Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Oklahoma Veterans Center - Claremore

Location: 3001 W Blue Starr Drive, Claremore, OK 74018

Onsite / Virtual: Onsite

Dates of Survey: 12/6/22 – 12/9/22

NH / DOM / ADHC: NH

Survey Class: For Cause

Total Available Beds: 302

Census on First Day of Survey: 211

VA Regulation Deficiency	Findings
	Initial Comments: A VA For Cause Survey was conducted from December 6, 2022 through December 9, 2022 at the Oklahoma Veterans Center - Claremore. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.43(a) (1)-(2) Drugs and medicines for certain veterans (a) In addition to the per diem payments under §51.40 of this part, the Secretary will furnish drugs and medicines to a State home as may be ordered by prescription of a duly licensed physician as specific therapy in the treatment of illness or injury for a veteran receiving nursing home care in a State home if— (1) The veteran: (i) Has a singular or combined rating of less than 50 percent based on one or more service-connected disabilities and	The facility was unable to demonstrate they received only drugs and medicines for Residents who were eligible to receive such medications. Based on record review, three (3) of eight (8) sampled Residents were ineligible to have all medications furnished by the VA but were receiving all medications from the VA Medical Center (VAMC) of jurisdiction. One (1) of the eight (8) sampled residents was eligible to receive medications only for those service-connected disabilities that were at a singular or combined rating of less than 50 percent. Two (2) of eight (8) had no eligibility to receive medications. The facility did not reimburse the VAMC of jurisdiction for medications received while the Residents did not have eligibility. In interview with Administrative Staff A, Administrative Staff B, and Consultant Staff A, it was identified that the facility failed to establish a mechanism to ensure only eligible Residents received medications from the VAMC of jurisdiction.

needs the drugs and medicines for a service-connected disability; and (ii) Needs nursing home care for reasons that do not include care for a VA adjudicated service-connected disability; or (2) The veteran: (i) Has a singular or combined rating of 50 or 60 percent based on one or more service-connected disabilities and needs the drugs and medicines; and (ii) Needs nursing home care for reasons that do not include care for a VA adjudicated service-connected disability. Level of Harm – No Actual Harm, with potential for minimal harm **Residents Affected** - Many	
§ 51.70 (c) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on record review and interview, the facility failed to conduct a timely final accounting upon the death of a resident with funds deposited in a trust account for two (2) of five (5) sampled accounts. The findings include: Review of facility records for residents who had expired with trust fund accounts revealed final disbursements had not occurred for two (2) residents who expired with accounts on [DATE], and [DATE], respectively. In an interview, on 12/9/22, at 11:50 a.m., Administrative Staff C confirmed the conveyance of funds had not been done because they were still learning the process.
§ 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	Based on record review and staff interview, the facility failed to provide evidence that a surety bond, or other assurance, was secured for the security of all personal funds of residents deposited with the facility. This affected all residents whose funds were managed by the facility. The findings include:

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	Review of a document provided by the facility for verification of a surety bond revealed that the facility held a Certificate of Liability Insurance and not a Surety Bond. During the Daily Debrief, on12/6/22, at 4:00 p.m., it was confirmed with Administrative Staff A that the document was not a Surety Bond and that the facility had not been granted approval by the Under Secretary of Health for the Veterans Administration to maintain an alternate form of protection for the residents' personal fund accounts.
§ 51.70 (f) (1) – (2) Grievances. A resident has the right to— (1) Voice grievances without discrimination or reprisal. Residents may voice grievances with respect to treatment received and not received; and (2) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on interview, observations, record review, and review of the facility's policies, the facility failed to make prompt efforts to resolve a grievance filed by one (1) of 24 sampled residents (Resident #7) regarding food temperatures at the point of service. The findings include: The facility policy titled, "Resident Grievance," (Policy Number 615.0 with a publish date of 11/14/18), stated: "Purpose: Every resident shall have the right to file formal grievances which are addressed promptly by the facility to resolve grievances. "Definitions: *GRIEVANCE*: a grievance is any written or verbal concern by a resident, relative or any other representative relating to resident care or quality of services provided. A grievance may include, but is not limited to … Quality of food provided." During an interview, at 11:11 a.m., on 12/6/22, Resident #7 (who resided on [LOCATION] of the facility) voiced complaints about the food, stating: "Food sucks. … The fried eggs are made in advance and are wrapped in plastic when served. They are hard when we get them – taste more like boiled eggs. They're supposed to be over easy." Resident #7 also stated, "It doesn't do any good to go to [Administrative Staff A]." In a follow-up interview, at 10:07 a.m., on 12/9/22, Resident #7 stated, "The food is cold. … The cabinets [food carts] the food comes in are open. The cabinets don't have doors on them and don't keep the food warm. I've told people about it, but they don't care. [Location] is the furthest from the [LOCATION] – they should be using cabinets with doors for our food to keep it warm." Record review revealed Resident #7 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease and

