed the margarine to the elements in the cooler, including the rack. There were also 13 five (5) lb. blocks of pasteurized American and Swiss cheese without expiration or use by dates, just the "packed on" date. The "packed on" dates ranged from 2/8/24, to 3/28/24. When asked, Dietary Staff B stated they were not sure of the expiration dates of the cheeses and the margarines, and that Dietary Staff C had a list of foods and when to discard them in their office. They were not in the facility, and Dietary Staff B was not sure how to obtain that information. They stated they would have to wait until Dietary Staff C returned to determine if something was past its expiration/use by date.<br><br>Observations and interview, on 6/25/24, at 9:51 a.m., with Dietary Staff B in the [LOCATION] revealed four (4) six (6) ounce (oz.) clear plastic, clam shell containers that stored blueberries, which had mold on them. Also observed were approximately 40 lbs. of sweet potatoes, contained in two (2) cardboard boxes, which had molded spots on many of the sweet potatoes. Also observed was a small plate with chopped, iceberg lettuce salad, wrapped in plastic film, dated 6/20/24; pineapple chunks in a small bowl, wrapped in plastic film, dated 6/18/24; and four (4) chopped, iceberg lettuce salads with cucumber slices on small plates, and wrapped in plastic film, dated 6/18/24, to 6/25/24, which represented the date the salad was made and the date to discard. These food items were |

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| | visibly inappropriate to be served, as they were discolored and/or very wilted in appearance. Dietary Staff B stated they were supposed to each have a date, representing when the item was made, and a discard date. Although the policy stated these items could be used up to six (6) days after they were made, they were visibly not appealing or usable.<br><br>Observations, on 6/25/24, of the lunch trays that arrived at [LOCATION], at 11:53 a.m., revealed that the trays arrived on an approximately six (6) foot tall, open, uncovered, metal cart with rungs the trays sat on. The trays were set up with cold beverages and foods, while each unit had its own plates, bowls, and plate covers used to assemble the hot items. There were several insulated cups of juice observed without lids on the trays, and four (4) small cartons of milk (two (2) 2% and two (2) 4%). While Dietary Staff A took the temperatures of the hot foods, they did not take any temperatures of the cold foods. The time taken from when the trays arrived on the floor to the end of the food service was approximately one (1) hour.<br><br>An observation, on 6/25/24, at 12:29 p.m., of the nourishment refrigerator on [LOCATION] revealed an opened, 46 oz. container of apple juice, dated with an opened date of 5/30/24. There was also an unopened, 46 oz. container of cranberry juice with a date on it of 3/11/24.<br><br>Observations and interview, on 6/25/24, at 12:18 p.m., revealed that when Dietary Staff A took the temperature of the cooked spinach, they touched the bottom of the pan with the tip of the stem-type thermometer. When asked if the thermometer touched the bottom of the pan, they stated it did not. At 12:46 p.m., Dietary Staff A took the temperature of pureed spaghetti and pureed sauce, and again touched the bottom of the steam table pans with the tip of the stem-type thermometer. At 12:59 p.m., Dietary Staff A was observed taking the temperature of Cream of Wheat, and once again touched the bottom of the pan with the thermometer. The Surveyor heard the thermometer hit the metal pan each time as the temperatures were taken.<br><br>Observations, on 6/25/24, at 12:36 p.m., revealed Dietary Staff A made two (2) cheeseburgers for a resident. In the process, they pulled the hamburger buns out of the package and opened them on the plate with their gloved hands, went to the pantry cooler for some cheese slices where they opened a door, opened the cooler door in the pantry, and then opened the door back into [LOCATION]. The pantry was a large room that had doors that led to [LOCATION] and [LOCATIONS]. They touched the hamburger patties with their thumb while they put the patties on the buns, opened the package of cheese, pulled the cheese slices out of the package with their hands, and placed them on the hamburgers and then placed the bun tops |

