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

Location: 3001 W Blue Starr Dr., Claremore, OK 74018

Onsite / Virtual: Onsite

Dates of Survey: 5/17/22 – 5/20/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 302

Census on First Day of Survey: 191

Regulation#	Statement of Deficiencies
	Initial Comments: A VA Annual survey was conducted from May 17, 2022, through May 20, 2022, at the Oklahoma Veterans Center. The facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 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 received medications from the VA of jurisdiction for only those residents who were eligible. Based on interviews and record reviews, the facility reported having access to the VA pharmacy prime vendor contract. The facility reported that the VA then processed and paid for the order. The facility submitted a monthly reconciliation of the costs for non-eligible Veterans to the VA. Per review of the reconciliation, the facility only listed as non-eligible those Veterans for whom the facility received the prevailing rate of VA reimbursement. The facility provided reconciliations for the months of [DATE] and [DATE]. Per review of the [DATE] reconciliation, there was a census of 153, and 73 were non-eligible based on the prevailing rate. On 5/17/2022, the facility was requested to

	provide validation for the remaining 80 who were reportedly eligible; the facility was unable to provide this validation. Per review of the [DATE], there was a census of 154, and 74 were non-eligible based on the prevailing rate. On 5/17/2022, the facility was requested to provide validation for the remaining 84 who were reportedly eligible; the facility was unable to provide this validation. It was also identified that the facility was obtaining medication from the VA of jurisdiction for one (1) Veteran for whom the facility received the prevailing rate of VA reimbursement. Consultant Staff A validated this information.
§ 51.43(d) Drugs and medicines for certain veterans 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. Level of Harm – No Actual Harm, with potential for minimal harm. Residents Affected - Many	The facility was unable to demonstrate that the VA only furnishes drugs or medicines as set forth in a written agreement. Based on interviews and record reviews, the facility does not have a written agreement with the VA of jurisdiction for medications being provided. The facility was unable to provide documentation that written agreement is in place nor that one has ever been in place. According to an interview with Administrative Staff A, the facility had made a request to the VA of jurisdiction to begin the process of initiating a written sharing agreement. The VA of jurisdiction confirmed that this request was received on 3/1/2022.
§ 51.43(e) Drugs and medicines for certain veterans 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. Level of Harm – No Actual Harm, with potential for minimal harm. Residents Affected - Many	The facility was unable to demonstrate submission to the Veterans Affairs (VA) medical center of jurisdiction a completed VA Form 10-0460 for each eligible Veteran. Based on interviews and record reviews, the facility obtained medications from the VA of jurisdiction for all residents of the facility. According to interviews on 5/17/22 with Administrative Staff A, it was identified the facility failed to complete and submit VA Form 10-0460 as required for each eligible Veteran. According to Administrative Staff A, the facility began utilizing the VA Form 10-0460 approximately 3 weeks prior to the start of the survey. There were no VA Form 10-0460s available for the months of [DATE] and [DATE] to verify eligibility.
§51.70(a) Resident Rights	Based on observations, record review and interviews, the facility failed to ensure that Resident #132 was not left undressed

The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The facility management must protect and promote the rights of each resident, including each of the following rights: Level of Harm – No Actual Harm, with potential for minimal harm. Residents Affected – Few	without a privacy curtain drawn and visible from the hallway. This impacted one (1) of three (3) residents reviewed for right to a dignified existence. The findings include: The facility's "Quality of Life - Dignity" policy, revised August 2009, included in pertinent part, "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality .... Staff shall promote, maintain and protect resident privacy." Review of Resident #132's clinical record revealed an admission date of [DATE]. According the [DATE] MDS assessment, the resident had a BIMS score of four (4) out of 15, indicative of severe cognitive impairment. The resident required extensive assistance from staff to perform Activities of Daily Living (ADLs). On 5/17/22 at 11:20 a.m. and 11:42 a.m. Resident #132 was observed laying in their bed wearing an adult brief with no pants on. Resident #132 was not covered and the door to their room, which was located near the common area, was open. Administrative Nurse A was interviewed on 5/18/22 at 12:33 p.m. they said that staff received training on maintaining resident dignity. They said that staff should have the door closed and/or curtains pulled if a resident was not dressed, or when care was being provided. The family of Resident #132 was interviewed on 5/19/22 at 9:52 a.m. They said that they had cared for the resident in their home for 10 years prior to admission to the facility. They said that prior to the resident's cognitive decline Resident #132 was a proud man who would want to be covered up.
§51.70(c)(2) Protection of Funds Management of personal funds. Upon written authorization of a resident, the facility management must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3) through (c)(6) of this section. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Many	Based on record review and interviews, the facility failed to have written authorizations from residents in order to manage their funds. The facility opened trust accounts for all residents residing in the facility without authorization from the resident or a resident representative. This failure impacted 178 residents residing at the facility. The findings include: The Resident Handbook, reviewed February 2021, read in pertinent part on page 40, "Upon admission, a resident is encouraged to open a trust fund account. Any funds deposited in the facility Accounting Office by or for a resident, will be deposited in a trust fund account in the resident's name. A resident may make a withdrawal by visiting the Accounting

	Office between the hours of 8:30 a.m. and 3:00 p.m. Monday through Friday." Review of the "Accounts Receivable Summary" for the billing period [DATE] to [DATE] included the trust fund account balance for each resident at the facility; the total trust fund account balance totaled $393,987.72. The facility could not provide written authorizations to manage the trust fund account for any of the 191 residents. Administrative Staff B was interviewed on 5/20/22 at 10:05 a.m. They said that the facility opened a trust account for all residents upon admission to the facility. They said that the facility did not have individual written authorizations from residents or resident representatives for the purpose of managing the resident trust fund accounts.
§51.70(c)(6) Assurance of financial security The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Many	Based on record review and interview, the facility failed to have a surety bond, or otherwise provide assurance satisfactory to the Under Secretary of Health, to protect the funds of 178 residents who currently reside in the facility. The findings include: The facility had a Certificate of Liability Insurance, dated [DATE], with an expiration date of [DATE]. The Certificate made no mention of protection of residents' funds. The coverage limit listed for "Crime" was set at $50,000.00. Review of the Accounts Receivable Summary for the billing period [DATE] to [DATE] included the trust fund account balance for residents at the facility; the trust fund account balance totaled $393,987.72. Administrative Staff B and Administrative Staff C were interviewed on 5/20/22 at 10:05 a.m. They said that they thought the Certificate of Liability Insurance was a Surety Bond. Administrative Staff C said that they were aware of the regulatory requirement for the facility to have a Surety Bond that covered the total amount of resident fund trust accounts. Administrative Staff B said that they did not know when the trust account balance exceeded the liability insurance limit.
§51.90(a) Restraints (1) The resident has a right to be free from any chemical or physical restraints imposed for purposes of discipline or convenience. When a restraint is applied or used, the purpose of the	Based on observations, interviews, and record review, the facility failed to identify a positioning chair as a physical restraint for two (2) of three (3) residents reviewed for compliance with restraint requirements (Resident #119, Resident #105). The findings include:

restraint is reviewed and is justified as a therapeutic intervention. (i) Chemical restraint is the inappropriate use of a sedating psychotropic drug to manage or control behavior. (ii) Physical restraint is any method of physically restricting a person's freedom of movement, physical activity or normal access to his or her body. Bed rails and vest restraints are examples of physical restraints. (2) The facility management uses a system to achieve a restraint-free environment. (3) The facility management collects data about the use of restraints. (4) When alternatives to the use of restraint are ineffective, a restraint must be safely and appropriately used. Level of Harm – Immediate Jeopardy to resident health or safety. Residents Affected – Few	1. Review of Resident #119's medical record revealed an initial admission date of [DATE]. Resident #119's medical diagnoses included Dementia without Behavioral Disturbance, Repeated Falls, and Psoriatic Arthritis. Review of the admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) of 11 out of a total 15 possible points, indicating moderately impaired cognition. According to the MDS assessment, Resident #119 required limited assistance with locomotion on and off the nursing unit and required supervision with meals. On 5/17/22 at 11:13 a.m., Resident #119 was observed in a fully reclined Broda chair in the television area across from the nursing station. The footrest attached to the chair was fully elevated. Resident #119's right leg was hanging over the chair and their right foot was positioned flat on the floor. They were restless and were observed making repeated, but unsuccessful, attempts to rise from the chair. Review of Resident #119's Physician Order revealed an order dated [DATE] for a Broda chair to prevent falls from a wheelchair. On 5/17/22 at 12:28 p.m., Resident #119 was observed in the Broda chair. The chair was fully reclined. Resident #119 was positioned in the TV area across from the nurse's station. The footrest was elevated. Resident #119 was repeatedly swinging their legs over the left side of the chair while attempting to use their arms to rise from the chair. A staff member approached Resident #119 and asked them why they were trying to get out of the chair. Resident #119 responded, "I need to go to the bathroom!" The staff member assisted Resident #119 to their room and then returned them to the television area in a fully reclined position with the footrest fully elevated. Resident #119 continued their attempts to rise from the chair. Review of Resident #119's Progress Note revealed an entry dated [DATE]. The note was authored by Consultant Staff B. The note indicated that Consultant Staff B had received two (2) phone calls from Administrative Nurse B requesting to change Resident #119's Broda chair due to the resident scooting forward in the chair. Consultant Staff B responded to Administrative Nurse B that they should place a non-skid material on the seat of the chair. Consultant Staff B noted Resident #119 was in a "High Broda" chair that tilted and reclined. Consultant Staff B educated nursing staff that the "High Broda" chair placed Resident #119 at an increased risk for falls due to their restless behaviors. Consultant Staff B identified Resident #119 as "constantly wanting to move around" and that they would "benefit from a chair that would allow them to do so."

