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 – Clinton

Location: 1901 S. 4th Street Clinton, OK 73601

Onsite / Virtual: Onsite

Dates of Survey: 2/20/24 – 2/23/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 148

Census on First Day of Survey: 132

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from February 20, 2024 through February 23, 2024 at the Oklahoma Veterans Center - Clinton. The survey revealed 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** – Few	The facility was unable to demonstrate that medications are only furnished subject to the limitations in § 51.41(c)(2). Based on interviews and record reviews, it was identified that the facility received medications from the VAMC of jurisdiction for two (2) Veterans for whom the facility is being paid at the prevailing rate. The facility did not ensure that medication costs for Veterans for which the facility receives the prevailing rate are covered in full by the facility. Review of records for [DATE], revealed that the facility did not pay for medications for two (2) prevailing rate Veterans, for which the facility is responsible for all medication costs. Administrative Staff A verified these findings.
§ 51.70 (c) (6) Assurance of financial security. The facility management must purchase a surety bond, or otherwise provide	Based on interview and record review, the facility did not ensure the protection of resident funds, held on deposit, by maintaining a surety bond as required for protection against loss.

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	The findings include: Review of financial documents provided by Administrative Staff A revealed the facility maintained individual accounts for the veterans. The facility did not provide proof that they had been granted approval by the Under Secretary of Health to assure the security of all personal funds of residents deposited with the facility in place of a surety bond. During an interview Administrative Staff A stated that the facility did not have a surety bond and that it was in negotiations with the Oklahoma Department of Veterans Affairs (ODVA) and that a "packet" was submitted to the Under Secretary.
§ 51.110 (e) (2) Comprehensive care plans. A comprehensive care plan must be— (i) Developed within 7 calendar days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interviews, record reviews, and review of facility policy, the facility failed to revise the Care Plan timely to and provide interventions for safe smoking for one (1) of two (2) residents reviewed for smoking (Resident #12). The findings include: A review of the facility policy dated January 2023 titled "Interdisciplinary Care Plan" read in part: "Purpose: 1. Give direction to the staff members who care for the patient by directing that care toward identified problems and appropriate goals. 2. Allows for a consistent approach to the delivery of care. 3. Addresses patient behavior and staff function. 4. Acts as a communication tool that allows staff members to interact with one another regarding patient care." Resident #12 was admitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting the Left Non-dominant Side, and Nicotine Dependence to Cigarettes. A review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident had a Brief Interview for Mental Status score was three (3) out of 15, which indicated the resident was severely cognitively impaired. The assessment revealed the resident did not answer some of the questions. The assessment identified the resident had upper extremity impairment on one (1) side. A review of the Care Plan initiated on [DATE] and revised on [DATE] identified the resident was a smoker and was able to smoke independently and unsupervised in the designated smoking areas. The interventions initiated on [DATE] included staff who were to provide instructions about the facility policy on smoking location, times, and safety concerns. The resident's smoking supplies were supposed to be stored at the [LOCATION].

	A review of Progress Notes revealed: [DATE] There was a strong smell of cigarette smoke coming from [LOCATION]. PNA reported resident [name] smoking in [their] room in [their] bed. The supervisor explained to the resident why they had to take [their] cigarettes and lighter, explained to [them] that [they] could not smoke in [their] room or in [their] bed, and must smoke in the designated smoking area. The resident's cigarettes and lighter were put in the [LOCATION] in a plastic bag. [DATE] resident was observed smoking in [their] room. Staff went to the room, reminded the resident of the smoking policy and that [their] cigarettes and lighter would be taken to the [LOCATION]. The resident was reminded [they] would be given a cigarette at the appropriate times, and [they] would be able to use the lighter at the smoking area. [They] stated that [they] asked to be taken to smoke and no one took [them], so [they] smoked in [their] room. The resident's cigarettes and lighter were taken to the [LOCATION]. During an observation and an interview on 2/21/24 at 11:55 a.m., Resident #12 was in their room sitting on the bed. They were wearing a brown colored shirt with a pocket. The resident had two (2) packs of cigarettes in the pocket. They stated they had a lighter and they already went out to smoke. They stated they had returned from an appointment and went to smoke. The resident stated no one (staff) went out with them. They said, "I go out and smoke once a day when the weather is good. I go see who is out there." The resident stated they had not smoked in their room because they had to go out to the [LOCATION] to smoke. They stated they kept their cigarettes with them all of the time. The resident said, "They [staff] told me I cannot smoke in my room because someone caught on fire. They told me when I first came in." Licensed Nurse A attempted to retrieve the cigarettes from the resident, and they refused to give them to Licensed Nurse A. Administrative Nurse A suggested Licensed Nurse A offer a soda or something in exchange for cigarettes. Licensed Nurse A stated that did not work with them. Licensed Nurse A reminded the resident they could not keep their cigarettes with them, and the resident gave the cigarettes to Licensed Nurse A. During an interview on 2/21/24 at 8:51 a.m. Licensed Nurse B said we have two (2) smokers down here. We had another one (1), but they moved [them] to the [LOCATION]. During an interview on 2/21/24 at 8:55 a.m. Certified Nurse Aide A identified Resident #12 as a smoker. They said, "We have to