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| | on the cheeseburgers. They resumed serving. While serving, Dietary Staff A touched the tall metal food cart several times to move it out of the way. Dietary Staff A did not change gloves or perform hand hygiene throughout this process. Dietary Staff A then proceeded to open the nourishment refrigerator to get some ice cream, touched the door handles, went back to serving the food, and touched plates on the rims, then made another cheeseburger at 1:02 p.m., and used the same technique described before to include touching the bun with their hands.<br><br>Record review, on 6/26/24, at 9:30 a.m., of the food temperature log sheets for the month of June 2024, revealed many days had missed documentation. All the components of one (1) or more meals were missed on the following dates: 6/2/24, 6/4/24, 6/5/24, 6/7/24, 6/8/24, 6/9/24, 6/10/24, 6/13/24, 6/14/24, 6/15/24, 6/16/24, 6/20/24, 6/21/24 and 6/24/24. Most of these were missing the dinner meal temperatures. The following had parts of the temperatures for the meals missing: 6/3/24, 6/12/24, 6/17/24, 6/18/24, and 6/19/24. Very few of the cold items had recorded temperatures, and of those that did, mainly the salad temperatures were logged; missing were temperatures for the cold beverages and desserts.<br><br>Observation, on 6/26/24, at approximately 9:38 a.m., revealed Dietary Staff D pushed a large trash can next to the dish machine with a full bag of trash tied closed. They explained how the dish machine temperatures and sanitation levels were measured. While they explained, they picked up a clean (on the drying rack), clear plastic, four (4) quart, square container used for food storage. They also picked up a very large, metal, deep cooking pan and put it back down on the rack. This was done with no hand hygiene or glove changes by Dietary Staff D, after they touched the trash and trash can, and before they picked up the clean food use items.<br><br>Observations, on 6/26/24, starting at 11:01 a.m., revealed Dietary Staff B took the temperatures of foods that came from the oven. They touched the bottom of the steam table pans of macaroni and cheese, ground ham, and four (4) hamburgers. To take the temperature of the hamburgers, which had plastic film wrap over the container, they put the thermometer through the plastic film wrap that covered the hamburgers, and into the hamburgers. They also tilted a small pan of pureed ham and took the temperature in the corner of the pan. The process continued with two (2) small pans of plain macaroni, where the stem-type thermometer rested on the bottom of the pans to obtain the temperatures. This Surveyor verified the thermometer rested on the bottom of the pan by touching it, or by hearing it touch the bottom of the pan. |

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| | Through an interview with Dietary Staff E, on 6/26/24, at approximately 11:40 a.m., they were made aware of the missing temperatures on the food logs (hot and cold), the produce with mold, and the unappealing looking salads observed the day before with Dietary Staff B. They were also informed of the way the food temperatures were taken. Dietary Staff E was on site for the morning of 6/26/24, as they covered for Dietary Staff C. When asked about the margarine and cheese blocks in the walk-in cooler, they stated they should have had a received by and an expiration date on them. They stated they did not know why these items had been taken out of the boxes they were delivered in, because staff typically wrote the dates on them.<br><br>Observations, on 6/26/24, beginning at 12:01 p.m., revealed Dietary Staff F set up the hot foods in the holder on [LOCATION]. They took the temperatures of the following foods while the thermometer rested on the bottom of the pans: soup, green beans, ground ham, and ground hot dog. Dietary Staff F also ran out of alcohol pads to clean the thermometer between foods. They took some paper towels from the sink in the [LOCATION] and got them wet under the faucet, and then proceeded to wipe the stem of the thermometer between foods with the wet paper towels. Throughout the meal service observation, the temperatures were not taken of the cold foods or the beverages. The cold beverages (juices) were observed to be on an approximately six (6) foot tall, open, uncovered, metal cart. There were no covers on the beverages that had been transported from the [LOCATION] to the floor.<br><br>An observation, on 6/26/24, at 11:58 a.m., revealed three (3) Health Shakes in the reach-in nourishment freezer on [LOCATION] that were broken and had leaked out of the container. They appeared to have thawed and been refrozen.<br><br>On 6/26/24, at 12:13 p.m., Dietary Staff F was observed to don new gloves, then touched their head, and their cell phone to scroll and make a call. They then touched papers on the counter, touched the coffee pot push handle, and returned to serving the food. At 12:16 p.m., They pulled slices of bread out of a bread bag and placed the bread on residents' plates, all without changing gloves or performing hand hygiene.<br><br>Via correspondence, on 6/28/24, Dietary Staff C supplied the Daily Cleaning Tasks sheet, dated 6/1/24, for the [LOCATION]. It revealed staff names were written in the boxes to show assignments. However, staff were not filling out the boxes which showed they performed the task. Dietary Staff C stated they were not very good at doing that yet, and they were taking small steps to get to that point. |