	Consultant Staff B also noted that they observed the resident's chair was in a reclined position and that both of their legs had been placed on a footrest which had been elevated to a position where Resident #119 could not move the chair themself. Review of Resident #119's fall history revealed a fall on [DATE] which indicated Resident #119 was observed on the floor next to their bed. Their pants were wet, and they had spilled some water on themself and on the floor. The facility implemented a Broda chair for positioning. Continued review of Resident #119's fall history revealed a documented fall on [DATE] which indicated Resident #119 was again observed on the floor next to their bed. The incident report indicated Resident #119 was to be placed in a Broda chair at the nurse's station while awake. Review of Resident #119's Comprehensive Care Plan revealed a focus area for an Activity of Daily Living (ADL) self-care deficit related to Dementia. Resident #119's Care Plan goal was to "maintain current level of functioning through the next review." The first intervention read, "Broda chair for mobility" and was created on [DATE]. Continued review of Resident #119's Care Plan revealed a focus area for falls related to weakness. An intervention dated [DATE] directed staff to ensure Resident #119 was up in a Broda chair at the nurse's station while awake. On 5/18/22 at 10:25 a.m., Resident #119 was again observed in the Broda chair in the TV area. They were positioned in front of the television. The chair was fully reclined, and the footrest was elevated. They were repeatedly moving their left leg on and off the chair's footrest. They were observed grabbing at their groin and frowning. When asked if they were feeling ok, Resident #119 stated, "No! I need to go to the bathroom, but I can't get up!" A staff member was notified of Resident #119's request, and they were assisted to the restroom. Staff then assisted Resident #119 to their bed. On 5/18/22 at 1:55 p.m., an interview was conducted with Administrative Nurse C When asked how the facility reached the determination that a Broda chair was appropriate for Resident #119, Administrative Nurse C explained that the resident was "constantly jerking around" and that they would "probably fall out of a regular wheelchair." Administrative Nurse C explained that Resident #119 was placed in the Broda chair "soon after admission" and that it was a decision made jointly by the Nursing and Therapy departments. When asked about other attempted measures before the use of the Broda chair, Administrative Nurse C explained that a regular wheelchair and two other Broda chairs had been trialed but that Resident #119 could "get out of those." Administrative Nurse C was asked whether they had received any training or education on the facility's practices for restraints. Administrative Nurse C stated

	that they had and that Resident #119 "wasn't being physically held down." When asked whether a device preventing Resident #119 from rising independently would be considered a restraint according to the facility's policy, Administrative Nurse C stated, "No." On 5/18/22 at 2:58 p.m., an interview was conducted with Consultant Staff B. They explained that Resident #119 was participating in therapy "fairly well" when they were initially admitted but that they had since suffered a significant decline. Consultant Staff B described Resident #119 as being "lethargic most of the time." When asked about the note that they had authored on [DATE], Consultant Staff B explained that they had given a recommendation for a tilting Broda chair that would allow Resident #119 to use their feet to propel themself. Consultant Staff B stated that they obtained the chair for Resident #119 and provided it to them. After providing the chair to the resident, the Nursing department "demanded that the chair be changed back" to the High Broda that reclined fully because "[they were] constantly trying to get out of the chair." Consultant Staff B added that they were directed by Administrative Nurse D to "put [them] in this chair [High Broda] and leave [them] there." When asked what they felt was leading to Resident #119's decline, Consultant Staff B became tearful and stated, "I think it's because they put [them] on the Ativan and just left [them] in the chair." Consultant Staff B stated that they reported their concerns to Consultant Staff C and was told to "just keep documenting." Consultant Staff B stated Resident #119 simply wanted to move around and that the "High Broda" was preventing them from doing so. Consultant Staff B identified Resident #119 as now being unable to feed themself but confirmed that they were able to do so upon admission. Consultant Staff B added that they felt the best plan of action for Resident #119 would be to place them on the "special needs unit and provide [them] with a high-back wheelchair so that they would be able to propel themself." They also added that they had a conversation with Resident #119's treating Medical Provider about their concerns and was later told by Administrative Nurse D that they should report any concerns to the Nursing department and to not speak with the Medical Provider independently. On 5/19/22 at 10:35 a.m., an interview was conducted with Consultant Staff D. They confirmed that they were familiar with Resident #119 and that they were providing Speech Therapy services for them. Consultant Staff D stated that they had not received any concerns from Consultant Staff B about Resident #119's chair or positioning. They did identify Resident #119 as suffering a decline in ability to eat and that they "seem[ed] very sleepy." They stated that they had communicated their concerns to the Nursing department and to the Medical Provider and that

	they were told "it would probably be a couple weeks while [their] medications [were] adjusted." Consultant Staff D confirmed that any device that prevented a resident from rising independently would be considered a restraint according to the facility's policies and practices. On 5/19/22 at 10:47 a.m., an interview was conducted with Consultant Staff C. They confirmed that they were familiar with Resident #119's care and that they were receiving OT services for "strengthening and self-care." Consultant Staff C stated that "any recommendations made by [Consultant Staff B] would be appropriate and considered the actual recommendations for [Resident #119] because [Consultant Staff B] treats them daily." Consultant Staff C identified Resident #119 as suffering a decline and stated, "[They have] definitely declined from when I evaluated [them] on admission." Consultant Staff C stated Resident #119 was initially using a wheelchair on admission and that the Nursing Department placed them in a "High Broda" chair because "[they] kept falling." Consultant Staff C stated that Consultant Staff B had obtained "a particular Broda that would allow the resident to propel [themselves]" and that Consultant Staff B advised Consultant Staff C that the Nursing Department switched the chair back to the one (1) that reclined completely. Consultant Staff C stated Resident #119 would benefit from being more mobile and added that they would need to be "closely supervised." On 5/19/22 at 11:05 a.m., an observation of Resident #119 was conducted. They were observed in a new, titling Broda chair. The footrest was fully elevated, and they were not able to reach the floor with their feet in order to propel themself. On 5/19/22 at 11:09 a.m., an interview was conducted with Certified Nurse Aide A. They confirmed that they were familiar with Resident #119's care requirements. Certified Nurse Aide A identified Resident #119 as being able to "pedal with [their] feet" while in a chair. When asked about the Broda chair and the elevated footrest, Certified Nurse Aide A stated, "They put the footrest up to keep [them] from standing because [they] like[d] to fall a lot." Certified Nurse Aide A confirmed that Resident #119 was in the Broda chair in a reclined position with the footrest elevated "most of the time." Certified Nurse Aide A also confirmed that Resident #119 required more assistance to eat than they did on admission. When asked whether Certified Nurse Aide A had received any training or education regarding resident positioning, Broda chairs, or the facility's restraint practices, they stated, "I probably did when I was hired but I'm not sure." On 5/19/22 at approximately 12:45 p.m., an interview was conducted with Administrative Nurse D. They were asked which

	wheelchair Resident #119 should be using. Administrative Nurse D stated Resident #119 should be using the Broda chair "that tilts and allows for [their] feet to touch the ground." Administrative Nurse D added that they didn't think Resident #119 was able to propel themself but stated that they agreed that the footrest should not be elevated on either chair because it restricts Resident #119's movement and mobility. Regarding the facility's practices for determining appropriate assistive devices for each resident, Administrative Nurse D explained, "We usually rely more on the therapist to make that determination." Administrative Nurse D was not able to recall having a discussion with Consultant Staff B about appropriate Broda chairs for Resident #119. The facility's policy titled, "Use of Restraints" was reviewed. There was no effective or revision date on the policy. The policy statement read, "Restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience, or for the prevention of falls." Bullet point four (4) of the policy read, "Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: C. placing a resident in a chair that prevents the resident from rising." A Progress Note dated [DATE] at 5:08 p.m. and authored by Consultant Staff C indicated Resident #119 was observed in a "high tilt back Broda chair in the common area." The OT noted that Resident #119's chair was titled back and that they were moving their legs on each side of the leg support. Consultant Staff C also noted that they observed Resident #119 to be misaligned in the chair. Consultant Staff C assisted Resident #119 to reposition in the chair and documented that the resident continued to be restless after being repositioned. Consultant Staff C noted a recommendation for Resident #119 to have a "low Broda chair so [their] feet touch the floor so pt [patient] will be able to move [their] Broda chair even if [their] chair is tilted back." The note also indicated Consultant Staff C was recommending trial usage of a standard wheelchair while in the Therapy gym to assess whether Resident #119 would be appropriate for wheelchair mobility. A Progress Note authored by the assigned nurse dated [DATE] at 7:47 p.m. read, "Resident on unit near nurse's station moving around in low Broda. States [they] like the chair." --- The facility's policy titled, "Assistive Devices and Equipment" was reviewed. The policy was revised July 2017. Bullet point two (2) of the policy read, "Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident's plan of care."

	Bullet point five (5) of the policy directed staff to address factors such as "appropriateness for resident condition, personal fit, device condition, and staff practices." Immediate Jeopardy was identified on 5/19/22 at 4:00 p.m. Immediate Jeopardy is a situation in which the deficient practice has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident or residents. Administrative Staff C was notified of the Immediate Jeopardy findings on 5/19/22 at 5:55 p.m. and a Removal Plan was requested. The facility provided a Removal Plan and policy revision on 5/19/22 at 8:05 p.m. The plan did not meet removal criteria and corrections were requested. The facility provided a Removal Plan and policy revision on 5/19/22 at 9:45 p.m. The plan did not meet removal criteria and corrections were requested. The facility provided a Removal Plan and policy revision on 5/19/22 at 11:20 p.m. The plan did not meet removal criteria and corrections were requested. The facility provided an amended Removal Plan on 5/20/22 at 1:50 p.m. which addressed concerns with the facility's structures and processes for fall investigations and implementation of appropriate interventions. The plan was accepted. 2. Review of Resident #105's clinical record documented the diagnoses: Alzheimer's, Chronic Pain, Major Depressive Disorder, and Insomnia. Review of Resident #105's Annual Minimum Data Set (MDS) Assessment dated [DATE] documented the resident had short and long-term memory difficulties, had severely impaired decision-making skills, and rejected care one (1) to three (3) days during the seven (7) day observation period. The MDS documented the resident required extensive assistance of two (2) people with bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #105 required supervision with ambulation and locomotion and utilized a wheelchair. The resident was not steady on their feet, but able to stabilize themself without staff assistance when moving from a seated to a standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet, and surface-to-surface transfers. The MDS documented the resident had a decrease in range of motion (ROM) of the upper and lower body and had one (1) noninjury fall since the previous