	Essential Tremors. Review of the resident's most recent Minimum Data Set assessment (MDS), with an Assessment Reference Date (ARD) of [DATE], found the Brief Interview for Mental Status (BIMS) was scored 13 out of 15, indicating Resident #7 was cognitively intact. A request was made for all grievances filed by, or on behalf of, residents in [DATE]. Review of the grievance binder found a Grievance/Complaint Report, dated [DATE], that had been filed by Resident #7. In the section of the form titled "Receipt of Grievance/Complaint," a description of the concern stated: "When I was admitted here in [DATE] the grill was open until 6pm, which allows veterans to have a meal choice, but now it is closed early or not open at all. Before it was open for two hours each meal. Some of the food we are not able to tell what it is. Food is cold. Eggs made ahead of time, but are still cooking in warmer and hard. The grill must stay open." In the section of the form titled, "Documentation of Facility Follow-Up," notations indicated the individuals designated to take action on this resident's concerns regarding food were Dietary Staff A and Administrative Staff D. "Date assigned" was [DATE], and "Date to be resolved by" was [DATE]. Further notations in this section stated: "[Administrative Staff D] explained that the grill is open as much as possible but sometimes has to close due to staffing. [Resident #7] advised that [they] got a burnt sandwich did not ask for it to be sent back. [sic] See back." Review of additional notations on the reverse side of the form found discussion about the preparation of eggs and menu planning. The notations also indicated staff from the Dietary Department also spoke with the resident about "the Staffing and grill usage," as well as Resident #7's food preference and an agreement by Dietary Staff A to prepare the resident's eggs "at service time to ensure tit wasn't over cooked [sic]." In the section of the form titled "Resolution of Grievance/Complaint," the grievance was marked as having been resolved, and notations stated, "See back. Most food issues were resolved with [Dietary Staff A]. The grill usage issues can't be completely resolved. Dietary staff open it when they can." There were no notations on either side of this form to indicate that the facility had addressed Resident #7's complaint about the food being cold.

	An observation of the lunch meal dining service occurred at 11:00 a.m., on 12/7/22, with Dietary Staff A. A test tray was requested to be sent on the cart to the [LOCATION], which was farthest from the [LOCATION]. The test tray left the [LOCATION] at 11:50 a.m. The cart the trays were on was open, without any enclosures or doors. The food was served in Styrofoam containers. When the open cart reached the third floor, two (2) Certified Nurse Aides began passing out the trays to the residents. It took approximately 30 minutes to pass the trays to the residents. At 12:21 p.m., the temperatures of the hot food items on the test tray were measured as follows: - Lima beans - 123.8 degrees Fahrenheit (F) - Mixed vegetables - 130 degrees F - Chicken - 113 degrees F On 12/7/22, at 12:25 p.m., Dietary Staff A stated that, although the facility did not have a policy, hot foods should be 130 degrees F when it reached the resident. Dietary Staff A also acknowledged that the food temperatures at the point of delivery might be better if more people helped pass out the trays, and if the food were transported in an enclosed or heated cart.
§ 51.100 (a) Dignity. (a) Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on resident interview, observations, and staff interview, the facility failed to enhance the dignity of one (1) of 24 sampled residents (Resident #6), by serving meals in disposable containers with plastic flatware contrary to the resident's wishes. The findings include: During an interview, on 12/6/22, at 11:45 a.m., Resident #6 stated, "The food is always cold. … It's always served on Styrofoam. … I asked them to send my breakfast up on regular plates, but they won't do it." When asked if they had reported this concern to anyone, they stated, "I told [Consultant Staff B], my social worker when I was on [LOCATION]]." Resident #6 also stated, "I have asked someone to come up here, but they don't come. They said they came when I was asleep." During this interview, staff announced the arrival of the food cart containing lunch for the residents on the [LOCATION]. Observation of the food cart, at 11:52 a.m., on 12/6/22, found a two-tiered open cart with hinged Styrofoam containers on both shelves stacked two (2) to three (3) containers high, as well as smaller, clear plastic containers on a tray on the bottom shelf, each containing a dessert item. Each hinged Styrofoam container had a resident's tray ticket taped across the top of it. Record review revealed Resident #6 was initially admitted to the facility on [DATE], with diagnoses including Crohn's Disease and the presence of a Colostomy. Review of the resident's most