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| **§ 51.190 (a) Infection control program.**<br>The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.<br>(a) Infection control program. The facility management must establish an infection control program under which it—<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Few | Based on observation, interview, and record review, the facility failed to ensure staff provided care in a manner that prevented the spread of infection by:<br><br>1. Staff failed to perform hand hygiene and glove changes during wound care for one (1) of 16 sampled residents (Resident #2).<br><br>2. Staff failed to remove personal protective equipment (PPE; equipment used to prevent or minimize exposure to infection) appropriately after completing wound care on one (1) of 16 sampled residents (Resident #2).<br><br>The findings include:<br><br>1. Review of the facility policy titled, "HOM-029, Hand Hygiene," last reviewed on 3/19/24, indicated: "Procedure…A. When to perform hand hygiene: …3. Before moving from work on a soiled body site to a clean body site on the same patient."<br><br>Review of the CDC's "Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings," dated 4/12/24, indicated: "Core Practices…5a. Hand Hygiene…2. Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: …c. Before moving from work on a soiled body site to a clean body site on the same patient …e. After contact with blood, body fluids or contaminated surface."<br><br>Review of the facility policy titled, "Wound / Skin Care – Non-Sterile Dressing," last reviewed 3/24/22, indicated: "Procedure…Key Points…n. Clean wound with normal saline or prescribed cleanser…q. Upon completion, remove gloves, wash hands and apply new gloves…s. Apply prescribed topical agent to wound. t. Apply wound dressing."<br><br>Record review revealed Resident #2 was admitted on [DATE], with diagnosis that included Bullous Pemphigold (a rare skin condition that causes large, fluid-filled blisters) and Methicillin-resistant Staphylococcus aureus (MRSA, a germ resistant to some antibiotics and can spread in healthcare facilities).<br><br>Review of the Admission Minimum Date Set (MDS), with an Assessment Reference Date (ARD) of [DATE], indicated Resident #2 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The skin assessment on the MDS indicated the presence of one (1) unstageable pressure ulcer.<br><br>Review of Wound Care Notes, dated [DATE], indicated a stage 2 buttock pressure ulcer (an open sore). |

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| | Further record review revealed a Physician Order, dated [DATE], which indicated: “cleanse left buttock with normal saline, apply MediHoney [honey-based dressing for wounds with leaking drainage], Adaptic [non-adhering petrolatum dressing] and cover with foam dressing [a dressing that maintains a moist environment for wound healing].”<br><br>On 6/26/24, between 10:10 a.m., and 10:20 a.m., the surveyor observed Licensed Nurse A perform the above ordered treatment to the wound on Resident #2’s buttocks.<br><br>When the treatment was performed, Licensed Nurse A did not perform hand hygiene or don new gloves after cleaning the wound. Licensed Nurse A cleansed the wound with normal saline and gauze and made sure no blood or drainage remained on the skin. Licensed Nurse A retrieved the clean adaptic gauze and applied the MediHoney to the adaptic. Licensed Nurse A then applied the adaptic and MediHoney to the wound and covered it with a foam dressing.<br><br>During an interview with Licensed Nurse A, on 6/26/24, at 10:25 a.m., they stated they should have performed hand hygiene and changed their gloves after cleaning the wound.<br><br>2. Review of the facility policy titled, “HOM-031, Personal Protective Equipment,” last revised 7/31/23, indicated: “Proper use of PPE…B. How to take off (doff) PPE…2. Remove gown…b. Reach up to the shoulders and carefully pull or roll gown down and away from body.”<br><br>Review of facility training document titled, “Donning and Doffing Personal Protective Equipment (PPE),” revised 4/15/24, indicated: “Doffing (Removing) PPE. Remove PPE SLOWLY [sic] and deliberately to prevent self-contamination…3. Grasp the front of the gown and pull it away from the body so the ties break, touching the outside of the gown only with GLOVED hands.”<br><br>On 6/26/24, between 10:10 a.m., and 10:20 a.m., the surveyor observed Licensed Nurse A perform the above ordered treatment to the wound on Resident 2’s buttocks.<br><br>After Licensed Nurse A completed the treatment, Licensed Nurse A removed the PPE in the following manner: Licensed Nurse A removed gloves. Licensed Nurse A placed both hands behind their shoulders grasping the gown on each side and pulled the gown overhead; as the gown lifted, Licensed Nurse A hair fell forward onto the front of the gown, which caused contact with the contaminated side of the gown. |