	assessment. The MDS documented the resident did not have a physical restraint. Review of Resident #105's Care Plan for falls with the initiation date of [DATE] listed the intervention to offer a Broda chair (chair that is low to the ground that allows a resident to propel themselves, sometimes used for residents with a history of falls) for rest after breakfast. Review of the Fall Investigations and Nurses' Notes revealed Resident #105 sustained 11 falls, from [DATE] to [DATE], with one (1) fall resulting in a pelvic fracture. Observation on 5/17/22 at 10:55 a.m. revealed Resident #105 sitting in a Broda chair in the [LOCATION] with their legs up. Observation on 5/19/22 at 3:20 p.m. revealed Resident #105 sitting in a Broda chair, and their feet were not touching the floor and no footrest was in place. Further observation at 3:23 p.m. revealed two (2) visitors visited with the resident for a short period of time and then left the unit. The resident then attempted to get out of the Broda chair. The surveyor alerted Administrative Nurse B who then wheeled the resident to the other [LOCATION]. At that time, Certified Nurse Aide B and Certified Nurse Aide C assisted the resident out of the Broda chair and walked with them to the bathroom in their room. Observation on 5/20/22 at 10:34 a.m. revealed Resident #105 was sitting in a recliner in [LOCATION]. The resident stood up from the recliner and staff placed them in a Broda chair and wheeled them into the other [LOCATION]. In an interview with Certified Nurse Aide D on 5/20/22 at 10:37 a.m., they stated that they did not know why the staff placed Resident #105 in the Broda chair. In an interview with Administrative Nurse D on 5/20/22 at 3:40 p.m., they stated that the staff placed Resident #105 in a Broda chair after they fell and fractured their pelvis. They stated that the resident had not been assessed for the use of the Broda chair prior to being placed in it and had not been evaluated to see if the Broda chair was the least restrictive device for them. Review of Resident #108's Quarterly Minimum Data Set (MDS) Assessment dated [DATE], documented the resident's cognition was not assessed and the resident did not display any behaviors. The MDS documented that Resident #108 required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. The resident required limited assistance with walking and supervision with locomotion. The resident was not steady on their feet and was only able to

	stabilize with staff assistance when moving from a seated to standing position, walking, turning around and facing the opposite direction, moving on and off the toilet and surface-to-surface transfers. Resident #108 utilized a wheelchair, had two (2) or more noninjury falls and did not have a physical restraint. Review of Resident #108's Care Plan for falls revised [DATE] listed the interventions: to encourage the use of the Broda chair and ensure the Broda chair was locked when stationary. Review of the Activity of Daily Living (ADL) Care Plan listed the intervention for a low Broda chair for mobility with the start date of [DATE]. Review of the Fall Investigations and Nurses' Note documented the resident had 23 falls since [DATE] of which five (5) occurred from the Broda chair. Observation on 5/17/22 at 11:06 a.m. revealed Resident #108 sat in the Broda chair in the [LOCATION]. Observation on 5/18/22 at 10:04 a.m. and 5/19/22 at 3:21 p.m. revealed Resident #108 sat in the Broda chair in the [LOCATION]. The Broda chair was reclined about 30 degrees and the residents' feet did not touch the floor. Further observation on 5/17/22 and 5/18/22 revealed the resident did not move the Broda chair around the unit. In an interview with Administrative Nurse D on 5/19/22 at 4:16 p.m., they stated that Resident #108 would reach over the side of the Broda chair and try to move the Broda chair with their fingers/hand. In an interview with Licensed Nurse A on 5/20/22 at 10:35 a.m., they stated that the interventions attempted for the decrease in falls included the Broda chair.
§51.120(d) Pressure sores Based on the comprehensive assessment of a resident, the facility management must ensure that- (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable;(2) A resident having pressure sores receives necessary treatment and services to promote	Based on observations, interviews, and record review, the facility failed to 1) prevent the development of pressure injuries by failing to identify risk factors for developing pressure injuries and 2) initiate prompt treatment and services for an identified pressure injury for one (1) resident of one (1) resident reviewed for compliance with pressure injury treatment requirements. (Resident #119). The findings include: Review of Resident #119's medical record revealed an initial admission date of [DATE]. Resident #119's medical diagnoses included Dementia without Behavioral Disturbance, Repeated Falls, and Psoriatic Arthritis.

healing, prevent infection and prevent new sores from developing. Level of Harm – Actual Harm that is not immediate jeopardy. Residents Affected – Few	Review of the admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) of 11 out of a total 15 possible points, indicating moderately impaired cognition. According to the MDS assessment, Resident #119 required limited assistance with locomotion on and off the nursing unit and required supervision with meals. The admission assessment did not identify the presence of a pressure injury. During an interview with Resident #119 on 5/17/22 at 12:28 p.m., they stated that they were experiencing some discomfort on their buttocks. They were not able to rate the discomfort and describe the characteristics. Resident #119 was unsure of whether they had any skin concerns to the area. Review of Resident #119's nursing Progress Notes revealed an entry dated [DATE] at 6:27 p.m. which indicated redness noted to the coccyx and an open area to the left buttock. The note added that Resident #119 "moves [their] body and limbs constantly while in the chair and that the wound was "possibly from shearing." The note indicated that a "wound care communication form" was completed and that the hospice provider was notified. The note did not indicate that the Medical Provider and/or Resident Representative were notified. Review of Resident #119's Physician Order on [DATE] revealed no active treatment orders for the area of concern. On 5/19/22 at 11:09 a.m., an interview was conducted with Certified Nurse Aide A, they confirmed that they were familiar with Resident #119's care requirements. Certified Nurse Aide A was asked whether Resident #119 had any pressure injuries. They explained that Resident # 119 had an "open area" to their left buttock. Certified Nurse Aide A stated, "it has been there for a few days." They were unsure how the area was being treated. On 5/19/22 at approximately 12:45 p.m. an interview was conducted with Administrative Nurse D regarding the facility's pressure injury prevention and treatment practices. Administrative Nurse D stated that they was not sure whether Resident #119 had a pressure injury. For newly discovered pressure injuries, the Medical Provider should be notified and a treatment order should be obtained and implemented at that time. As part of the pressure injury prevention practices, they explained that the facility's policy was for a licensed nurse to conduct a skin assessment weekly for each resident and that the findings of the skin assessment should be documented in the medical record. A Skin/Wound Note dated [DATE] was reviewed. The note indicated Resident #119 was assessed by the wound team and

	that a new wound was noted to the left medial buttock. The wound measured 0.5cm X 1.4cm X 0.1cm. The surrounding skin was noted to be dark pink in color. The medical provider was notified and a treatment order was obtained. The wound was classified as a Stage II pressure injury by the wound care provider. The facility's policy, titled "Pressure Ulcer Prevention," was reviewed. The policy did not indicate an effective or revision date. The policy identified risk factors for the development of pressure injuries such as friction and shear, immobility, and poor nutritional status. The policy directed staff to report any signs of a developing pressure injury to the physician and to include efforts to stabilize, reduce, or remove underlying risk factors. The facility's policy, titled "Pressure Ulcer Treatment," was reviewed. The policy did not indicate an effective or revision date. The policy directed staff to determine the causative factors and to change dressings per the Medical Provider's order.
§51.120(i) Accidents The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. Level of Harm – Actual Harm that is not immediate jeopardy. Residents Affected – Few	Based on observations, interviews, and record review, the facility failed ensure residents received appropriate care and services to prevent falls by failing to 1) Investigate the circumstances of falls and/or 2) Implement appropriate fall reduction measures for four (4) of four (4) residents reviewed for falls (Resident #119, Resident #105, Resident #107, Resident #108) and failed to maintain the environment and/or equipment in a safe manner for two (2) residents (Resident #134 and Resident #135). The findings include: 1. Review of Resident #119's medical record revealed an initial admission date of [DATE]. Resident #119's medical diagnoses included Dementia without Behavioral Disturbance, Repeated Falls, and Psoriatic Arthritis. Review of the admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) of 11 out of a total 15 possible points, indicating moderately impaired cognition. According to the MDS assessment, Resident #119 required limited assistance with locomotion on and off the nursing unit. On 5/18/22 at 10:25 a.m., Resident #119 was observed in the Broda chair in the TV area. They were positioned in front of the television. The chair was fully reclined, and the footrest was elevated. They were repeatedly moving their left leg on and off the chair's footrest. They were observed grabbing at their groin and frowning. When asked if they were feeling ok, Resident

	#119 stated, “No! I need to go to the bathroom, but I can’t get up!” A staff member was notified of Resident #119’s request, and they were assisted to the restroom. Staff then assisted Resident #119 to their bed. Review of Resident #119’s Physician Order revealed an order dated [DATE] for a Broda chair to prevent falls from using a wheelchair. Review of Resident #119’s fall history revealed a documented fall on [DATE]. Resident #119 was observed on the floor next to their bed. The facility’s investigation indicated the resident was provided with a “trough mattress” to prevent Resident #119 from rolling out of the bed. The investigation did not identify causative factors of the fall. Continued review of Resident #119’s fall history revealed a documented fall on [DATE]. which indicated Resident #119 was observed on the floor next to their bed. Their pants were wet, and they had spilled some water on themself and on the floor. The facility implemented a Broda chair for positioning. Review of the facility’s investigation revealed that causative factors of the fall had not been identified. Continued review of Resident #119’s fall history revealed a documented fall on [DATE] which indicated Resident #119 was again observed on the floor next to their bed. The incident report indicated Resident #119 was to be placed in a Broda chair at the nurse’s station while awake. Review of the facility’s investigation revealed that causative factors of the fall had not been identified. During an interview with Administrative Nurse C on 5/18/22 at 1:55 p.m., they explained that they were familiar with Resident #119’s care. When asked about Resident #119’s risk factors for falls, Administrative Nurse C explained that Resident #119 had sustained several falls since admission and attributed the falls to the resident’s behaviors of “constantly moving and jerking around.” Administrative Nurse C was unable to identify the causative factors for Resident #119’s falls on [DATE] and was unable to recall whether Resident #119 suffered any injuries. Administrative Nurse C stated Resident #119 was placed in a “high back Broda chair” after the falls to “keep [them] from standing up so much.” Administrative Nurse C added that the decision to place Resident #119 in a Broda chair after the falls was a joint decision between the Nursing and Therapy Departments. Administrative Nurse C was then asked whether Resident #119 was continent of bowel and/or bladder. They stated that Resident #119 was able to request assistance to the restroom

