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: Oklahoma Veterans Center – Claremore

Location: 3001 W. Blue Starr Drive, Claremore, Oklahoma, 74018

Onsite / Virtual: Onsite

Dates of Survey: 7/23/24 – 7/26/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 302

Census on First Day of Survey: 215

VA Regulation Deficiency	Findings
	Initial Comments: A VA annual survey was conducted from July 23, 2024, through July 26, 2024, at the Oklahoma Veterans Center – Claremore. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.41 (c) (2) Payments under State home care agreements. (2) The State home shall not charge any individual, insurer, or entity (other than VA) for the nursing home care paid for by VA under a State home care agreement. Also, as a condition of receiving payments under paragraph (c), the State home must agree not to accept drugs and medicines from VA provided under 38 U.S.C. 1712(d) on behalf of veterans covered by this section and corresponding VA regulations (payment under this paragraph (c) includes payment for drugs and medicines). **Level of Harm** – No Actual Harm, with potential for minimal harm	The facility was unable to demonstrate that no individual, insurer, or entity was charged for the nursing home care paid for by VA under a VA provider agreement for dental and mental health services rendered by VA. The findings include: Based on communications and record reviews, it was identified that Residents for whom the facility receives the prevailing rate receive dental and mental health services at the VA Medical Center of jurisdiction without an executed sharing agreement. The facility leadership could not provide evidence to demonstrate that the facility had paid the costs for Prevailing Rate Veterans in receipt of dental and mental health services. Administrative Staff A was informed of the findings on August 1, 2024.

Residents Affected – Many	
§ 51.43 (b) Drugs and medicines for certain veterans. 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). **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Many	The facility was unable to demonstrate they provided drugs and medicines for sixteen Residents for whom the facility receives the prevailing rate of VA Per Diem (Prevailing Rate Veterans) pursuant to 38 U.S.C. 1712(d), as implemented by §17.96 of this chapter subject to the limitations in § 51.41(c)(2). The findings include: Based on communication with Administrative Staff A and Consultant Staff A, it was identified that the facility did not ensure that drugs and medicines were covered in full by the facility for sixteen Prevailing Rate Veterans. The facility identified receiving drugs and medicines for sixteen Prevailing Rate Residents who had a portion of prescribed drugs and medicines related to their hospice diagnosis provided by a hospice agency and not the facility. The facility leadership confirmed understanding that, as a condition of receiving payments under § 51.41(c)(2), the State home shall not charge any individual, insurer or entity (other than VA) for nursing home care paid for by VA under a State home care agreement.
§ 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 interview and record review, the facility failed to provide evidence that a surety bond, or other satisfactory assurance, for the security of all personal funds of residents who had deposited personal funds with the facility. This failure affected all residents whose funds were managed by the facility. The findings include: Review of a document provided by the facility for verification of a surety bond revealed that the facility held a policy of Liability Crime Insurance, which expired July 1, 2024, but did not have a surety bond. On 7/26/24, at 12:07 p.m., Administrative Staff A confirmed via interview that the facility had not been granted approval by the Under Secretary of Health for the Veterans Health Administration to maintain an alternate form of protection for the residents' personal fund accounts. Administrative Staff A stated that they did not have a surety bond.
§51.100 (h) (1) Social Services (1) The facility management must provide medically related social services to attain or maintain the highest practicable mental and	Based on interview and record review, the facility failed to provide medically related social services to attain or maintain the highest practicable mental and psychosocial wellbeing for one (1) of (1) one sampled resident (Resident #16). The findings include:

psychosocial well-being of each resident. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	On 7/23/24, at 11:10 a.m., during an interview with Resident #16, they stated that the facility was trying to "kick" them out of the facility. They further stated that everybody wanted them out, even Consultant Staff B. On 7/24/24, at 9:40 a.m., Resident #16's Consultant Staff B stated that the administration would have all the notes relating to the resident's care. Consultant Staff B stated that they spoke to Resident #16 only to schedule meetings with the Interdisciplinary Care Plan (IDCP) team. They further stated that they worked for the facility, and not for an outside company, and their job was not to come to the facility and advocate for the resident. When asked what their job responsibility or description was, the Consultant Staff B stated that they did not remember because they had been working for the facility for over 2 years. Review of Resident #16's Progress Notes, dated 6/12/24, at 12:15 p.m., revealed Consultant Staff B noted: "[Consultant Staff B] hand delivered involuntary discharge paperwork to resident. [They were] outside smoking. [Consultant Staff B] showed resident (on the paperwork) resources to call to advocate for him. Resident asked [Consultant Staff B] 'so you're not going to help me?' [Consultant Staff B] asked the resident what [they were] asking. Resident thought [Consultant Staff B] worked for an outside agency to help advocate for him. [Consultant Staff B] works for the Claremore Veterans Affairs (SVH). [Consultant Staff B] showed resident the contacts in the paperwork. [Consultant Staff B] notified resident that Norman VA declined [them]. Resident reports 'because you all told them about my Marijuana.'" On 7/26/24, at 1:19 p.m., Consultant Staff B stated that they did not know their job description. They stated that it was a long time ago since they were hired. They stated their job responsibility was to schedule a meeting for the resident with Interdisciplinary Team (IDT), not to advocate for the resident.
§ 51.120 (i) Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	Based on interviews, record review, and facility policy review, the facility failed to ensure residents received adequate supervision to prevent accidents for two (2) of 10 residents who were reviewed for falls (Resident #12 and #18). The findings include: Review of facility policy, dated March 2018, and titled, "Assessing Falls and Their Causes," revealed the section titled "Identifying Causes of a Fall or Fall Risk," listed the following:

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	"1. Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident-specific evidence including medical history, known functional impairments, etc. 2. Evaluate chains of events or circumstances preceding a recent fall, including: a. Time of day of the fall; b. Time of the last meal; c. What the resident was doing; d. Whether the resident was standing, walking, reaching, or transferring from one position to another; e. Whether the resident was among other persons or alone; f. Whether the resident was trying to get to the toilet; g. whether any environmental risk factors were involved (e.g., slippery floor, poor lighting furniture or objects in the way) and/or h. Whether there is a pattern of falls for this resident. 3. Continue to collect and evaluate information until the cause of falling is identified or it is determined that the cause cannot be found. 4. As indicated, the attending physician will examine the resident or may initiate testing to try to identify causes. 5. Consult with the attending physician or medical director to confirm specific causes from among multiple possibilities. When possible, document the basis for identifying specific factors as the cause. 6. If the cause is unknown but no additional evaluation is done, the physician or nursing staff should note why (E.g., workup already done, finding a cause would not change the approach, etc.)" 1. Review of the medical record for Resident #12 revealed an admission date of [DATE], with a readmission on [DATE], after a hospital stay. Diagnoses included Congestive Heart Failure, Deep Tissue Injury to the Right Ankle, Gastroesophageal Reflux Disease, Depression, Pain, Chronic Obstructive Pulmonary Disease, Atherosclerosis, Dysphagia, Atrial Fibrillation, Aortic Aneurysm, Hyperlipidemia, Hypertension, Chronic Kidney Disease Stage Three (3), and Peripheral Vascular Disease. Review of the Progress Notes for Resident #12 revealed a fall occurred on [DATE], when Resident #12 was found lying in the bathroom on their right side, complaining of pain in their right hip, and was unable to move their right leg. Per the note, staff did not move the resident due to a suspected hip fracture. Resident #12 was sent to the hospital. Review of the facility reported "VHA [Veteran's Health Administration] Issue Brief," dated [DATE], revealed a Root Cause Analysis (RCA) was completed on the incident and found Resident #12 had an unsteady gait and had not used their assisted device. Per the Brief, upon return to the facility Resident #12 would be assessed by therapy.