	recent Minimum Data Set assessment (MDS), with an Assessment Reference Date (ARD) of [DATE], found the Brief Interview for Mental Status was scored 15 out of 15, indicating Resident #6 was cognitively intact. During a follow-up interview, on 12/9/22, at 9:36 a.m., when asked how long they had been receiving meals served in Styrofoam containers, Resident #6 stated, "Almost since I got here. I got here the [DATE]. Pretty much all the time." Observation found regular eating utensils on the resident's overbed table. When asked if the facility had provided them with these utensils, Resident #6 replied in the negative, stating that they had their spouse bring them from home, "since they only give us plastic." Resident #6 reported meals served on regular plates with regular utensils was important to them, and noted, "I like my breakfast foods all on one (1) plate – not in separate containers like they sent this morning." In an interview, on 12/7/22, at 11:15 a.m., Dietary Staff A stated the [LOCATION] had been short staffed for the past six (6) months and was down nine (9) positions. Dietary Staff A stated the facility used a lot of disposables due to a lack of staff.
§ 51.110 (c) Accuracy of assessments. (1) Coordination— (i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals. (ii) Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment. (2) Certification. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on staff interview and record review, the facility failed to ensure the accuracy of assessments for one (1) of 24 sampled residents who received dialysis (Resident #5). The findings include: Record review revealed Resident #5 was initially admitted to the facility on [DATE], with diagnoses including Diabetes Mellitus and Chronic Kidney Disease. Since admission, Resident #5 had multiple acute transfers to the hospital, with the most recent transfer having occurred on [DATE]. Resident #5 subsequently returned to the facility on [DATE]. Further record review revealed an order, dated [DATE], that stated: "Schedule Visits to Dialysis Center and Coordinate care accordingly. Dialysis Monday, Wednesday, Friday @ 0515 Sandwich and Sugar free snack and drink to be sent with resident." [sic] Review of documents uploaded into Resident #5's electronic health record revealed they were admitted to the local dialysis center on an outpatient basis on [DATE]. Review of the resident's most recent Minimum Data Set assessment (MDS), with an Assessment Reference Date (ARD) of [DATE], found "Item O0100J, Dialysis" was not marked to indicate Resident #5 had received dialysis either "While NOT a Resident" (e.g., during the most recent hospital stay), or "While

	a Resident" (e.g., upon returning to the facility after the hospital stay). In an interview, on 12/7/22, at 2:52 p.m., Administrative Nurse A reported Resident #5 started receiving dialysis while in the hospital in [DATE] and continued to receive dialysis on an outpatient basis after returning to the facility. Administrative Nurse A confirmed that "Item O0100J, Dialysis" on the [DATE], MDS was not marked to reflect this.
§ 51.120 (a) (4) Reporting of Sentinel Events The facility management must establish a mechanism to review and analyze a sentinel event resulting in a written report no later than 10 working days following the event. The purpose of the review and analysis of a sentinel event is to prevent injuries to residents, visitors, and personnel, and to manage those injuries that do occur and to minimize the negative consequences to the injured individuals and facility. **Level of Harm – No Actual Harm, with potential for more than minimal harm** **Residents Affected** – Few	Based on record review and staff interview, the facility failed to provide a written report to the Director of the VA Medical Center (VAMC), containing review and analysis of sentinel events involving Resident #35 and Resident #36, no later than 10 working days following the event. This occurred for two (2) of three (3) sentinel events reviewed. The findings include: On the morning of 12/8/22, in response to a request for the written reports for all sentinel events occurring since the last annual survey (which had an exit date of 5/20/22), Administrative Staff E provided documentation of three (3) sentinel events. Review of this documentation found two (2) of three (3) sentinel events did not include a written report containing a review or analysis of each event. 1. Review of the sentinel event involving Resident #35 revealed this resident was observed in the [LOCATION] by staff at 6:20 p.m., on [DATE]. The resident began to walk independently away from their wheelchair and when their gait became unsteady, they lost their balance, and the resident fell to the floor. A nursing assessment conducted at the time of the incident found no apparent injuries, and Resident #35 was assisted back into the wheelchair. At 9:23 p.m., on [DATE], the Administrative Nurse B was notified that Resident #35 was experiencing pain while in bed. The provider was notified and ordered that Resident #35 be sent to the emergency room for further evaluation. At 11:56 p.m., on [DATE], Resident #35 returned to the facility with medication orders to treat pain. The resident verbalized pain when being transferred back into their bed upon returning from the hospital. Documentation from the hospital noted that x-rays of the resident's hips and right shoulder were negative. On [DATE], Resident #35 continued to verbalize pain, and the medical provider adjusted the resident's pain medication. The