	when needed but was unsure whether Resident #119's bowel and bladder pattern had been established. Administrative Nurse C then added that Resident #119 was on a "check and change program." During an interview with Consultant Staff B on 5/18/22 at 2:58 p.m., they explained that Resident #119 was at an increased risk of falls because they remained in the High Broda chair. Consultant Staff B described Resident #119 as able to independently propel themself around and that the Broda chair was preventing them from doing so. Consultant Staff B also described Resident #119 as being able to alert staff when needing to use the restroom. They added that Resident #119's restless behaviors were "dangerous" and that the behaviors were stemming from their inability to move around. When asked about the facility's processes for investigating falls, Consultant Staff B explained that falls were discussed only by the Nursing Department and that the discussions occurred after the daily clinical meeting. Consultant Staff B confirmed that the interdisciplinary team (to include the Therapy Department) was not part of the fall discussions and stated that they were told "it takes too long to talk about in the clinical meeting." On 5/19/22 at 11:09 a.m., an interview was conducted with Certified Nurse Aide A. They confirmed that they were familiar with Resident #119's care requirements. They identified Resident #119 as a fall risk and explained that they were in a Broda chair in a reclined position "to keep [them] from standing because [they] like[d] to fall a lot." Certified Nurse Aide A stated Resident #119 was able to use the restroom with assistance but that they were not on a toileting program. Review of Resident #119's Comprehensive Care Plan revealed a focus area for falls. Interventions dated [DATE] directed staff to provide prompt response to all requests for assistance and to "follow facility fall protocol." Additional interventions included placing Resident #119 in a Broda chair at the nurse's station while awake and placement of a "trough mattress" in their bed. The Care Plan did not identify bowel or bladder patterns and did not indicate an active toileting program despite Resident #119 being able to use the restroom with staff assistance. The facility's policy, titled "Assessing Falls and Their Causes," was reviewed. The policy indicated a revision date of March 2018. The policy directed staff to identify the causes of a fall by evaluating chains of events or circumstances preceding the fall, including the time of the fall, time of the last meal, what the resident was doing, whether the resident was trying to get to the toilet, and any environmental risk factors involved.

	The facility's policy, titled "Falls – Clinical Protocol," was reviewed. The policy indicated a revision date of March 2018. The second section of the policy, titled "Cause Identification," directed staff to identify possible causes of the fall within 24 hours. The third section of the policy, titled "Treatment/Management," directed staff to use the preceding assessment to identify pertinent interventions to try to prevent subsequent falls. The facility's policy, titled "Managing Falls and Fall Risk," was reviewed. The policy indicated a revision date of March 2018. The section titled, "Resident-Centered Approaches to Managing Falls and Fall Risk," directed staff to implement a resident-centered fall prevention plan to reduce the specific risk factors of falls. 2. Review of Resident #105's clinical record documented the diagnoses Alzheimer's, Chronic Pain, Major Depressive Disorder, and Insomnia. Review of Resident #105's Annual Minimum Data Set (MDS) Assessment dated [DATE] documented that the resident had short and long-term memory difficulties, had severely impaired decision-making skills, and rejected care one (1) to three (3) days during the seven (7) day observation period. The MDS documented the resident required extensive assistance of two (2) people with bed mobility, transfers, dressing, toileting, and personal hygiene. Resident #105 required supervision with ambulation and locomotion and utilized a wheelchair. The resident was not steady but able to stabilize without staff assistance when moving from a seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet, and surface-to-surface transfers. The MDS documented the resident had a decrease in range of motion (ROM) of the upper and lower body. The resident had one (1) noninjury fall since the previous assessment. Review of Resident #105's Care Plan for falls with the initiation date of [DATE] listed the interventions: anticipate and meet the resident's needs, ensure resident had proper fitting clothes, music and memory, offer assistance to bed/recliner after lunch, offer Broda chair (chair that was low to the ground that allowed a resident to propel themselves, sometimes used for residents with a history of falls) for rest after breakfast, offer diversional activities at table before breakfast, restorative nursing, toilet after meals and toilet every two (2) hours. Review of the Fall Assessments from [DATE] to [DATE] scored the resident at a high fall risk except for [DATE] when the resident was scored at a moderate risk for falls.

	Review of the Fall Investigations and Nurses' Notes revealed the following 11 falls: [DATE]. - staff found the resident on the floor of another resident's room. [DATE]. – staff found the resident on the floor of another resident's room. [DATE] – the resident fell while walking down the hall. [DATE] – staff found the resident on the floor. [DATE] – staff found the resident on the floor. [DATE] – staff found the resident on the floor. [DATE] – staff found the resident sitting on the floor. [DATE] – staff found the resident on the floor. [DATE] – staff found the resident on the floor, and they sustained a pelvic fracture. [DATE] -- the resident slid out of the Broda chair. [DATE] – the resident was found tipped over in a recliner. Observation on 5/17/22 at 10:55 a.m. revealed Resident #105 sitting in a Broda chair in the [LOCATION] with their legs supported to the knees in the up position, but from the knees they were not supported while in the up position up. Observation on 5/18/22 at 10:40 a.m. revealed Resident #105 sitting in a wheelchair in their room with an anti-tip device on the wheelchair. Observation on 5/19/22 at 3:20 p.m. revealed Resident #105 sitting in a Broda chair and their feet not touching the floor and no footrest in place. Further observation at 3:23 p.m. revealed two (2) visitors visited with the resident for a short period of time and then left the unit. The resident then attempted to get out of the Broda chair. The surveyor alerted the Administrative Nurse B who then wheeled the resident to the other [LOCATION]. At that time two Certified Nurse Aide B and Certified Nurse Aide C assisted the resident out of the Broda chair and walked with them to the bathroom in their room. Observation on 5/20/22 at 10:34 a.m. revealed Resident #105 was sitting in a recliner in the [LOCATION]. The resident stood up from the recliner and staff placed them in a Broda chair and wheeled them into the other [LOCATION]. In an Interview with Administrative Nurse D on 5/20/22 at 3:40 p.m., they revealed that after a fall occurred the nurse working with the resident at that time should put an immediate intervention in place to prevent future falls. At the next morning meeting (Monday-Friday) the Administrative Nurse A and other administrative nurses discussed all the falls and put interventions in place to prevent further falls. Administrative Nurse E or one (1) of the other administrative nurses

	documented the intervention on the Care Plan. Therapy staff were not involved with the morning meetings and the nurse managers would only ask for a therapy evaluation if the resident had frequent falls. In an interview with Licensed Nurse A on 5/20/22 at 10:56 a.m., they stated that the resident had sustained a pelvic fracture and the staff placed the resident in a Broda chair. The resident's fall prevention interventions included: nonskid footwear and a Broda chair. The resident had previously used a posey hat (cushioned hat to protect the head) and elbow pads, which the resident no longer used. Review of the clinical record lacked an assessment for the use of the Broda chair and individualized interventions for the prevention of falls. 3. Review of Resident #107's clinical record revealed an admission date in [DATE] and a readmission date of [DATE]. The diagnoses included: Vascular Dementia with Behavioral Disturbances, Anxiety Disorder, Muscle Weakness, Insomnia, Major Depressive Disorder, Gout and Macular Degeneration. Resident #107's Admission Minimum Data Set (MDS) Assessment dated [DATE] documented the Brief Interview for Mental Status (BIMS) score of eight (8) out of 12, indicating moderately impaired cognition. The MDS documented the resident required limited assistance with bed mobility, ambulation, and dressing and required extensive assistance with transfers, toilet use, personal hygiene, and bathing. The resident was not steady on their feet and only able to stabilize themself with staff assistance when moving from a seated to standing position, walking, turning around and facing the opposite direction, moving on and off the toilet and surface-to-surface transfers. Resident #107 utilized a wheelchair and had two (2) or more noninjury falls and one (1) not major injury fall since the previous MDS. The MDS documented the resident did not receive therapy or restorative services. Review of the Fall Care Plan dated [DATE] listed the interventions: anticipate and meet the resident's needs, be sure the resident's call light was within reach and encourage the resident to use it, the resident needed prompt response to all requests for assistance, encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, ensure the resident was wearing appropriate footwear, medical review for behaviors, place resident at nurses' station when they appeared agitated, and trough mattress (wing mattress).

	Review of Resident #107's Fall Assessments from [DATE] to [DATE] scored the resident at a high fall risk. Review of the Fall Investigations and Nurses' Notes documented the following seven (7) falls since [DATE]: [DATE] – staff found the resident on the floor. [DATE] – staff found the resident on the floor in their room. [DATE] – staff found the resident on the floor in their room. [DATE] – staff found the resident on the floor in the dining room. The resident was sitting in the Broda Chair prior to the fall. [DATE] – staff found the resident on the floor. [DATE] – the resident fell while holding onto the table [DATE] – staff found the resident on the floor in their room. Observation on 5/17/22 at 11:18 a.m. revealed Resident #107 lying in bed with their eyes closed, no fall mats were noted by the bed. Observation on 5/19/22 at 3:29 p.m. revealed staff wheeled Resident #107 from their room in a wheelchair and placed them in front of the TV. In an interview with Licensed Nurse A on 5/17/22 at 11:18 a.m., they stated that the resident was blind and had had some falls with injuries. In an interview with Administrative Nurse F on 5/19/22 at 4:11 p.m., they stated that the resident had a "raging" Urinary Tract Infection in [DATE] and would get up and fall. During an interview with Certified Nurse Aide D on 5/20/22 at 10:39 a.m., they stated that Resident #107 required one (1) person assistance when using the commode, utilized a wheelchair to get around the facility, and had bilateral fall mats by the bed. During an interview with Licensed Nurse A on 5/20/22 at 10:53 a.m., they stated that Resident #107's fall interventions consisted of a Dycem in the wheelchair and nonskid footwear. The clinical record lacked individualized and effective interventions for the prevention of falls for Resident #107. 4. Review of Resident #108's clinical record revealed an admission date of [DATE] and the diagnoses included: Dementia with Behaviors, Aphasia, Diabetes, Epilepsy, Major Depressive Disorder, Anxiety, and Pain. Review of Resident #108's Quarterly Minimum Data Set (MDS) Assessment dated [DATE] documented the resident's cognition

	was not assessed and the resident did not display any behaviors. The MDS documented the resident required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. The resident required limited assistance with walking and supervision with locomotion. The resident was not steady on their feet and only able to stabilize themself with staff assistance when moving from a seated to standing position, walking, turning around and facing the opposite direction, moving on and off the toilet and surface-to-surface transfers. Resident #107 utilized a wheelchair and had two (2) or more noninjury falls. The resident received a hypnotic seven (7) days of the seven (7) day look back period and received restorative services for transfers and ambulation five (5) days of the seven (7) day look back period. Review of the Fall Assessments completed from [DATE] to [DATE] placed the resident at a high fall risk. Review of Resident #108's Care Plan for falls initiated [DATE] and revised [DATE] listed the fall interventions prior to [DATE]: anticipate and meet the resident's needs, assist resident to bed after dinner, check for proper fitting of clothes, diversional activity at bedside, encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility, encourage use of Broda chair, encourage use of recliner when reading, remove food tray when done eating, offer music and memory with headphones, offer nonskid socks at bedtime, offer rest periods, offer stimulating activities based on cognitive abilities, offer to take to bathroom before breakfast, trough mattress, walk to dine (dining room) with restorative aide, while resident is active, utilize wheelchair with an anti-roll back device, ensure dining tables were raised when meals are over, ensure public restroom was locked, ensure the resident was wearing appropriate non-slip footwear and nonslip socks when not wearing shoes, frequent toileting, low bed mats, medication review for sleep aide, offer warm blanket, offer weighted blanket, posey hat, snacks after dinner, staff assist resident to recliner, and staff to offer standing and stretching periodically. Review of resident #108's Care Plan for falls listed the interventions since [DATE]: bed height assessment, ensure Broda chair was locked when stationary, move closer to the nurses' station, offer toileting before dinner, offer toileting with each round, toilet after lunch, toilet prior to assistance to bed and resident to nurses' station after dinner. Review of the Activity of Daily Living (ADL) Care Plan listed the intervention for a low Broda chair for mobility with the start dated of [DATE].