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| | During an interview with Licensed Nurse A, on 6/26/24, at 10:25 a.m., when asked the proper way to remove PPE, Licensed Nurse A stated that they just "take it off." During the interview, when Licensed Nurse A was reminded that the gowns were designed to be easily removed by pulling, Licensed Nurse A stated they did not know why they pulled the gown over their head; they should have folded the back of the gown toward the front.<br><br>During an interview with Administrative Nurse A, on 6/27/24, at 12:44 p.m., they stated staff were trained to grab gowns at the shoulders and pull down until the gown tears from around the neck while the gown was being folded toward itself. Administrative Nurse A further stated staff were never taught to pull a gown over their head. |
| **§ 51.200 (a) Life safety from fire.**<br>(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.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Many | **<u>Smoke Barriers and Sprinklers</u>**<br><br>1. Based on records review and interview, the facility failed to test and inspect the Fire Alarm in accordance with the code. The deficient practice affected 24 of 24 smoke compartments, staff, and all residents. The facility had the capacity for 200 beds with a census of 53 on the first day of the survey.<br><br>The findings include:<br><br>Document review, on 6/25/24, at 11:00 a.m., of the fire alarm testing and inspection records for the 12-month period prior to the survey revealed there was no documentation of semi-annual visual inspections of the smoke detectors as required by table 14.3.1 of NFPA 72, National Fire Alarm and Signaling Code. The last visual inspection of the smoke detectors was during the annual inspection of the fire alarm on 1/10/23.<br><br>An interview, on 6/25/24, at 11:00 a.m., with Maintenance Staff A revealed the facility was unaware of the requirement for a semi-annual visual inspection of the facility smoke detectors.<br><br>Document review, on 6/25/24, at 11:10 a.m., of the fire alarm testing and inspection records for the 12-month period prior to the survey revealed there was no documentation of semiannual testing of the alarm system battery charger, load voltage, or discharge test for the back-up batteries, as required by table 14.4.5 of NFPA 72, National Fire Alarm and Signaling Code. Further review of alarm system testing and inspection documents revealed the facility last completed required alarm system battery testing on 1/10/23.<br><br>An interview with Maintenance Staff A, on 6/25/24, at 11:10 a.m., revealed the facility replaced its alarm batteries annually, |

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| | and was unaware of the requirements to have charger testing, discharge testing, and load voltage testing completed.<br><br>The census of 53 was verified by Administrative Staff A on 6/25/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the LSC exit interview on 6/26/24, at 11:00 a.m.<br><br>**Actual NFPA Standard: NFPA 101, Life Safety Code (2012)**<br>**19.3.4.1 General.** Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6.<br>**9.6 Fire Detection, Alarm, and Communications Systems.**<br>**9.6.1* General.**<br>**9.6.1.1** The provisions of Section 9.6 shall apply only where specifically required by another section of this Code.<br>**9.6.1.2** Fire detection, alarm, and communications systems installed to make use of an alternative permitted by this Code shall be considered required systems and shall meet the provisions of this Code applicable to required systems.<br>**9.6.1.3** A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use.<br>**9.6.1.4** All systems and components shall be approved for the purpose for which they are installed.<br>**9.6.1.5*** To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code.<br>**4.6.12 Maintenance, Inspection, and Testing.**<br>**4.6.12.1** Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction.<br>**4.6.12.2** No existing life safety feature shall be removed or reduced where such feature is a requirement for new construction.<br>**4.6.12.3*** Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed.<br>**4.6.12.4** Any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or |

operation to ensure its maintenance shall be tested, inspected, or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction.
**10.2 Purpose.** The purpose of fire alarm and signaling systems shall be primarily to provide notification of alarm, supervisory, and trouble conditions; to alert the occupants; to summon aid; and to control emergency control functions.
**10.3 Equipment.**
**10.3.1** Equipment constructed and installed in conformity with this Code shall be listed for the purpose for which it is used.

**Actual NFPA Standard: NFPA 72, National Fire Alarm and Signaling Code (2010)**
**14.4.2* Test Methods.**
**14.4.2.1*** At the request of the authority having jurisdiction, the central station facility installation shall be inspected for complete information regarding the central station system, including specifications, wiring diagrams, and floor plans that have been submitted for approval prior to installation of equipment and wiring.
**14.4.2.2*** Systems and associated equipment shall be tested according to Table 14.4.2.2.
**14.3 Inspection.**
**14.3.1*** Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction.
**14.4.5* Testing Frequency.** Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction.
**Table 14.3.1 Visual Inspection Frequencies**
**Table 14.4.2.2 Testing Schedule Frequencies**

2. Based on records review and interview, the facility failed to maintain the [LOCATION] suppression system in accordance with the code. The deficient practice affected one (1) of 24 smoke compartments, staff, and no residents. The facility had a capacity for 200 beds with a census of 53 on the first day of the survey.