	medication change was not effective, and at 12:30 p.m., the resident was sent back out to the hospital for further evaluation. The resident returned to the facility at 10:30 p.m., with identification of a right femur fracture and an orthopedic consult that did not recommend surgery. The resident was placed on comfort care. The facility reported the fall with fracture to VAMC at 11:19 a.m., on [DATE], and a Communication Result Report indicated the fax was successfully transmitted to the VAMC. The resident subsequently expired on [DATE], with cause of death attributed to end-stage dementia. The facility submitted a VHA Issue Brief to VAMC at 2:20 p.m., on [DATE], and a Communication Result Report indicated the fax was successfully transmitted to the VAMC. The VHA Issue Brief contained a chronology of the event beginning with the fall and ending with the resident's death. The chronology did not contain an analysis of the causal and/or contributing factors leading up to the fall. In an interview, at 11:28 a.m., on 12/8/22, Administrative Staff D was asked for any additional information provided by the facility to the VAMC of an analysis of the incident. At 11:49 a.m., on 12/8/22, Administrative Staff D reported there was no further information to the VAMC on this incident. They also reported being unaware that an analysis was necessary. 2. Review of the sentinel event involving Resident #36 revealed this resident sustained an unwitnessed fall while walking in the hallway at 8:20 p.m., on [DATE], striking their head. The resident was transferred to the local hospital for evaluation. On [DATE], the hospital notified the facility that Resident #36 had been air flighted to a trauma facility with parietal and occipital fractures, bilateral subdural hematomas, and subarachnoid hemorrhaging. The facility faxed initial notification of the event to the VAMC at 8:38 a.m., on [DATE], and a Communication Result Report indicated the fax was successfully transmitted to the VAMC. The resident was admitted to the trauma facility's intensive care unit. On [DATE], the family informed the facility that Resident #36 had expired. The facility submitted a VHA Issue Brief to VAMC at 11:23 a.m., on [DATE], and a Communication Result Report indicated the fax was successfully transmitted to the VAMC. The VHA Issue Brief contained a chronology of the event beginning with the fall

	and ending with the resident's death. The chronology did not contain an analysis of the causal and/or contributing factors leading up to the fall. In an interview, at 10:22 a.m., on 12/8/22, Administrative Staff E was asked if there was any additional information that provided an analysis of the fall itself. Administrative Staff E said they would have to check the incident report that was entered into the facility's electronic recordkeeping system, Point Click Care (PCC). When asked if this analysis would have been sent to the VAMC, Administrative Staff E stated, "That's a good question." In an interview at 10:35 a.m., on 12/8/22, Administrative Staff E provided a copy of the incident report from PCC, identifying predisposing environmental, physiological, and situation factors, and containing a description of the video recording of the fall itself. There was no apparent precipitating event, as it appeared the resident experienced a sudden loss of balance while walking in the hallway. Administrative Staff E agreed this information was not included in the VHA Issue Brief that had been faxed to the VAMC.
§ 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 – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on interview, record review, and policy review, it was determined that the facility failed to ensure appropriate supervision was maintained to prevent an elopement for one (1) of 24 sampled members (Resident #17). The findings include: The facility policy, "Wandering, Unsafe Resident," revised August 2014, documented: "The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement." Policy Interpretation and Implementation, documented: 1. Staff will identify residents who are at risk for harm because of unsafe wandering (including elopement) 2. The Staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering. 3. The resident's care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring plan will be included. 5. When the resident returns to the facility, the Director of Nursing or Charge Nurse shall: "F. Document relevant information in the resident's medical record." Resident #17 was admitted to the facility on [DATE], with diagnoses including: Personal History of Traumatic Brain Injury, Anxiety Disorder, Quadriplegia, Chronic Pain, and Diabetes.

	On [DATE], it was discovered the resident had been sent to the hospital with a fever. The resident remained in the hospital for the remainder of the survey. The Quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental status (BIMS) which coded the resident as having moderate cognitive impairment with daily ADL's. The MDS also coded the resident as having no wandering behaviors. The resident was coded as using an electric wheelchair for ambulation. The Annual MDS, dated [DATE], coded the resident as having a BIMS score of 11, indicating moderate cognitive impairment. The resident was also coded as having no behaviors and no wandering. The resident was again coded as using an electric wheelchair for ambulation. Review of an "Incident Report," dated [DATE], revealed Resident #17 had eloped on [DATE]. The report documented that Administrative Nurse B was notified that the resident was in the middle of the road, outside. The resident was assisted back into the building and back into bed. When asked what the resident was doing, they stated, "I was trying to straighten something out." No injuries were noted. Resident Representative and Consultant Staff C were notified. Interventions documented to be put in place were hourly rounding on resident to ensure safety. Review of the "Wandering Risk Scale,"" dated [DATE], coded Resident #17 as an elopement risk of eight (8), which was considered low risk. The report indicated the resident had no history of wandering and had no episodes of wandering in the past three (3) months. The "Wandering Risk Scale," dated [DATE], coded the resident at a 12, which was considered high risk. The report indicated the resident had wandered in the nursing home without leaving the grounds, had a history of wandering, and had wandered in the past three (3) months. The most recent "Wandering Risk Scale," dated [DATE], coded the resident with a score of 10, which indicated a risk to wander. The report indicated the resident had a history of wandering, but did not wander in the past three (3) months. Review of Resident #17's Care Plan revealed wandering and/or elopement risk had not been added as a potential care deficit after the actual elopement on [DATE]. The intervention of nursing staff implementing hourly safety rounds was not included on the Care Plan until [DATE]. The resident was Care Planned for acute infections of the urinary tract. An interview was conducted, on 12/7/22, at 2:00 p.m., with Administrative Nurse C, who stated they would look for the documentation for the hourly checks. They stated the resident eloped only one time and they normally didn't leave their room.