	Review of the Fall Investigations and Nurses' Notes documented the following 23 falls since [DATE]: [DATE] – staff found the resident on the floor in another resident's room. [DATE] – staff found the resident on the floor in another resident's room. [DATE] – staff found the resident on the floor. [DATE] – staff found the resident on the floor. [DATE] – staff found the resident on the floor mat. [DATE] – staff found the resident on the floor. [DATE] – staff found the resident on the floor. [DATE] – staff found the resident on the floor. [DATE] – the resident stood up from the Broda chair and fell. [DATE] – staff found the resident on the floor previously in the Broda chair. [DATE] – staff found the resident on the floor mat by the bed. [DATE] – staff found the resident under the dining room table. [DATE] – staff found the resident on the floor. [DATE] – staff found the resident on the floor. [DATE] – staff found the resident on the floor. [DATE] – staff found the resident on the floor in front of the bathroom. [DATE] – staff found the resident on the floor in the bathroom. [DATE] – staff found the resident on the floor in the common bathroom. [DATE] – staff found the resident on the floor. [DATE] --staff found the resident on the floor from the Broda chair. [DATE] -- staff found the resident on the floor from the Broda chair. [DATE] – staff found the resident on the floor mat. [DATE] – staff found the resident on the floor with the Broda chair next to the resident. Observation on 5/17/22 at 11:06 a.m. revealed Resident #108 sat in the Broda chair in the [LOCATION]. Observation on 5/18/22 at 10:04 a.m. and 5/19/22 at 3:21 p.m. revealed Resident #108 sat in the Broda chair in the [LOCATION]. The Broda chair was reclined about 30 degrees and the resident's feet did not touch the floor. The resident could not reach the floor in an effort to move the Broda chair In an interview with Administrative Nurse D on 5/19/22 at 4:16 p.m., they stated that the resident would reach over the side of the Broda chair and try to move the Broda chair with their fingers and hands. Administrative Nurse D stated that restorative services walked with the resident, but they did not know how they walked with them (with a walker, handheld, etcetera).

	In an interview with Licensed Nurse A on 5/20/22 at 10:35 a.m., they stated that the interventions attempted for the decrease in falls included a Dycem in the wheelchair, a Broda chair, and a posey hat that Resident #108 no longer wore. 5. The facility "Maintenance Procedure," undated, read in pertinent part that the first step to mopping floors was to set up "wet floor" signs. Review of Resident #134's medical record revealed an admission date of [DATE]. According the [DATE] Minimum Date Set (MDS) assessment, the resident had a Brief Interview for Mental Status (BIMS) score of thirteen (13) out of fifteen (15); a Fall Risk Assessment was completed on [DATE]; the resident had been assessed as being a High Risk for falls. On 5/17/22 at 12:23 p.m. Resident #134 was observed in their room transferring themself from their wheelchair to the bed. The floor was visibly wet the length of the room from the far wall to the doorway. There were no signs indicating that the floor had been mopped or to use caution. On 5/17/22 at 12:27 p.m. Administrative Nurse G observed the wet floor in Resident #134's room. They said "The wet floor is a fall hazard; it would be a fall hazard for anyone. There should be a sign up." Maintenance Staff A was interviewed on 5/18/22 at 1:43 p.m. They said that before staff start mopping, they should put down a "Wet Floor" sign. They said that this was a caution to alert residents and staff that the floor could be slippery. 6. Review of Resident #135's medical record revealed an admission date of [DATE]. According to the [DATE] Minimum Data Set (MDS) assessment, the resident utilized a wheelchair for mobility. A Fall Risk Assessment was completed on [DATE] and the resident had been assessed as being at High Risk for falls. On 5/18/22 at 10:53 a.m. Resident #135's wheelchair was observed in their room. On the footrest of the wheelchair there appeared to be a "make-shift" foot cushion with folded material that was secured to the footrest with an ace bandage. Review of the resident record revealed no documentation indicating when or why the wheelchair was modified.

	On 5/18/22 at 10:57 a.m. Certified Nurse Aide E observed the wheelchair cushion that was crafted and said that it was made from a folded bed cover and ace wrap. They said that it was the first time that they had noticed that the wheelchair had been modified and that it was not something Certified Nurse Aide E would do. Licensed Nurse B was interviewed on 5/18/22 at 11:03 a.m. They said that it was their first day working on the unit and they had not previously noticed the cushion on the wheelchair. They said, "it looks like someone tried to make a cushion." They said that it could be a safety concern because it was not designed for the wheelchair. On 5/19/22 at 11:07 a.m., Consultant Staff B observed the wheelchair cushion that had been crafted and said it would not be a modification that would ever be recommended by therapy. They said that therapy does not recommend pillows being utilized with wheelchairs because it changes how the resident was positioned in the chair. They said that the material of the bed cover and ace wrap could be slippery or cut the resident and create a hazard.
§51.120(j) Nutrition Based on a resident's comprehensive assessment, the facility management must ensure that a resident— (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; (2) Receives a therapeutic diet when a nutritional deficiency is identified. Level of Harm – Actual Harm that is not immediate jeopardy. Residents Affected – Few	Based on observations, interviews, and record review, the facility failed to ensure that acceptable nutritional parameters were maintained by failing to 1) identify causative factors for excessive weight loss and 2) implement appropriate measures to improve a resident's nutritional status for one (1) resident reviewed for compliance with nutrition requirements (Resident #119). The findings include: Review of Resident #119's medical record revealed an initial admission date of [DATE]. Resident #119's medical diagnoses included Dementia without Behavioral Disturbance, Repeated Falls, and Psoriatic Arthritis. Review of the admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) of 11 out of a total 15 possible points, indicating moderately impaired cognition. According to the MDS assessment, Resident #119 required limited assistance with locomotion on and off the nursing unit and required assistance with meals. A Nutritional Assessment dated [DATE] identified Resident #119 as having a meal intake of 76-100% and that they were alert, able to feed themself, and had no chewing or swallowing problems. There were no additional documented nutritional assessments.

	Review of Resident #119's weight history revealed a weight of 166.8 pounds on [DATE]. Review of Resident #119's Physician Order revealed an order dated [DATE] for Ensure Plus as needed for meal intake less than 50%. Review of Resident #119's meal intakes for [DATE] revealed 19 instances of meal consumption less than 50% and nine (9) instances of meal refusals. Review of Resident #119's Administration Records for [DATE] revealed no documented administrations of the Ensure Plus supplement as ordered by the Medical Provider. A second weight of 151.4 pounds was documented on [DATE]. Review of Resident #119's Progress Note revealed a Nutrition/Dietary Note dated [DATE] which indicated Resident #119 had experienced a significant weight loss of 8.9% in one month. The recommendation was to "continue to monitor weight status and PO [by mouth] intake and monitor skin integrity." There were no new nutritional interventions recommended or ordered. There was no documentation of Medical Provider notification. A nutrition/dietary note dated [DATE] at 1:32 p.m. indicated intake fluctuated between 25-75% at most meals. The recommendation was to continue monitoring weight status, skin integrity, and meal intake. There were no new nutritional interventions recommended or ordered. A third weight of 146.8 pounds was documented on [DATE]. A nutrition/dietary note dated [DATE] at 10:50 a.m. read, "diet recommendation continue current POC [Plan of Care], continue to monitor weight status." There were no new nutritional interventions recommended or ordered. There was no documentation of Medical Provider notification. Review of Resident #119's Comprehensive Care Plan revealed a focus area for unintentional weight loss. An intervention dated [DATE] directed staff to provide and serve supplements as ordered. On 5/18/22 at 2:58 p.m., an interview was conducted with Consultant Staff B. During the interview, they voiced concerns that Resident #119 was "lethargic most of the time" and that they had suffered a significant decline in most Activities of Daily Living (ADLs), including the ability to feed themself. Consultant Staff B explained that they had noticed some weight loss but were not sure what was being done to address it.

	On 5/19/22 at 10:35 a.m., an interview was conducted with Consultant Staff D. They confirmed that they were familiar with Resident #119 and that they were providing Speech Therapy services for them. They did identify Resident #119 as suffering a decline in the ability to eat and that they "seem[d] very sleepy." Consultant Staff D stated that they had communicated their concerns to the Nursing department and to the Medical Provider and that they were told "it would probably be a couple weeks while [their] medications [were] adjusted." On 5/19/22 at 11:09 a.m., an interview was conducted with Certified Nurse Aide A. They confirmed that they were familiar with Resident #119's care requirements. Certified Nurse Aide A also confirmed that Resident #119 required more assistance to eat than they did on admission and that their meal intake had decreased. When asked whether Resident #119 was offered the Ensure Plus supplement, Certified Nurse Aide A stated that they were not sure. The facility's policy, titled "Nutrition (Impaired)/Unplanned Weight Loss – Clinical Protocol," was reviewed. The policy did not indicate an effective or revision date. The policy defined the threshold for significant unplanned and undesired weight loss as 5% in one (1) month and greater than 5% as being severe. The policy indicated that monitoring was required, such as recognizing deviations from the resident's usual habits and preferences, observing for, and documenting, any sustained decline in appetite and/or food intake, and observing for, and reporting, significant weight gain or loss.
§51.120(l) Special needs The facility management must ensure that residents receive proper treatment and care for the following special services: (1) Injections; (2) Parenteral and enteral fluids; (3) Colostomy, ureterostomy, or ileostomy care; (4) Tracheostomy care; (5) Tracheal suctioning; (6) Respiratory care; (7) Foot care; and (8) Prostheses.	Based on observations, interviews and record reviews, the facility failed to ensure that residents received proper treatment and care for respiratory services and diabetic nail care. Specifically, the facility administered oxygen therapy to Residents #133 without a Physician Order and failed to provide them with diabetic nail care. The findings include: The facility's "Oxygen Administration" policy and procedure, dated 4/2/07, included in pertinent part, "Purpose The purpose of this procedure is to provide guidelines for safe oxygen administration. Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration." Review of Resident #133's medical record revealed an admission date of [DATE], with a medical history to include a diagnosis of Personal History of COVID-19.

Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Review of Resident #133's medical record revealed there was no Physician Order that specified the use of oxygen or the liter flow per minute that the resident should receive. Review of Resident #133's "Weights and Vital Summary" revealed beginning [DATE], the resident intermittently had an unknown amount of oxygen by way of a nasal cannula. On 5/17/22 at 11:00 a.m., Resident #133 was observed laying on their bed. They were receiving oxygen therapy via (by way of) an oxygen mask. Consultant Staff E was interviewed on 5/18/22 at 9:34 a.m. They said that residents who received oxygen therapy should have an order specifying the liter flow. They said that there should be a range, or a specific liter flow amount, and an oxygen saturation percentage to maintain. They said that it was a treatment provided and there were risks to receiving too much or too little oxygen. They said that if someone was on too much oxygen, the individual could become lightheaded. They said that there were additional risks for individuals who smoked or had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). They said that nursing staff should be checking to ensure that residents who received oxygen therapy were on the correct liter flow and their oxygen saturation was checked at least once daily. Administrative Nurse H was interviewed on 5/18/22 at 10:29 a.m. They reviewed the resident's clinical record and confirmed that the resident did not have a Physician Order for the administration of oxygen. They stated that Resident #133 received oxygen therapy at two (2) liters per minute. They said that there were no risks associated with receiving too much or too little oxygen. Administrative Nurse A was interviewed on 5/18/22 at 12:33 p.m. They said that there should always be a Physician Order for the administration of oxygen. They said that Resident #133 wore oxygen routinely. They said that there were risks for residents receiving too little or too much oxygen, which was why there should always be an order from a physician. 2. The facility's undated policy, titled "Fingernails/Toenails, Care of," included in part: "Purpose The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Preparation 1. Review the resident's care plan to assess for any special needs of the resident. … General Guidelines 1. Nail care includes daily cleaning and regular trimming ... 3. Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments. 4. Trimmed and smooth nails prevent the resident from

	accidentally scratching and injuring his or her skin ... 6. Stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease." Review of Resident #133's medical record revealed an admission date of [DATE], with a medical history to include a diagnosis of Type II Diabetes Mellitus. On 5/17/22 at 11:00 a.m., Resident #133 was observed laying on their bed. The resident's toenails were observed to be thick, overgrown, and splintered. Consultant Staff E was interviewed on 5/18/22 at 9:34 a.m. They said that diabetic nail care needed to be done by a licensed nurse because if the nail was cut too far back for someone with poor circulation, it could put them at risk of losing a digit or a whole limb. They said that if the nail became thick and grown, it would need to be trimmed by a podiatrist.
§51.120(n) Medication errors The facility management must ensure that - (1) Medication errors are identified and reviewed on a timely basis; and (2) strategies for preventing medication errors and adverse reactions are implemented. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on observations, interviews, record review, and review of the facility's policy, the facility failed to administer medications according to the Physician Orders for Resident #140 and Resident #141, two (2) of three (3) residents observed for medication administration. The findings include: 1. Review of the facility's policy titled, "Instillation of Eye Drops," revised January 2014, documented: "Purpose The purpose of this procedure is to provide guidelines for instillation of eye drops to treat medical conditions, eye infections and dry eyes … General Guidelines … 4. When administering two or more different eye drops allow three to five minutes between each application." Review of Resident #140's Physician Order listed orders to include: Omeprazole 40 mg (milligram) every day with the start date of 8/3/19; Brimonidine 2% one (1) drop in each eye three (3) times a day; and Dorzolamide 2% one (1) drop in each eye two (2) times day. During medication administration observation on 5/18/22 beginning at 9:14 a.m., Certified Nurse Aide F was observed to prepare and place in a medication cup one (1) capsule of Omeprazole (used to treat stomach and esophagus problems) 20 mg to administer to Resident #140. Prior to Certified Nurse Aide F administering the medication to the resident, the surveyor alerted Certified Nurse Aide F of the order for two (2) capsules of the Omeprazole. Certified Nurse Aide F immediately placed an additional capsule of Omeprazole into

	the medication cup and administered it to Resident #140. Further observation revealed Certified Nurse Aide F administered one (1) drop of Brimonidine 2% (an eyedrop medication used to treat Glaucoma) into Resident #140's eye. Certified Nurse Aide F waited 90 seconds then administered one (1) drop of Dorzolamide 2% (an eyedrop medication used to treat Glaucoma) into the resident's eye. In an interview with Certified Nurse Aide F on 5/18/22 at 9:23 a.m., they stated that Resident #140 should receive two (2) capsules of the Omeprazole and they just missed it. Certified Nurse Aide F also stated that they should wait five (5) minutes between each eye drop. In an interview with Administrative Nurse A on 5/20/22 at 1:14 p.m., they stated that the staff should wait for five (5) minutes between administering eye drops. 2. Review of Resident #141's Physician Order listed an order for Omeprazole suspension 40 mg with a start date of [DATE]. During medication administration observation on 5/18/22 at 11:08 a.m., Certified Nurse Aide G administered Omeprazole Suspension through Resident #141's gastrostomy tube (g-tube). Certified Nurse Aide G poured the Omeprazole into the tubing, but did not rinse the medication cup out, which left a thick white substance in the medication cup. In an interview with Certified Nurse Aide G immediately following the observation, they stated that they did not routinely rinse out the medication cups (to ensure the resident received all the medication prescribed) when providing liquid medication through the g-tube.
§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 observation, interview and record review the facility failed to ensure that whole milk was kept at 41 degrees Fahrenheit (F) or below. The findings include: Observation on 5/22/22 at 11:03 a.m. in the main kitchen of the Dietary Staff A checking the temperature of an 8 (eight) ounce (oz.) carton of whole milk revealed that the temperature was at 45 degrees F. In an interview on 5/22/22 at 11:06 a.m., Dietary Staff A stated that the milk temperatures were high because the milk cartons were at the front of the case. Record review of the facility's policy titled, "Policy and Procedure Manual HACCP and Food Safety," dated 2021, revealed: "The U.S. Department of Health and Human Services Food Code Use 41 degrees for cold foods."

§51.180(d) Labeling of drugs and biologicals Drugs and biologicals used in the facility management must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on observation, interview and review of the facility's policy, the facility failed to date when multi dose vials of medication were opened and failed to discard a multi dose vial of Insulin when expired. Four (4) medication carts and two (2) medication rooms were reviewed for drug storage and labeling. The findings include: Review of the policy titled, "Medication Storage in the Facility," dated 1/2018, documented that certain medications or package types, such as multi dose injectable vials, once opened, required an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency. When the original seal of a manufacturer's container or vial was initially broken, the container or vial should be dated. The nurse shall place a "date opened" sticker on the medication and enter the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days, unless the manufacturer recommends another date or regulations/guidelines require different dating. The nurse will check the expiration date of each medication before administering it. No expired medication should be administered to a resident. Observation of the [LOCATION] on 5/18/22 at 9:00 a.m., revealed an opened, undated multi dose vial of Lantus Insulin; an opened, undated 50 milliliter (ml) multi dose vial of Lidocaine 1%; and an opened multi dose vial of Novolog Insulin with an expiration date of 5/16/22. In an interview with Administrative Nurse A on 5/20/22 at 1:14 p.m., they stated that all the nurses were responsible for making sure the multi dose vials of medications were dated and that expired medications were discarded.
§51.190(a) Infection Control 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. (a) Infection control program. The facility management must establish an infection control program under which it— (1) Investigates, controls, and prevents infections in the	Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe environment to help prevent the possible development and transmission of Coronavirus Disease (COVID-19) in two (2) of five (5) units and failed to implement appropriate transmission-based precautions to reduce the risk of communicable disease transmission for two (2) of four (4) residents (Resident #127 and Resident #128). The findings include: I. Improper use of PPE. According to the Centers for Disease Control and Prevention (CDC) guidance, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the

facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Many	Coronavirus Disease 2019 (COVID-19) Pandemic," updated 2/2/22, retrieved online from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html on 5/23/22, source control measures included the following: "Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing." On 5/17/22 at 11:52 a.m., lunch service in the [LOCATION] was observed. During this observation, Certified Nurse Aide H, Certified Nurse Aide I, and Certified Nurse Aide J were observed as they provided meal assistance to residents who were unable to feed themselves. They all had their masks pulled below their noses while providing meal assistance to the residents. Licensed Nurse C was interviewed on 5/19/22 at 9:31 a.m. They said that the facility was in "outbreak mode" until 5/22/22. They said that two (2) staff members had tested positive for COVID-19 in the current outbreak. They said that all nursing personnel had received regular training and reeducation on the proper use of PPE. Licensed Nurse C said that supervisory staff would do rounds every day and each day there would be one (1) to two (2) staff members who required direction to fix their mask or other PPE to fit properly. They said, "I feel like they should be taking it seriously, but some still don't." They said that they had to "let some staff go" because of it. They said that some staff may feel like there was no need for them to worry because they had already had COVID-19, but they would be reminded that, "it's not just about you; it's about the residents, the visitors and your coworkers." II. Improper sanitization According to the CDC guidance, "Best Practices for Environmental Cleaning in Healthcare Facilities," updated 4/21/2020, retrieved online from https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html on 5/23/22, noted that "hand rails in patient areas are considered to be a high-touch surface." The guidance included, "The determination of environmental cleaning procedures for individual patient care areas, including frequency, method, and process, should be based on the risk of pathogen transmission. Risk-based environmental cleaning frequency principles included the following: -Probability of contamination: Heavily contaminated surfaces and items require more frequent and thorough environmental cleaning than moderately contaminated surfaces, which in turn