The findings include:

Document review, on 6/25/24, at 11:20 a.m., of the facility [LOCATION] suppression inspection, testing, and maintenance reports revealed the facility did not have the suppression system maintained on a semi-annal basis as required by chapter 11.2.1 of NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Documentation showed the last scheduled testing and maintenance of the [LOCATION] suppression system was completed on 11/1/2023.

An interview, on 6/25/24, at 11:22 a.m., with Maintenance Staff A revealed the facility was aware of the semi-annual maintenance requirement and had not yet received funding to have the system maintained.

The census of 53 was verified by Administrative Staff A on 6/25/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the LSC exit interview on 6/26/24, at 11:00 a.m.

**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)**
**11.2 Inspection, Testing, and Maintenance of Fire-Extinguishing Systems.**
**11.2.1*** Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months.

3. Based on records review and interview, the facility failed to maintain the [LOCATION] hood ventilation system in accordance with the code. The deficient practice affected one (1) of 24 smoke compartments, staff, and no residents. The facility had a capacity for 200 beds with a census of 53 on the first day of the survey.

The findings include:

Document review, on 6/25/24, at 11:20 a.m., of the facility [LOCATION] hood inspection and maintenance reports revealed

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| | the facility did not have the [LOCATION] hood system inspected or cleaned as required by chapter 11.4, 11.5, and 11.6 of NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. The facility had no records of the hood ventilation system being cleaned since installation.<br><br>An interview, on 6/25/24, at 11:23 a.m., with Maintenance Staff A revealed that the facility was aware of the requirement for semi-annual hood exhaust cleanings and had not yet received funding to maintain a cleaning schedule. Additional interview revealed the Maintenance and Engineering department had previously changed the filters of the hood exhaust system on an as needed basis, and no components of the exhaust system were cleaned or inspected above the filters.<br><br>The census of 53 was verified by Administrative Staff A on 6/25/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the LSC exit interview on 6/26/24, at 11:00 a.m.<br><br>**Actual NFPA Standard: NFPA 101 Life Safety Code (2012)**<br>**19.3.2.5 Cooking Facilities.**<br>**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.<br>**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.<br>**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.<br><br>**Actual NFPA Standard: NFPA 96, Standard for Ventilation Control and Fire Protections of Commercial Cooking Operations (2011)**<br>**11.4* Inspection for Grease Buildup.**<br>The entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4.<br>**11.5 Inspection**, **Testing, and Maintenance of Listed Hoods Containing Mechanical, Water Spray, or Ultraviolet Devices.**<br>Listed hoods containing mechanical or fire-actuated dampers, internal washing components, or other mechanically operated devices shall be inspected and tested by properly trained, qualified, and certified persons every 6 months or at frequencies |

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| | recommended by the manufacturer in accordance with their listings.<br>**11.6 Cleaning of Exhaust Systems**.<br>**11.6.1** Upon inspection, if the exhaust system is found to be contaminated with deposits from grease-laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction.<br>**11.6.2*** Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge.<br>**11.6.3** At the start of the cleaning process, electrical switches that could be activated accidentally shall be locked out.<br>**11.6.4** Components of the fire suppression system shall not be rendered inoperable during the cleaning process.<br>**11.6.5** Fire-extinguishing systems shall be permitted to be rendered inoperable during the cleaning process were serviced by properly trained and qualified persons.<br>**11.6.6** Flammable solvents or other flammable cleaning aids shall not be used.<br>**11.6.7** Cleaning chemicals shall not be applied on fusible links or other detection devices of the automatic extinguishing system.<br>**11.6.8** After the exhaust system is cleaned, it shall not be coated with powder or other substance.<br>**11.6.9** When cleaning procedures are completed, all access panels (doors) and cover plates shall be restored to their normal operational condition.<br>**11.6.10** When an access panel is removed, a service company label or tag preprinted with the name of the company and giving the date of inspection or cleaning shall be affixed near the affected access panels.<br>**11.6.11** Dampers and diffusers shall be positioned for proper airflow.<br>**11.6.12** When cleaning procedures are completed, all electrical switches and system components shall be returned to an operable state.<br>**11.6.13** When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises.<br>**11.6.14** After cleaning or inspection is completed, the exhaust cleaning company and the person performing the work at the location shall provide the owner of the system with a written report that also specifies areas that were inaccessible or not cleaned.<br>**11.6.15** Where required, certificates of inspection and cleaning and reports of areas not cleaned shall be submitted to the authority having jurisdiction. |