	They mentioned that the resident was being treated for a Urinary Tract Infection (UTI) at the time and they were acting differently than usual. On 12/8/22, at 1:30 p.m., in an interview with Administrative Nurse C, they stated they had an orange vest that was placed on wheelchairs for residents who wander, but couldn't remember when it was placed on Resident #17's chair. They also acknowledged that the Care Plan should have been updated at the time of the incident to reflect the measures put in place, and had been added to the infections/UTI plan.
§ 51.140 (d) Food. Each resident receives and the facility provides— (1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (2) Food that is palatable, attractive, and at the proper temperature; (3) Food prepared in a form designed to meet individual needs; and (4) Substitutes offered of similar nutritive value to residents. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on observation, interview, and record review, it was determined the facility failed to ensure foods served were palatable and at appropriate temperatures to accommodate residents' preferences. The facility was aware residents were not satisfied with food quality, consistency, and temperatures, however, failed to address the residents' concerns. This had the potential to affect all residents who consumed meals served from the [LOCATION]. The findings include: 1. During the initial tour, on 12/6/22, the following residents verbalized a concern with the quality of the food and food temperatures: Resident #21, at 10:45 a.m., stated, "The food is usually cold. They usually have a 'one pot meal' made of leftovers. I've told people, they don't listen." Resident #31, at 10:55 a.m., stated, "The food on the weekends is not good. It appears to be sparse." Resident #32, at 11:00 a.m., stated, "The food isn't always warm enough, but its ok." Resident #33, at 11:06 a.m., stated "They serve lunch for dinner and dinner for lunch." They explained that they get soup and sandwiches for dinner, which they didn't like. "There is no choice for dinner because they shut down the grill." Resident # 7, at 11:11 a.m., stated, "Food sucks! The fried eggs are made in advance and are wrapped in plastic when served. They are hard when we get them. The grill is shut down because of no staff in the [LOCATION]. It doesn't do any good to go to [Administrative Staff A]." Resident #6, at 11:45 a.m., stated, "The food is always cold. It's always served on Styrofoam and has been since I got here." The resident stated they told the consultant staff.

	Resident #1, at 2:42 p.m., stated," The food quality and menus planning are poor." Resident #37 stated the surveyor needed to check out the food. They stated they order out often, but that some can't afford to. They stated they went to the Resident Council meeting, and it had been brought up. The stated they were served chopped up meat with crackers for dinner this past weekend. The residents made the following comments regarding the food on 12/8/22: Resident #5, at 12:47 p.m., stated "Food is cold. They always have the grill shut down, so there are no food choices if you don't like what is served." Resident #24, at 3:00 p.m., stated the lunch meal was "too terrible to eat," and could not identify what was served. They stated a nurse ordered them a ham sandwich as an alternative. The residents made the following comments regarding food on 12/9/22: Resident #4, at 9:52 a.m., stated: "They have the [LOCATION] staffed too short. I don't eat up here on the unit anymore, the food was always cold and late. Even when they serve it in the [LOCATION], the food isn't hot. I'm a picky eater, but I don't eat off the grill anymore. When they do use the grill, the food is not completely cooked." Resident #7, at 10:07 a.m., stated: "The food is cold. The cabinets (food carts) the food comes in is always open. The cabinets don't have doors on them and don't keep the food warm. I've told people about it, but they don't care. The [LOCATION] is the furthest from the [LOCATION]-they should be using cabinets with doors for our food to keep warm." Resident #21, at 9:36 a.m., stated, "We had mush last night. They need a cookbook on how to cook." Resident #32, at 9:30 a.m., stated, "The food is not always on schedule." 2. Review of the Resident Council meeting minutes revealed residents had made the facility aware of the many food concerns during each 2022 monthly council meeting. There had been no resolution regarding the many reported concerns, and residents continued to voice food complaints during the survey dates. Examples of Resident Council reported concerns included:

	A “Resident Council Resolution Form,” dated March, 2022 documented that two (2) residents were getting their orders wrong from the [LOCATION]. The “Department Resolution,” dated 4/14/22, documented that the dietary staff had been in-serviced on the importance of taking orders properly and serving food the way the residents wanted it. It was also documented that the Dietary department was working diligently to get more staff, “so no one feels like they are waiting too long.” A “Resident Council Resolution Form,” dated May, 2022, documented, “Residents stated they don’t like the hot dogs, they suspect they are turkey dogs.” The Department Resolution, dated 5/27/22, documented by Dietary Staff A, noted: “I have already changed the hot dog order to all beef ones. I have two cases in stock.” A menu survey was sent to all the residents at that time. Resident Council meeting minutes, dated 10/26/22, documented “concerns about food not being edible” as new business. 3. An observation of the lunch meal dining service occurred, with Dietary Staff A, on 12/7/22, at 11:00 a.m. A test tray was requested to be sent on the cart to the [LOCATION], which was farthest from the [LOCATION]. The test tray left the [LOCATION] at 11:50 a.m. The cart the trays were on was open, without any enclosures or doors. The food was served in Styrofoam containers. When the open cart reached the residents’ unit, there were two Certified Nurse Aides who were passing out the trays to the residents. It took approximately thirty minutes to pass the trays to the residents. At 12:21 p.m., the test tray temperatures were the following: lima beans 123.8 degrees, mixed vegetables were 130 degrees, chicken was 113 degrees. On 12/7/22, at 12:25 p.m., Dietary Staff A stated that, although they don’t have a policy, the food should be 130 degrees when it reached the resident. They also stated that if more people passed out the trays, the temperatures of the food might be better, and that an enclosed cart or heated cart would be better to transport the food in. 4. On 12/7/22, at 11:15 a.m., in an interview with Dietary Staff A, they stated the [LOCATION] was short staffed for the past six (6) months. They stated they were down nine (9) positions. They mentioned they used to serve from a steamtable on the [LOCATIONS], and the residents missed that. After they lost staff, they were not able to do that. They stated they use a lot of disposables due to lack of staff. They mentioned they were taking pictures of the food before they sent it up due to complaints about not giving correct portions.

	On 12/9/22, at 10:00 a.m., in an interview with Dietary Staff A, they stated that they and the Dietary Staff B would often update the resident's food preferences when they had food complaints. They stated Dietary Staff C is involved in the menu planning and that the menus are changed based on food preferences. They acknowledged that the grill sometimes had to be closed due to not having enough staff, but the residents could make requests of what they wanted. Dietary Staff A stated that they were aware that the residents verbalized a lot of frustration when the grill was closed. They also mentioned that Administrative Staff A and Administrative Staff D have helped out in the [LOCATION] along with Administrative Staff members. On 12/9/22, at 10:15 a.m., in an interview with Administrative Staff A, they acknowledged the [LOCATION] had been short staffed for a while. They stated they were going to speak to their supervisor next week to halt admissions until they could better staff the [LOCATION]. They mentioned that they help out sometimes. Dietary Staff A told them about the food complaints. They stated they usually send out a survey annually which includes food; they didn't receive many food complaints at that time. They stated they tried to get a staffing agency and they didn't have any staff. They acknowledged the food complaints were a concern. On 12/9/22, at 2:25 p.m., in an interview with Consultant Staff B, they stated that they spoke to Resident #21 and were aware of their food complaints. They stated they asked the resident what they would prefer, and they would pass it on to dietary. Consultant Staff B stated that since April the resident hasn't liked the food. Consultant Staff B stated they didn't think they were happy being there. They stated they thought the resident ate the food. They stated that if people complained a lot about an issue, they were encouraged to fill out a formal grievance. Although the facility was aware of residents being unhappy with the food, the facility was not able to correct the situation.
§ 51.190 (a) Infection control program. 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	Based on observation, staff interviews, and record review, the facility failed to ensure that proper disinfection of glucometers was performed by one (1) of three (3) staff observed for blood glucose checks. The findings include: Review of the policy and procedure titled, "Blood Sampling-Capillary (Finger Sticks) dated 2001, revised 2014, revealed General Guidelines: "1. Always ensure the blood glucose meters intended for reuse are cleaned and disinfected between

it— (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	resident uses. Steps in the Procedure 3. Place blood glucose monitoring device on clean field." Review of the un-dated in-service training titled, "Rosie glucometer: Caring for your meter," it was noted to: "Wash and dry your hands thoroughly before use or handling of the meter or strips. How to clean and disinfect the meter? The meter must be cleaned prior to the disinfection. Use one disinfecting wipe to clean exposed surfaces of the meter thoroughly and remove any visible dirt, blood or any other body fluid with the wipe. Use a second wipe to disinfect the meter. Do NOT use organic solvents to clean the meter. Disinfecting Procedure: 1. Put on non-sterile gloves. 2. Take out one disinfecting wipe from the package and squeeze out any excess liquid in order to prevent damage to the meter. 3. Wipe all exterior surface of the meter including the display and buttons. Hold the meter with the test strip slot pointing down and wipe the area around the test slot, be careful not to allow excess liquid to get inside. Keep the meter moist with disinfection solution contained in the wipe for a minimum of two minutes. Follow the instructions on the package of disinfecting wipe. Use two or more wipes if necessary." Observation with Licensed Nurse A, on 12/9/22, beginning at 10:57 a.m., for Resident #29 revealed Licensed Nurse A cleaned the glucometer with an alcohol wipe then placed the glucometer back onto the treatment cart. Licensed Nurse A left the treatment cart to check the computer and placed the glucometer and bottle of blood glucose test strips in their pocket. Licensed Nurse A did not sanitize their hands and did not wear gloves. Licensed Nurse A entered the resident's room at 11:01 a.m. and placed the supplies and glucometer on the resident's bed, without a barrier, then sanitized their hands and donned gloves. The resident's finger was cleaned with an alcohol swab and a finger stick was completed. At 11:10 a.m., Licensed Nurse A cleaned the glucometer with an alcohol wipe and returned it to the treatment cart. Licensed Nurse A proceeded to Resident #30's room, set the glucometer and supplies on the overbed table, without a barrier, sanitized their hands then donned gloves. Licensed Nurse A cleaned the resident's finger with an alcohol wipe and proceeded to use a lancet to stick the resident's finger. An interview with Licensed Nurse A, on 12/9/22, at 11:45 a.m., revealed that they did perform blood glucose checks on a regular basis. Licensed Nurse A could not remember if they had received training specific to blood glucose checks and always used alcohol wipes to clean the glucometer. Licensed Nurse A was not aware of barrier sheets to be used for use with supplies, although was able to find the box of barriers in the treatment cart. Certified Medication Aide A was beside Licensed