	require more frequent and rigorous environmental cleaning than lightly or non-contaminated surfaces and items. -Vulnerability of patients to infection: Surfaces and items in care areas containing vulnerable patients require more frequent and rigorous environmental cleaning than surface and items in areas with less vulnerable patients. -Potential for exposure to pathogens: High-touch surfaces require more frequent and rigorous environmental cleaning than low-touch surfaces." On 5/17/22 at 12:16 p.m., Maintenance Staff B was observed wiping down the handrailing on the [LOCATION] utilizing a sanitizing wipe. They wiped approximately five (5) feet of the railing and then dropped the sanitizing wipe on the ground. They then picked up the sanitizing wipe and proceeded to continue to wipe down the handrail which ran the length of the hallway and was approximately 20 yards long. Maintenance Staff A was interviewed on 5/18/22 at 1:43 p.m. They said that all housekeeping staff had received training on how to properly sanitize and disinfect various areas of the facility. They said that high-touch surfaces, such as handrails, were sanitized twice a day. They said that for the length of the hallway on the second-floor unit, several sanitizing wipes should be used for sections of the handrailing. They said that a sanitizing wipe should be discarded if it falls on the floor. 2. On 5/18/22 at 10:12 a.m., observations of rooms [LOCATION] and [LOCATION] were conducted. Certified Nurse Aide K was observed in room [LOCATION] checking Resident #127's vital signs with an electronic vital sign machine. After checking the resident's blood pressure, the employee removed the blood pressure cuff from the resident's arm. They did not remove their gloves or wash their hands. They did not clean the vital sign machine, oxygen saturation probe, or blood pressure cuff. Certified Nurse Aide K then approached Resident #128 and placed the same blood pressure cuff on their left arm and attached the oxygen saturation probe to a finger on the resident's right hand. Certified Nurse Aide K was wearing the same gloves used to provide care to Resident #127. After obtaining Resident #128's vital signs, Certified Nurse Aide K placed the oxygen saturation probe and blood pressure cuff back into the basket attached to the vital sign machine. They did not clean either piece of equipment. The employee then removed their PPE, including their mask, and disposed of it in a biohazard bin at the foot of Resident #127's bed. Certified Nurse Aide K did not wash or sanitize their hands after removing their gloves. Certified Nurse Aide K then exited the room with the vital sign machine and rolled it to a medication cart at the nurse's station. Certified Nurse Aide K picked up a bottle of eye drops that had been left on the cart uncapped. They placed the

	cap on bottle of eyedrops and placed the bottle in a plastic bag which they stored in the medication cart. On 5/18/22 at 10:25 a.m., an interview was conducted with Certified Nurse Aide K. They explained that Resident #127 and Resident #128 were on transmission-based precautions for exposure to novel coronavirus (COVID-19). They added that exposure to COVID-19 required staff and visitors to follow strict droplet precautions. Certified Nurse Aide K acknowledged that they failed to clean the vital sign equipment, failed to change their gloves, and failed to wash their hands after providing care to Resident #127 and prior to providing care for Resident #128. On 5/19/22 at 9:33 a.m. an interview was conducted with Licensed Nurse C. They confirmed that Resident #127 and Resident #128 were on transmission-based precautions for exposure to COVID-19. When reviewing the observations of Certified Nurse Aide K, Licensed Nurse C explained that Certified Nurse Aide K should have cleaned the equipment with sanitizing wipes kept at the nurse's station, then removed their gloves, and washed their hands prior to providing care for Resident #128. The facility's policy, titled "Handwashing/Hand Hygiene," was reviewed. A revision date of August 2015 was noted. The policy statement read, "The facility considers hand hygiene the primary means to prevent the spread of infections." Bullet point seven (7) of the policy instructed staff to use an alcohol-based hand rub containing at least 62% alcohol before and after direct contact with residents, after contact with objects such as medical equipment, and after removing gloves. Bullet point eight (8) of the policy read, "Hand hygiene is the final step after removing and disposing of personal protective equipment."
§51.200(a) Life safety from fire The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Many	**<u>Smoke Barriers and Sprinklers</u>** 1. Based on observation and interview, the facility failed to install a sprinkler sign in accordance with the code. The deficient practice affected 14 of 17 smoke compartments, staff, and all residents. The facility had the capacity for 302 beds with a census of 191 on the day of survey. The findings include: Observation during the building inspection tour on 5/18/22 at 9:25 a.m. revealed a hydraulic design information sign for the hydraulically designed sprinkler system was not secured to the main sprinkler riser, as required by section 24.5 of NFPA 13, Standard for the Installation of Sprinkler Systems. An interview at that time with Maintenance Staff C revealed the facility was

not aware of the missing hydraulic design information sign and the sprinkler contractor did not inform the facility that the sign was missing.

The census of 191 was verified by Administrative Staff A on 5/17/2022. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff C during the exit interview on 5/20/22 at 4:00 p.m.

Actual NFPA Standard: NFPA 101, Life Safety Code (2012)
19.3.5 Extinguishment Requirements.
19.3.5.1 Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5.
9.7.1 Automatic Sprinklers.
9.7.1.1* Each automatic sprinkler system required by another section of this Code shall be in accordance with one of the following:
(1) NFPA 13, Standard for the Installation of Sprinkler Systems
Actual NFPA Standard: NFPA 13, Standard for the Installation of Sprinkler Systems (2010)
24.5 * Hydraulic Design Information Sign.
24.5.1 The installing contractor shall identify a hydraulically designed sprinkler system with a permanently marked weatherproof metal or rigid plastic sign secured with corrosion-resistant wire, chain, or other approved means. Such signs shall be placed at the alarm valve, dry pipe valve, preaction valve, or deluge valve supplying the corresponding hydraulically designed area.

2. Based on observation, record review, and interview, the facility failed to properly inspect, test, and maintain the automatic sprinkler systems in accordance with the code. The deficient practice affected 17 of 17 smoke compartments, staff, and all residents. The facility had a capacity for 302 beds with a census of 191 on the day of the survey.

The findings include:

Record review on 5/17/22 at 3:00 p.m. of the wet sprinkler systems inspection and testing quarterly reports dating back one (1) year prior to the survey revealed the quarterly inspection of the fire department connection was not performed as required by section 13.7.1 of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. An interview with Maintenance Staff C at that time

	revealed the facility was not aware that the sprinkler contractor did not inspect the fire department connections quarterly and would contact the sprinkler contractor to schedule an inspection. Records review on 5/17/22 at 3:10 p.m. of the annual wet sprinkler system inspection and testing report noted a deficiency that the five (5) year internal inspections of the alarm check valve and check valves were required to be inspected internally to verify that they were free of physical damage, as required by section 13.4.1.2 and 13.4.2.1 of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. An interview with Maintenance Staff C at that time revealed the facility was not aware of the requirement and would contact the sprinkler contractor to perform the inspections in accordance with NFPA 25. Observation during the building inspection tour on 5/18/22 at 11:49 a.m. of [LOCATION] revealed a painted sprinkler head located in the corridor ceiling at the entrance to [LOCATION]. From floor level, white paint was observed on the chrome sprinkler head's frame and glass bulb. The sprinkler head was not replaced as required by section 5.2.1.1.4 of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. An interview with Maintenance Staff C at that time revealed the facility was not aware of the painted sprinkler head and would contact the sprinkler contractor to replace the sprinkler head. The census of 191 was verified by Administrative Staff A on 5/17/22. The findings were acknowledged by the Administrative Staff C and verified by Maintenance Staff C during the exit interview on 5/20/22 at 4:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.5** Extinguishment Requirements. **19.3.5.1** Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. **9.7.5** Maintenance and Testing. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. **Actual NFPA Standard: NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011)** **5.2 * Inspection.** **5.2.1 Sprinklers.**

	5.2.1.1 * Sprinklers shall be inspected from the floor level annually. **5.2.1.1.1 *** Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). **5.2.1.1.2** Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer **5.2.1.1.3 *** Any sprinkler that has been installed in the incorrect orientation shall be replaced. **5.2.1.1.4** Any sprinkler shall be replaced that has signs of leakage; is painted, other than by the sprinkler manufacturer, corroded, damaged, or loaded; or is in the improper orientation. **13.1.1.2** Table 13.1.1.2 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. **13.4 System Valves.** **13.4.1 Inspection of Alarm Valves.** Alarm valves shall be inspected as described in 13.4.1.1 and 13.4.1.2. **13.4.1.2 *** Alarm valves and their associated strainers, filters, and restriction orifices shall be inspected internally every 5 years unless tests indicate a greater frequency is necessary. **13.4.1.3 Maintenance.** **13.4.1.3.1** Internal components shall be cleaned/repaired as necessary in accordance with the manufacturer's instructions. **13.4.1.3.2** The system shall be returned to service in accordance with the manufacturer's instructions. **13.4.2 Check Valves.** **13.4.2.1 Inspection.** Valves shall be inspected internally every 5 years to verify that all components operate correctly, move freely, and are in good condition. **13.4.2.2 Maintenance.** Internal components shall be cleaned, repaired, or replaced as necessary in accordance with the manufacturer's instructions. **13.7 Fire Department Connections.** **13.7.1** Fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged.