	go out and supervise [them]. [They] cannot reach the lighter and [are] not allowed to have [their] own lighter." The only time staff do not go out to supervise was when residents were independent smokers. Certified Nurse Aide A stated the resident did not have cigarettes with them. During an interview on 2/21/24 at 8:57 a.m. Licensed Nurse A said, "We have cigarettes here" and opened the drawer next to [them]. "[They] currently [have] cigarettes with [them] because [they were] out with transport to an appointment." [They] stated the resident usually smoked after [they] showered because [they] did not like to get out of bed. During an interview on 2/22/24 at 9:41 a.m. Administrative Nurse A stated the Care Plan was updated during the quarterly review or full review Care Plan meeting and after daily morning meetings as needed. Administrative Nurse A stated Resident #12's Care Plan was updated in [DATE]. They stated the interdisciplinary team discussed the resident's behavior of smoking in the resident's room in [DATES] after the incident. Administrative Nurse A stated the Care Plan should have already been updated in [DATES] to reflect the incidents. Administrative Nurse A stated it was important to update the resident Care Plans, so staff knew all of the interventions. They stated the best way to communicate the updated interventions was in the electronic medical record. There were lights on the system and the Certified Nurse Aides saw it and were aware of the interventions to stay on top of the new interventions. During an observation and interview in the presence of Administrative Nurse A and Licensed Nurse A on 2/22/24 at approximately 10:00 a.m., the resident sat in their wheelchair in the hallway across from the [LOCATION]. They wore a blue colored pullover sweater coat with a t-shirt with a pocket. The resident retrieved a pack of cigarettes from the pocket. The resident said, "My cigarettes are in my pocket; I did not get them from the nurse."
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care.	Based on observations, interviews, record review, and facility policy review, the facility failed to complete accurate skin assessments for one (1) of one (1) resident reviewed for bruising (Resident #11). In addition the facility failed to follow the care plan for one (1) of one (1) resident for fall maintenance (Resident #15). The findings include: 1. Review of the facility policy and procedure titled, "Skin Team", dated 5/13/21 read in part: "Policy: To establish protocol and procedure for prevention and treatment of skin breakdown. The skin team will consist of wound care manger [sic], provider,

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	nursing, dietary, physical therapy and administration. Skin team will meet weekly to review all wounds. The skin team nurse along with the physician and unit manager if available will make routine rounds to view any new or worsening wounds. Only the provider can diagnose a wound and/or determine if it is pressure and diagnose the stage of the wound. They will consult with wound nurse, unit nursing, dietary and physical therapy as needed for recommendations and any needed changes such as treatments or referrals to promote healing. The provider and wound care nurse will assess, measure, and document status of all new pressure, vascular and diabetic wounds. If a wound care nurse or manager is not available, the [Licensed Nurse] or [Licensed Nurse] will assist with rounds." The policy did not address bruises as a skin condition. Procedure: Reporting and Documentation 1. A Braden scale skin risk assessment note in PCC [Point Click Care] will be completed on each new admission by the admitting nurse and updated quarterly or as needed. … 3. [Certified Nurse Aides] are to report any new wounds found to the [Licensed Nurses]. 4. [Licensed Nurses] observe every resident's skin 1 [one] time per week during bathing time. Documentation this is in the "Skin observation assessment. 5. New wounds are reported by the [Licensed Nurse] and placed in a "Skin /Wound progress note" the description and location of the wound, not a diagnosis. This note will come up on the dashboard in PCC to alert providers and skin team. 6. Providers and the skin team nurse will view and evaluate wound, cause of and determine treatment and intervention.' [sic] The policy did not include protocols and procedures related to bruises. Resident #11 was admitted on [DATE] with diagnoses that included Hypertension, Chronic Systolic Congestive Heart Failure, Vascular Dementia Moderate with Behavioral Disturbance, and Muscle Weakness. Review of the quarterly Minimum Data Set (MDS) Assessment dated [DATE] identified the resident's Brief Interview for Mental Status (BIMS) score was eight (8) out of 15 which indicated the resident was moderately cognitively impaired. The MDS did not identify skin concerns. Review of the Care Plan did not identify bruising as a problem. Review of 43 "Skin Assessments" from [DATE] to [DATE] did not identify a description of the bruises to include color, stage, size, and location. Observation on 2/20/24 at 11:38 a.m. the resident was in the [LOCATION] near the [LOCATION] sitting in their wheelchair. The resident had a bruise on the right side of the face and under the left eye. The bruises were greenish/yellowish in color.