	Nurse A during the conversation and stated that they were not aware of barriers for use during blood glucose checks. An interview with Administrative Nurse C, on 12/9/22, at 11:55 a.m., revealed that the facility had a policy and procedure for glucometer blood glucose checks and would provide them. Administrative Nurse C confirmed that supplies should never be placed in a pocket, and that the use of alcohol for cleaning the glucometer was not acceptable. An interview with Administrative Nurse D, on 12/9/22, at 12:18 a.m., revealed that twenty residents on [LOCATION] received finger stick blood glucose checks and no residents were diagnosed with a blood borne pathogen. An interview, on 12/9/22, at 12:38 a.m., with Licensed Nurse B revealed that in-services for Licensed Nurse A, related to finger stick blood glucose checks, were not found and they could not provide evidence of completion. They confirmed that Licensed Nurse A had started working for the facility in [DATE].
§ 51.200(a) Life safety from fire (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	**Electrical Systems** Based on observation and interview, the facility failed to complete the Patient Care Related Electrical Equipment (PCREE) testing of all in-service bio medical equipment as required by the code. The deficient practice affected one (1) of 11 smoke compartments, staff, and 40 residents. The facility had a capacity for 302 beds with a census of 211 on the day of the survey. The findings include: Observation during the tour of the facility, on 12/9/22, from 9:00 a.m., to 11:30 a.m., revealed three (3) Plum A+ IV pumps located in the [LOCATION] with inspection stickers showing each had last been inspected on 2/5/2020. Additional observations, on 12/9/22, from 9:00 a.m., to 11:30 a.m., of the stickers on all other PCREE in the facility revealed the facility inspects the PCREE annually. The three (3) Plum A+ IV pumps located, in the [LOCATION], were not inspected at intervals established by the facility, as required by section 10.5.2.1.1 of NFPA 99, Health Care Facilities Code. An interview, on 12/9/22, at 9:15 a.m., with Maintenance Staff A revealed the facility's bio medical vendor had overlooked the three (3) IV pumps on the [LOCATION] and would get them inspected as soon as possible to be in compliance with the code.

	The census of 211 was verified by Administrative Staff A on 12/8/22. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 12/9/22. **Actual NFPA Standard: NFPA 99 Health Care Facilities Code (2012)** **3.3.137 Patient-Care-Related Electrical Equipment.** Electrical equipment appliance that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care vicinity. **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 resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section. (2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. (3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine	Based on record review and interview, the facility's management failed to obtain a written agreement with a dental provider for residents as required to assure availability of dental services for 211 of 211 residents, and a sharing agreement that governed mental health services provided to 19 residents by the Veterans Administration Medical Center (VAMC). The findings included: Review of facility contracts and agreements revealed there was no written agreement with a dental provider for dental services for the residents. Review of Administrative documents provided by the facility did not identify a sharing agreement with the Veterans Administration Medical Center (VAMC) to cover residents receiving mental health services. During the exit debrief, on 12/6/22, at 4:00 p.m., Administrative Staff A provided hard copies of emails confirming the lack of an approved sharing agreement with the VAMC. In an interview, on 12/9/22, at 12:30 p.m., Administrative Staff A stated they had a provider who came to the facility once a year for preventative services only. They did not have an agreement for as-needed dental services for the residents.