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| | 4. Based on observation and interview, the facility failed to maintain [LOCATION] cooking equipment as required by the code. The deficient practice affected one (1) of 24 smoke compartments, staff, and no residents. The facility had a capacity for 200 beds with a census of 53 on the first day of the survey.<br><br>Observation during the building inspection tour, on 6/25/24, at 12:00 p.m., revealed a four (4) burner, gas-fired stove on wheels located on the cooking line and protected by the [LOCATION] hood suppression system. The cooking line appliances were not provided with an approved method that would ensure the appliances were returned to an approved design location after they had been moved for maintenance and cleaning, as required by section 12.1.2.3.1 of NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations.<br><br>An interview, on 6/25/24, at 12:05 p.m., with Maintenance Staff A revealed the facility was not aware of the requirement for wheeled equipment to have an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning.<br><br>The census of 53 was verified by Administrative Staff A on 6/25/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the LSC exit interview on 6/26/24, at 11:00 a.m.<br><br>**Actual NFPA Standard: NFPA 101 Life Safety Code (2012)**<br>**19.3.2.5 Cooking Facilities.**<br>**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.<br>**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.<br>**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.<br><br>**Actual NFPA Standard: NFPA 96, Standard for Ventilation Control and Fire Protections of Commercial Cooking Operations (2011)**<br>**11.2 Inspection, Testing, and Maintenance of Fire-Extinguishing Systems.** |

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| | **11.2.1*** Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every 6 months.<br>**12.1.2 Installation.**<br>**12.1.2.1** All listed appliances shall be installed in accordance with the terms of their listings and the manufacturer's instructions.<br>**12.1.2.2*** Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system.<br>**12.1.2.3** The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual.<br>**12.1.2.3.1** An approved method shall be provided that will ensure that the appliance is returned to an approved design location.<br><br>**<u>Building Services</u>**<br><br>5. Based on record review, interview, and observation, the facility failed to properly maintain the elevators as required by the code. The deficient practice affected 24 of 24 smoke compartments, staff, and all residents. The facility had a capacity for 200 beds with a census of 53 on the first day of the survey.<br><br>Document Review, on 6/25/24, at 1:28 p.m., of the facility elevator testing and maintenance records revealed there was no recorded monthly test of the firefighter's emergency recall operation as required by sections 9.4.3.2 and 9.4.6.2 of NFPA 101, Life Safety Code.<br><br>An interview, on 6/25/24, at 1:30 p.m., with Maintenance Staff A revealed the facility had not performed a monthly test of the Firefighters emergency recall and was unaware of the requirement to test the Firefighters emergency recall feature.<br><br>Observation during the facility tour, on 6/26/24, at 8:30 a.m., revealed all staff and resident elevators were equipped with a Firefighters emergency recall feature. |

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| | The census of 53 was verified by Administrative Staff A on 6/25/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the LSC exit interview on 6/26/24, at 11:00 a.m.<br><br>**Actual NFPA Standard: NFPA 101, Life Safety Code (2012)**<br>**19.5.3 Elevators, Escalators, and Conveyors.** Elevators, escalators, and conveyors shall comply with the provisions of Section 9.4.<br>**9.4.3 Fire Fighters' Emergency Operations.**<br>**9.4.3.1** All new elevators shall conform to the fire fighters' emergency operations requirements ofASMEA17.1/CSA B44, Safety Code for Elevators and Escalators.<br>**9.4.3.2** All existing elevators having a travel distance of 25 ft (7620 mm) or more above or below the level that best serves the needs of emergency personnel for fire-fighting or rescue purposes shall conform to the fire fighters' emergency operations requirements of ASMEA 17.3, Safety Code for Existing Elevators and Escalators.<br>**9.4.6 Elevator Testing.**<br>**9.4.6.1** Elevators shall be subject to periodic inspections and tests as specified in ASME A17.1/CSA B44, Safety Code for Elevators and Escalators.<br>**9.4.6.2** All elevators equipped with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASMEA 17.1/CSA B44, Safety Code for Elevators and Escalators.<br>**9.4.6.3** The elevator inspections and tests required by 9.4.6.1 shall be performed at frequencies complying with one of the following:<br>(1) Inspection and test frequencies specified in Appendix N of ASME A17.1/CSA B44, Safety Code for Elevators and Escalators<br>(2) Inspection and test frequencies specified by the authority having jurisdiction<br><br>**<u>Fire Safety and Operations</u>**<br><br>6. Based on records review and interview, the facility failed to conduct all required fire drills as required by the code. The deficient practice affected 24 of 24 smoke compartments, staff, and all residents. The facility had a capacity for 200 beds with a census of 53 on the first day of the survey.<br><br>The findings include:<br><br>Records review, on 6/25/24, at 11:30 a.m., of the fire drill reports from the 12 months preceding the survey revealed the facility had no documentation of a fire drill for first, second , or |