	Review of the RCA revealed the facility determined Resident #12's fall was attributed to: Resident #12 was ambulating without proper footwear, had attempted to ambulate without requesting assistance, and that Resident #12 neglected to use their call light. Per the RCA, staff also failed to anticipate Resident #12's needs. The RCA did not include a review of staff documentation in the medical record and did not include staff interviews by any potential witnesses, or staff who observed or assessed Resident #12 after the fall occurred. There was no documentation in the RCA of interviews with staff to indicate when the last time Resident #12 was observed or toileted. There was no documentation of interviews with staff to see if anyone had encouraged Resident #12 to wear proper footwear. There was no documentation Resident #12's call light was within reach before the fall. Review of the "VHA Issue Brief," found that it was noted that Resident #12 was ambulating without their assistive device, but on the RCA, it was noted that Resident #12 stated they were ambulating with their cane, and their feet slipped out of their shoes. The facility failed to complete a thorough investigation to determine why Resident #12 fell, or why the resident had not been provided with assistance while ambulating to the bathroom. 2. Review of the medical record for Resident #18 revealed an admission date of [DATE], and a discharge date of [DATE]. Diagnoses included Dementia, Depression, Diabetes Mellitus Type Two (2), Psychosis, Hyperlipidemia, Anxiety, Pain, Prostate Cancer, Insomnia, Arthritis of the Right Knee, and Post-Traumatic Stress Disorder. Review of the Progress Notes for Resident #18 revealed an unwitnessed fall occurred on [DATE], which resulted in a left hip fracture and pelvic fracture. Documentation noted Resident #18 was transferred to the hospital and had a surgical repair for the left hip fracture. A Nursing Progress Note, dated [DATE], documented that Resident #18 was sent to a different facility for rehabilitation. Review of the facility reported "VHA Issue Brief," dated [DATE], revealed an RCA was completed and documented on the initial and final report, with a determination the fall was a sentinel event. Review of the RCA noted Resident #18 failed to call for assistance with ambulating, failed to use their call light to request help with transferring, had a gait imbalance, and was at high risk for falls. Per the RCA, staff failed to anticipate Resident #18's needs, and a medication review should have been implemented to determine if any medications might have been a contributing factor due to the number of falls the resident

	had. The RCA investigation did not include interviews with any staff or residents who could have been witnesses to the actual fall or the events immediately following the fall. The "Brief Statement of Issue and Status" section of the investigation had documentation which noted a "nurse going down southwest hall to do neuro check on resident and heard a thud, observed resident sitting on the floor up against [their] bedroom door." Per the Brief Statement, the resident did not hit their head, but there was no documentation whether the fall was witnessed or not witnessed or to determine if a head injury had occurred or not. The report further revealed: "Resident complained of left hip pain and when touched toward buttock [they] winced and said it hurt. Assessed for other injuries and none noted. Notified [Licensed Nurse]] and order to send to be assessed at hospital [sic]." The final statement in the report noted: "As of [DATE], Resident remains in hospital; imaging completed; fracture to left acetabulum and pubic ramus [pelvic area]. Causative factors include dementia, ambulating without assist, improper footwear, gait imbalance." The RCA did not include a review of staff documentation in the medical record, and also did not include staff interviews by any witnesses or staff who observed Resident #18 after the fall. There was no documentation in the RCA of interviews with staff to indicate when the last time Resident #18 was observed or toileted. There was no documentation of interviews with staff to see if anyone had encouraged Resident #18 to wear proper footwear. There was no documentation Resident #18's call light was within reach before the fall. On the "VHA Issue Brief" it was noted that Resident #18 was wearing nonslip footwear, but in the final paragraph it was documented Resident #18 had on improper footwear. The facility failed to complete a thorough investigation as to why Resident #18 fell and had not been provided with assistance in ambulating to the bathroom. On 7/24/24, at 12:19 p.m., in a communication received from Administrative Staff A, they stated if the falls for Resident #12 and Resident #18 were not witnessed, then there would be no witness statements since no one saw the fall happen. In an interview with Administrative Staff A, they stated when asked what about the person who found the residents after the fall, or the nurse who assessed the residents after the fall, or another resident who could have been a possible witness, Administrative Staff A stated they would not be considered witnesses or interviewed since they did not see the fall occur, so they were not witnesses of the event; they would not have interviewed those people. The facility failed to provide documentation of supervision (such as: the last time each resident was toileted, if the call light was in reach, and the last time the resident was visualized by staff)