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	
§ 51.210 (j) Credentialing and Privileging. Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care practitioner, which may include physicians, podiatrists, dentists, psychologists, physician assistants, nurse practitioners, licensed nurses to provide patient care services in or for a health care organization. Privileging is the process whereby a specific scope and content of patient care services are authorized for a health care practitioner by the facility management, based on evaluation of the individual's credentials and performance. (1) The facility management must uniformly apply credentialing criteria to licensed practitioners applying to provide resident care or treatment under the facility's care. (2) The facility management must verify and uniformly apply the following core criteria: current licensure; current certification, if applicable, relevant education, training, and experience; current competence; and a statement that the individual is able to perform the services he or she is applying to provide. (3) The facility management must decide whether to authorize the independent practitioner to provide resident care or treatment, and each credentials file must indicate that these criteria are uniformly and individually applied. (4) The facility management must maintain documentation of current	Based on record review and interview, the facility failed to maintain current and complete Credentialing and Privileging Records for three (3) of three (3) Licensed Nurses and a part time dental staff. The findings include: Review of facility files for the purpose of documenting verification of credentials and granting of privilege to practice within the facility, revealed the files were not signed by Consultant Staff D to indicate the verification review was completed per the facility policy. In an interview, on 12/8/22, at 12:30 p.m., Administrative Staff F reviewed the files along with this surveyor and verified that the files were incomplete. They also stated that they were not aware that the files required the signature of Consultant Staff D.

credentials for each licensed independent practitioner practicing within the facility. (5) When reappointing a licensed independent practitioner, the facility management must review the individual's record of experience. (6) The facility management systematically must assess whether individuals with clinical privileges act within the scope of privileges granted. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	
§ 51.210 (o) (1) Clinical records. (1) The facility management must maintain clinical records on each resident in accordance with accepted professional standards and practices that are— (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, record review, and staff interview, the facility failed to ensure clinical records for two (2) of 24 sampled residents were complete. Resident #2's clinical record did not contain reports from outpatient podiatry services. Resident #14's clinical record did not contain the results of two (2) negative COVID-19 antigen tests, which had been used to determine that the resident could be moved out of isolation after having previously been positive for COVID-19. The findings include: 1. During an interview, at 3:00 p.m., on 12/6/22, Resident #6, who was noted to be wearing shoes while in bed and reported the shoes were new and were "causing blisters on my big toes." Record review revealed Resident #2 was admitted to the facility on [DATE], with diagnoses that included Polyneuropathy (a condition in which a person's peripheral nerves are damaged). Review of the resident's most recent Minimum Data Set assessment (MDS), with an Assessment Reference Date (ARD) of [DATE], found the Brief Interview for Mental Status was scored 11 out of 15, which indicated Resident #6's cognitive status was moderately impaired. Further record review found Resident #6 had Appointment Notes indicating the resident was receiving podiatry services on an outpatient basis. An inquiry was made of Administrative Nurse D for copies of consultation reports from the podiatry clinic. At 2:09 p.m., on 12/8/22, Administrative Nurse D confirmed there were no consultation reports from the podiatry clinic in

	Resident #6's clinical record, and that they were going to contact the podiatry provider to obtain copies of the reports. 2. An interview with Administrative Nurse E, on 12/8/22, at 2:10 p.m., revealed that Resident #14, who was COVID-19 positive and located on the [LOCATION], had two (2) negative COVID-19 tests, and was transferred out of the unit the morning of [DATE]. Review of the electronic record, on 12/9/22, at 9:15 a.m., revealed the negative antigen tests were not recorded in the electronic record. An interview with Licensed Nurse B, on 12/9/22, at 9:30 a.m., revealed they could not find the test results in the electronic record, but they should be there. They revealed the test results were recorded on the testing sheets. Review of the testing sheets dated [DATE], and [DATE], revealed both dates had negative test results. Licensed Nurse B stated that the nurse had been asked to make a late entry.
§ 51.210 (p) (2) Quality assessment and assurance. The quality assessment and assurance committee— (i) Meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develops and implements appropriate plans of action to correct identified quality deficiencies; and Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on review of facility policy and interview, the facility's Quality Assurance and Performance Improvement (QAPI) program failed to meet at least quarterly with all the required participants present. The findings include: Review of facility policy entitled, "Quality Assurance & Performance Improvement (QAPI) Plan for Claremore Veterans Center," updated 4/14/22, stated: "The QAPI committee must be composed of, at a minimum: • [Administrative Nurse C] • [Consultant Staff D] or [their] designee, and • At least three other staff, one of whom must be Administrative Staff A, owner, board member, or other individual in a leadership role who has knowledge of facility systems and the authority to change those systems • [Licensed Nurse B]" Review of the policy revealed it did not include how often the QAPI committee would meet. In an interview, on 12/18/22, at 3:30 p.m., Administrative Nurse C and Administrative Staff E confirmed that the facility policy was for the committee to meet monthly. Administrative Staff E provided attendance logs for January 2022 through November of 2022.

	Review of attendance logs provided revealed that neither Consultant Staff D, nor a designated representative of the medical team, was present for the February and March meetings, as per facility policy. Administrative Staff A, Licensed Nurse B, and/or Administrative Nurse C were not in attendance at random meetings during the review period. No attendance could be verified for July 2022.