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| | third shifts during the fourth quarter of 2023, as required by section 19.7.1.6 of NFPA 101, Life Safety Code.<br><br>An interview, on 6/25/24, at 11:32 a.m., with Maintenance Staff A revealed the facility was aware of the requirement to conduct quarterly fire drills for each shift, and they believe that there was an error in documentation of the drills.<br><br>The census of 53 was verified by Administrative Staff A on 6/25/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the LSC exit interview on 6/26/24, at 11:00 a.m.<br><br>**Actual NFPA Standard: NFPA 101 (2012) Life Safety Code**<br>**19.7.1.4*** Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.<br>**19.7.1.5** Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.<br>**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.<br>**19.7.1.7** When drills are conducted between 9:00 p.m. and 6:00 a.m. (2100 hours and 0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. |
| **§ 51.200 (b) Emergency power.**<br>(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.<br>(2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.<br>(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. | **Electrical Systems**<br><br>Based on records review, observation, and interview, the facility failed to properly inspect and test all components of the emergency generator as required by the code. The deficient practice affected 24 of 24 smoke compartments, staff, and all residents. The facility had a capacity for 200 beds with a census of 53 on the first day of survey.<br><br>The findings include:<br><br>Document review, on 6/25/24, at 1:45 p.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<br><br>An interview, on 6/25/24, at 1:47 p.m., with Maintenance Staff A revealed the facility was aware of the requirement and had been recording battery volt readings displayed on the emergency |

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| (4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Many | generator panel display, while the generator ran during monthly testing.<br><br>Observation during the facility tour, on 6/25/24, at 2:15 p.m., revealed sealed "Maintenance Free" type batteries used for the facility generator.<br><br>The census of 53 was verified by Administrative Staff A on 6/25/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the LSC exit interview on 6/26/24, at 11:00 a.m.<br><br>**Actual NFPA Standard: NFPA 101, Life Safety Code (2012)**<br>**19.5 Building Services.**<br>**19.5.1 Utilities.**<br>**19.5.1.1** Utilities shall comply with the provisions of Section 9.1.<br>**9.1.3 Emergency Generators and Standby Power Systems.**<br>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.<br>**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.<br><br>**Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems**<br>**(2010)**<br>**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.<br>**5.6.5.6.1** The remote manual stop station shall be labeled.<br>**8.3.7.1** Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. |
| **§ 51.210 (c) (7) Required Information.**<br>Annual State Fire Marshall's report.<br><br>**Level of Harm** – No Actual Harm, with potential for more than minimal harm<br>**Residents Affected** – Few | Based on record review and interview, the facility failed to obtain an Annual State Fire Marshal's report. The deficient practice affected 24 of 24 smoke compartments, staff, and all residents. The facility had the capacity for 200 beds with a census of 53 on the day of survey.<br><br>The findings include:<br><br>Document review, on 6/25/24, at 12:00 p.m., revealed there was no documentation to indicate that the facility has 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). Additional record review revealed the facility |

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| | last had a State Fire Marshal inspection completed in March of 2023.<br><br>An interview, on 6/25/24, at 12:15 p.m., with Maintenance Staff A revealed that the State Fire Marshal Office stated they were not responsible for the State Veterans Home annual fire inspection. Additional interview revealed they were last on site in March of 2023 for an initial inspection due to the request of an elected official.<br><br>The census of 53 was verified by Administrative Staff A on 6/25/24, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the LSC exit interview on 6/26/24, at 11:00 a.m. |