	for residents needing assistance with ambulation who had falls resulting in fractures.
§ 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 observations, interviews, and facility policy review, the facility failed to ensure effective and proper sanitary precautions were taken in the [LOCATIONS], and the facility failed to ensure proper trash disposal. These failures had the potential to affect all residents who reside at the facility. The findings include: 1. Review of the facility's undated policy titled, "Hand Washing," revealed the following: "Employees will wash hands as frequently as needed throughout the day using proper handwashing procedures…Procedure: Hands and exposed portions of the arms should be washed immediately before engaging in food preparation." The policy further revealed: "1. …b. After touching bare human body parts other than clean hands and wrists… g. During food preparation, as often as necessary to remove soil or contamination and prevent cross contamination when changing tasks…j. After engaging in other activities that contaminate the hands." On 07/23/24, at 11:30 a.m., Dietary Staff A was observed for approximately 15 minutes at the steam table and was observed to touch multiple surfaces. They handled utensils, trays, napkins, food tickets, and prepared resident plates. In the process, they were observed wiping their face with their bare hands. Dietary Staff A was not wearing gloves and did not perform hand sanitization nor wash their hands throughout all the task changes. Dietary Staff B, who assisted Dietary Staff A in preparing plates, also did not wear gloves, wash their hands, or use hand sanitizer. The hand sanitizer was located on the endcap of the steam table and in close proximity. In an interview, on 7/24/24, at 10:16 a.m., Dietary Staff A stated the following when asked about observations from earlier: "I get no help with making plates and I had to keep going and have to touch tickets. I would have washed my hands 24/7 to get food to the veterans on time." Dietary Staff A stated that hand sanitization was important because of bacteria and sicknesses, and they were told not to wear gloves because it was not allowed while serving. In addition, Dietary Staff A added: "Every time I got off the line, I got yelled at to get back. I have not received any training here other than computer training or recent in-services. My training came from other facilities. It's reliance training, no [LOCATION] training."

	2. Review of the facility's undated policy titled, "Food Storage," revealed the following: "Policy: Sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. Food will be stored in an area that is clean, dry, and free from contaminates. Food will be stored, at appropriate temperatures and by methods designed to prevent contamination or cross contamination." The policy further revealed: "Procedure: …10. Food should be stored a minimum of 6 [six] inches above the floor…12. Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated…13. Refrigerated food storage: …f. All foods should be covered, labeled, dated and routinely monitored to assure that foods (including leftovers) will be consumed by their safe dates, or frozen (where applicable) or discarded." On 07/23/24, at 11:00 a.m., observation during the initial tour of the [LOCATION] revealed the following: - Two (2) boxes of vegetable oil on floor in dry storage area. -One (1) tray of uncovered/uncooked bacon in the cooler, located on bottom of cart. -Round breakfast sausage patties, unsealed, sitting in the cooler. -Unopened Boost carton on floor in the cooler. -Two (2) white bread loaves and two (2) wheat bread loaves were found undated. -One (1) outdated white bread loaf, date stamped 05/26/24, located in the cooler and pureed bread found exposed, sitting on the counter, and not properly sealed or dated. In an interview, on 7/24/24 at 10:00 a.m., Dietary Staff B stated: "Dry foods should not be stored on the floor; regs says 6 [six] inches off floor but the shelf may have been full; outdated bread exposed cooler/freezer foods should be covered completely and labeled." 3. Review of the facility's undated policy titled, "General Food Preparation and Handling," revealed the following: "1. The [LOCATION] will be kept neat and orderly. a. The [LOCATION] surfaces and equipment will be cleaned and sanitized as appropriate." Review of the facility's undated policy titled, "Cleaning Instructions: Deep Fat Fryer," revealed the following: "Policy: Fryer's will be cleaned after each use…Procedure…4. Oil should be changed at least every 10 times the fryer is used. When the oil starts to turn a dark brown, starts to smell or the consistency changes, it is time to change the oil. 5. Remove food particles from the oil after each use."