	(4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. **(8)** The fire department connection clapper(s) is in place and operating properly**.** **13.7.2** If fire department connection plugs or caps are not in place, the interior of the connection shall be inspected for obstructions, and it shall be verified that the fire department connection clapper is operational over its full range. **13.7.3** Components shall be repaired or replaced as necessary in accordance with the manufacturer's instructions. **13.7.4** Any obstructions that are present shall be removed. 3. Based on observation and interview, the facility failed to maintain the smoke barrier to resist the passage of smoke in accordance with the code. The deficient practice affected 10 of 17 smoke compartments, staff, and residents. The facility had the capacity for 302 beds with a census of 191 on the day of survey. The findings include: Observation during the building inspection tour on 5/18/22 at 1:58 p.m. of the smoke barrier above the lay-in ceiling tile at the cross-corridor doors of [LOCATION] revealed an unsealed, one (1) inch hole with a red fire alarm cable running through it, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code. An interview with Maintenance Staff C at that time revealed the facility was not aware of the unsealed penetration. Facilities staff installed fire stopping prior to replacing the ceiling tile. Observation during the building inspection tour on 5/19/22 at 10:05 a.m. of the smoke barrier above the lay-in ceiling tile at the cross-corridor doors by room [LOCATION] revealed an unsealed, four (4) inch conduit with a bundle of cables running through it, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code. An interview with Maintenance Staff C at that time revealed the facility was not aware of the unsealed penetration. Facilities staff installed fire stopping prior to replacing the ceiling tile. Observation during the building inspection tour on 5/19/2022 at 10:30 a.m. of the smoke barrier above the lay-in ceiling tile at the cross-corridor doors by room [LOCATION] revealed an

	unsealed, four (4) inch conduit with a bundle of cables and an unsealed one (1) inch conduit with a red cable running through it, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code. An interview with Maintenance Staff C at that time revealed the facility was not aware of the unsealed penetration. Facilities staff installed fire stopping prior to replacing the ceiling tile. Observation during the building inspection tour on 5/19/22 at 10:44 a.m. of the smoke barrier above the lay-in ceiling tile at the cross-corridor doors by room [LOCATION] revealed an unsealed, one (1) inch open conduit with no cables running through it, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code. An interview with Maintenance Staff C at that time revealed the facility was not aware of the unsealed penetration. Facilities staff installed fire stopping prior to replacing the ceiling tile. Observation during the building inspection tour on 5/19/22 at 10:54 a.m. of the smoke barrier above the lay-in ceiling tile at the cross-corridor doors at the entrance to [LOCATION] revealed an unsealed, two (2) inch open conduit with a bundle of cables running through it, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code. An interview with Maintenance Staff C at that time revealed the facility was not aware of the unsealed penetration. Facilities staff installed fire stopping prior to replacing the ceiling tile. The census of 191 was verified by Administrative Staff A on 5/17/22. The findings were acknowledged by Administrative Staff C and Maintenance Staff C during the exit interview on 5/20/22 at 4:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.7.3** Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1⁄2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2) *Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. **8.5 Smoke Barriers**. **8.5.6 Penetrations.**

	8.5.6.1 The provisions of 8.5.6 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations of smoke barriers. **8.5.6.2** Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. **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. 4. Based on record review and interview, the facility failed to document the inspection and testing of Patient Care Related Electrical Equipment (PCREE). The deficient practice affected 12 of 17 smoke compartments, staff, and all residents. The facility had a capacity for 302 beds with a census of 191 on the day of the survey. The findings include: Record review on 5/17/22 at 3:00 p.m. revealed there was no documentation for the testing of resistance, leakage current, and touch current for any of the electrical resident beds, as

	required by sections 10.5.2.1 of NFPA 99, Health Care Facilities Code. An interview with Maintenance Staff C at that time revealed the facility was not aware that resident beds were considered PCREE equipment and would make plan for testing of beds and update the PCREE policy. The census of 191 was verified by Administrative Staff A on 5/17/22. The findings were acknowledged by Administrative Staff C and Maintenance Staff C during the exit interview on 5/20/22 at 4:00 p.m. **Actual NFPA Standard: NFPA 99 Health Care Facilities Code (2012)** **10.3 Testing Requirements — Fixed and Portable.** **10.3.1* Physical Integrity.** The physical integrity of the power cord assembly composed of the power cord, attachment plug, and cord-strain relief shall be confirmed by visual inspection. **10.3.2* Resistance.** **10.3.2.1** For appliances that are used in the patient care vicinity, the resistance between the appliance chassis, or any exposed conductive surface of the appliance, and the ground pin of the attachment plug shall be less than 0.50 ohm under the following conditions: (1) The cord shall be flexed at its connection to the attachment plug or connector. (2) The cord shall be flexed at its connection to the strain relief on the chassis. **10.3.2.2** The requirement of 10.3.2.1 shall not apply to accessible metal parts that achieve separation from main parts by double insulation or metallic screening or that are unlikely to become energized (e.g., escutcheons or nameplates, small screws). **10.3.3* Leakage Current Tests.** **10.3.3.1 General.** **10.3.3.1.1** The requirements in 10.3.3.2 through 10.3.3.4 shall apply to all tests. **10.3.3.1.2** Tests shall be performed with the power switch ON and OFF. **10.3.3.2 Resistance Test.** The resistance tests of 10.3.3.3 shall be conducted before undertaking any leakage current measurements. **10.3.3.3* Techniques of Measurement.** The test shall not be made on the load side of an isolated power system or separable isolation transformer. **10.3.3.4* Leakage Current Limits**. The leakage current limits in 10.3.4 and 10.3.5 shall be followed. **10.3.4 Leakage Current — Fixed Equipment.**

	10.3.4.1 Permanently wired appliances in the patient care vicinity shall be tested prior to installation while the equipment is temporarily insulated from ground. **10.3.4.2** The leakage current flowing through the ground conductor of the power supply connection to ground of permanently wired appliances installed in general or critical care areas shall not exceed 10.0 mA (ac or dc) with all grounds lifted. **10.3.5 Touch Current — Portable Equipment.** **10.3.5.1* Touch Current Limits.** The touch current for cord connected equipment shall not exceed 100 µA with the ground wire intact (if a ground wire is provided) with normal polarity and shall not exceed 500 µA with the ground wire disconnected. **10.3.5.2** If multiple devices are connected together and one power cord supplies power, the leakage current shall be measured as an assembly. **10.3.5.3** When multiple devices are connected together and more than one power cord supplies power, the devices shall be separated into groups according to their power supply cord, and the leakage current shall be measured independently for each group as an assembly. **10.3.5.4 Touch Leakage Test Procedure.** Measurements shall be made using the circuit, as illustrated in Figure 10.3.5.4, with the appliance ground broken in two modes of appliance operation as follows: **(1)** Power plug connected normally with the appliance on **(2)** Power plug connected normally with the appliance off (if equipped with an on/off switch) **10.3.5.4.1** If the appliance has fixed redundant grounding (e.g., permanently fastened to the grounding system), the touch leakage current test shall be conducted with the redundant grounding intact. **10.3.5.4.2** Test shall be made with Switch A in Figure 10.3.5.4 closed. **10.3.6* Lead Leakage Current Tests and Limits — Portable Equipment.** **10.3.6.1** The leakage current between all patient leads connected together and ground shall be measured with the power plug connected normally and the device on. **10.3.6.2** An acceptable test configuration shall be as illustrated in Figure 10.3.5.4. **10.3.6.3** The leakage current shall not exceed 100 µA for ground wire closed and 500 µA ac for ground wire open. **10.5.2.1 Testing Intervals.** **10.5.2.1.1** The facility shall establish policies and protocols for the type of test and intervals of testing for patient care–related electrical equipment. **10.5.2.1.2** All patient care–related electrical equipment used in patient care rooms shall be tested in accordance with 10.3.5.4 or 10.3.6 before being put into service for the first time and after any

	repair or modification that might have compromised electrical safety. **10.5.2.5*** System Demonstration. Any system consisting of several electric appliances shall be demonstrated to comply with this code as a complete system. **10.5.3 Servicing and Maintenance of Equipment.** **10.5.3.1** The manufacturer of the appliance shall furnish documents containing at least a technical description, instructions for use, and a means of contacting the manufacturer. **10.5.3.1.1** The documents specified in 10.5.3.1 shall include the following, where applicable: **(1)** Illustrations that show the location of controls **(2)** Explanation of the function of each control **(3)** Illustrations of proper connection to the patient or other equipment, or both **(4)** Step-by-step procedures for testing and proper use of the appliance **(5)** Safety considerations in use and servicing of the appliance **(6)** Precautions to be taken if the appliance is used on a patient simultaneously with other electric appliances **(7)** Schematics, wiring diagrams, mechanical layouts, parts lists, and other pertinent data for the appliance **(8)** Instructions for cleaning, disinfection, or sterilization **(9)** Utility supply requirements (electrical, gas, ventilation, heating, cooling, and so forth) **(10)** Explanation of figures, symbols, and abbreviations on the appliance **(11)** Technical performance specifications **(12)** Instructions for unpacking, inspection, installation, adjustment, and alignment **(13)** Preventive and corrective maintenance and repair procedures **10.5.3.1.2** Service manuals, instructions, and procedures provided by the manufacturer shall be considered in the development of a program for maintenance of equipment. **10.5.6 Record Keeping — Patient Care Appliances.** **10.5.6.1 Instruction Manuals.** **10.5.6.1.1** A permanent file of instruction and maintenance manuals shall be maintained and be accessible. **10.5.6.1.2** The file of manuals shall be in the custody of the engineering group responsible for the maintenance of the appliance. **10.5.6.1.3** Duplicate instruction and maintenance manuals shall be available to the user. 10.5.6.1.4 Any safety labels and condensed operating instructions on an appliance shall be maintained in legible condition. **10.5.6.2* Documentation.**

	10.5.6.2.1 A record shall be maintained of the tests required by this chapter and associated repairs or modifications. **10.5.6.2.2** At a minimum, the record shall contain all of the following: **(1)** Date **(2)** Unique identification of the equipment tested **(3)** Indication of which items have met or have failed to meet the performance requirements of 10.5.6.2 **10.5.6.3 Test Logs**. A log of test results and repairs shall be maintained and kept for a period of time in accordance with a health care facility's record retention policy. **10.5.8 Qualification and Training of Personnel.** **10.5.8.1*** Personnel concerned for the application or maintenance of electric appliances shall be trained on the risks associated with their use. **10.5.8.1.1** The health care facilities shall provide programs of continuing education for its personnel. **10.5.8.1.2** Continuing education programs shall include periodic review of manufacturers' safety guidelines and usage requirements for electrosurgical units and similar appliances. **10.5.8.2** Personnel involved in the use of energy-delivering devices including, but not limited to, electrosurgical, surgical laser, and fiberoptic devices shall receive periodic training in fire suppression. **10.5.8.3** Equipment shall be serviced by qualified personnel only.
§51.210(h) Use of outside services 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	Based on document review and interview, the facility failed to have a Sharing Agreement for the services of a psychiatrist. The findings include: Review of the list of residents who received Mental Health services outside of the facility revealed the names of eight (8) residents. An interview with Administrative Staff A on 5/17/22 at approximately 9:30 a.m. revealed the facility did not have a Sharing Agreement with the VA for Mental Health services.

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	