	On 07/23/24, at 11:10 a.m., observation conducted during the initial tour of the [LOCATION] revealed a heated, deep fryer containing black appearing grease, food particles, and seasonings floating on top, which were sizzling. In an interview, on 7/23/24, at 11:20 a.m., Dietary Staff C stated the grease bin should have been changed, but they did not know how often it should be done. They stated they did not know who was on the shift before, and the grates on the bottom should be visible. In an interview, on 7/23/24, at 12:00 p.m., Dietary Staff B stated the deep fryers should be cleaned twice per week. In an interview, on 7/24/24, at 10:00 a.m., Dietary Staff B stated the deep fryer was used daily, and it was changed with fresh oil twice per week, which covered the ten times it was used. The surveyor asked how the cleanliness of the deep fryer was monitored, and Dietary Staff B stated: "We have a new [person] here and [they are] going to show us how to use a solution to help remove carbons, along with it being monitored by a log that people fill out whenever they change it." When asked about the visibly observed crumbs, Dietary Staff B stated they had seen all of the crumbs, which told them it needed to be changed. Dietary Staff B stated the oil color was very dark, but that that was not an everyday practice. Dietary Staff B stated they usually kept it on all day unless they knew lunch was going to use it. Review of a "Fryer Changed" log, provided by Dietary Staff B on 7/24/24, at 10:15 a.m., revealed the last documented change was on 7/22/24. 4. On 7/24/24, at 12:10 p.m., observation of the facility's dumpster, located outside the [LOCATION] of the facility, revealed one trash compactor and one uncovered bin that was open and exposed trash visible, and had old, dried food surrounding the compactor area on the surrounding ground. Insects (ants and flying pests) were visibly present during this observation. On 7/24/24, at 2:10 p.m., the surveyor requested a policy from Administrative Staff B for outside trash disposal. They stated they did not have one.
§ 51.200 (a) Life safety from fire. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.	**<u>Smoke Barriers and Sprinklers</u>** 1. Based on observation and interview, the facility failed to properly maintain the smoke barriers. The deficient practice affected three (3) of 18 smoke compartments, staff, and 44

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	residents. The facility had the capacity for 302 beds with a census of 215 on the day of survey. The findings include: Observation during the building inspection tour, on 7/25/24, at 1:11 p.m., of the smoke barrier on [LOCATION], above the lay-in ceiling tiles revealed one (1) unsealed penetration, located by [LOCATION], with gray data cables running through it, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code. Observation during the building inspection tour, on 7/25/24, at 1:13 p.m., of the smoke barrier on [LOCATION], above the lay-in ceiling tiles revealed two (2) unsealed penetrations, located by [LOCATION], with data cables running through it, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code. An interview, on 7/25/24, at 1:15 p.m., with Maintenance Staff A revealed the facility was not aware of the unsealed penetrations. The census of 215 was verified by Administrative Nurse A on 7/25/24, at 8:35 a.m. The findings were acknowledged by Maintenance Staff A and verified by Administrative Staff A during the exit interview on 7/25/24, at 2:00 p.m. **Actual NFPA Standard: NFPA 101 (2012) Life Safety Code** **19.3.7.3** Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1⁄2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2)*Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. **8.5 Smoke Barriers.** **8.5.1*** General. Where required by Chapters 11 through 43, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke. **8.5.2*** Continuity. **8.5.2.1** Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor

	to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. **8.5.2.2** Smoke barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. **8.5.2.3** A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier. **8.5.3** Fire Barrier Used as Smoke Barrier. A fire barrier shall be permitted to be used as a smoke barrier, provided that it meets the requirements of Section 8.5. **8.5.6** Penetrations. **8.5.6.1** The provisions of 8.5.6 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations of smoke barriers. **8.5.6.2** Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. **8.5.6.3** Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless the requirements of 8.5.6.4 are met. **8.5.6.4** Where sprinklers penetrate a single membrane of a fire resistance–rated assembly in buildings equipped throughout with an approved automatic fire sprinkler system, noncombustible escutcheon plates shall be permitted, provided that the space around each sprinkler penetration does not exceed 1⁄2 in. (13 mm), measured between the edge of the membrane and the sprinkler. **8.5.6.5** Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be securely set in the smoke barrier, and the space between the item and the sleeve shall be filled with a material capable of restricting the transfer of smoke. **8.5.6.6** Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: (1) It shall be provided on either side of the smoke barrier. (2) It shall be designed for the specific purpose. **<u>Electrical Systems</u>**

	2. Based on observation and interview, the facility failed to properly store oxygen cylinders. The deficient practice affected two (2) of 18 smoke compartments, staff, and 167 residents. The facility had a capacity for 302 beds with a census of 215 on the day of the survey. The findings include: Observation during the building inspection tour, on 7/25/24, at 12:04 p.m., revealed the cylinders stored in the [LOCATION], located at the [LOCATION], on the second floor were a mix of full and empty cylinders. The empty cylinders were not segregated from the full, and not marked to avoid confusion, as required by sections 11.6.5.2 and 11.6.5.3 of NFPA 99, Health Care Facilities Code. Observation during the building inspection tour, on 7/25/24, at 12:41 p.m., revealed the cylinders stored in the [LOCATION], located at the [LOCTION], on the third floor were a mix of full and empty cylinders. The empty cylinders were not segregated from the full, and not marked to avoid confusion, as required by sections 11.6.5.2 and 11.6.5.3 of NFPA 99, Health Care Facilities Code. An interview, on 7/25/24, at 12:05 p.m., with Maintenance Staff A revealed that empty and full cylinders were stored together, and the facility was not aware of the requirements to segregate and mark the empty cylinders. The census of 215 was verified by Administrative Nurse A on 7/25/24, at 8:35 a.m. The findings were acknowledged by Maintenance Staff A and verified by Administrative Staff A during the exit interview on 7/25/24, at 2:00 p.m. **Actual NFPA Standard: NFPA 99 Health Care Facilities Code (2012)** **11.3.2.6** Cylinder or container restraints shall comply with 11.6.2.3. **11.6.2.3** Cylinders shall be protected from damage by means of the following specific procedures: (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. **Special Precautions-Storage of Cylinders and Containers** **11.6.5.2** If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. **11.6.5.3** Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.

§ 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. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on interview and review of facility documentation, it was determined the facility failed to ensure mental health services and dental services, provided outside of the facility, were provided under a written agreement. The findings include: 1. Based on record review and interview, the facility's management failed to obtain a sharing agreement for mental health services that were provided to twenty-three (23) residents by the VA Medical Center of jurisdiction. Review of documents provided by the Administrative Staff A revealed there is no sharing agreement with the VA Medical Center of jurisdiction for residents who received mental health services at the VA Medical Center of jurisdiction. The facility provided a document titled, "Claremore Sharing Agreement Flowchart," which only showed a flowchart detailing the process to obtain a sharing agreement with the VAMC. 2. Based on communications and record reviews, it was identified that Residents received dental at the VA Medical Center of jurisdiction without an executed sharing agreement. The facility leadership did not provide evidence to demonstrate an executed sharing agreement is in place. On 7/26/24, at 12:05 p.m., Administrative Staff A stated that they did not have any signed sharing agreements with the VA Medical Center of jurisdiction.
§ 51.210 (s) Compliance with Federal, State, and local laws and professional standards. The facility management must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This includes the Single Audit Act of 1984 (Title 31, Section 7501 et seq.) and the	The facility was unable to demonstrate that operations and services are provided in compliance with all applicable Federal, State, and local laws, regulations, codes, and with accepted professional standards related to one (1) resident using an e-cigarette in the facility. The findings include: Executive Order 2013-43 states, "the use of any electronic cigarette or vaping device shall be prohibited on any and all properties owned, leased or contracted for use by the State of Oklahoma, including but not limited to all buildings, land and

Cash Management Improvement Acts of 1990 and 1992 (Public Laws 101-453 and 102-589, see 31 USC 3335, 3718, 3720A, 6501, 6503). **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	vehicles owned, leased or contracted for use by agencies or instrumentalities of the State of Oklahoma." Based on observations, one (1) Resident on Unit 2B was observed using an e-cigarette in their room. The Resident had five (5) e-cigarette cartridges and cigarettes in their possession. Facility staff were notified and indicated this Resident has been told several times using an e-cigarette was prohibited. The Resident indicated they were aware they were not supposed to use an e-cigarette in their room and requested the facility management not be informed for fear they would be "kicked out."