	During an interview and then observation on 2/22/24 at 11:02 a.m., Administrative Nurse A said, “We document new and acute things, the nurses are not trained to document to follow things that are not wounds, bruises, on the skin assessments. They do not document after the initial bruise is identified.” They stated the initial skin assessment was completed by a Licensed Nurse and if something was new, they would tell the administrative staff. Skin assessments were done on bath days. The Licensed Nurse reviewed the form to see if something new needed to be addressed. Observation with Administrative Nurse A and Licensed Nurse A revealed the resident was in their room lying in bed with the call light in hand. The resident’s bruise on the right side of their face was fading and smaller in size. The bruise on the left side under the eye was faded and yellowish in color and much smaller (measurements were not taken). The Licensed Nurse stated when they were transferred to the [LOCATION], the resident looked like a raccoon. During an interview on 2/22/24 at 3:08 p.m., Certified Nurse Aide B and Certified Nurse Aide C stated they reported every bruise to the nurse on duty and reported every single skin issue. They stated they documented it in the computer program that alerted all staff of the concern. Certified Nurse Aide B stated the resident was moved to the unit about a month ago. They stated the resident fell and hit their face. They stated that the resident had bruises on their face, looked like a raccoon, when they were moved to the unit and the floor staff was healing them. Certified Nurse Aide B stated the nurses were responsible for skin documentation. Certified Nurse Aide B stated they did not document skin issues on the bath sheet unless it was something new. During an interview on 2/23/24 at 10:34 a.m., Licensed Nurse A explained that the nurses examined residents after their showers and completed the skin observation template. They stated they (nurses) looked for bruising, imperfections, and skin tears. They stated the nurses also completed a skin assessment when a resident fell, had a significant change in condition or when needed. Licensed Nurse A stated the documentation included measurements, size, color, and location. They said, “I guess we do; [nurses] are supposed to document bruises, they do not make us measure.” Licensed Nurse A stated the nurse completing the assessment was supposed to look at the previous week’s information to see if the bruise was healing. Licensed Nurse A said, “It is important to document how it happened and how to prevent bruising, I guess.” 2. Review of Resident #15’s medical record revealed they were admitted to the facility [DATE] with diagnoses that included

	Dementia, Fracture of Upper End of Right Humerus (Closed Fracture), History of Healed Fracture, Restlessness and Agitation, Depression and History of Falling. Per the Significant Change Minimum Data Set (MDS) dated [DATE], Resident #15 was rarely or never understood and had a Brief Interview for Mental Status score of two (2), which indicated severe mental impairment. Resident #15 was incontinent of both bowel and bladder and received antipsychotic medications. The medical record further documented the resident had a fall on [DATE] that resulted in a Right Proximal Humerus Fracture, for which they wore a sling. Physical Therapy documented a concern for the resident to keep the sling in place due to their confusion and dementia. During a review of the Incident Report regarding Resident #15's fall, it was documented that they were at the end of the hallway and a staff member observed them get up out of their wheelchair and began to fall. The report noted the staff member could not reach the resident in time to prevent the fall or assist the resident to the ground. Review of the Resident 15's Care Plan revealed the intervention after the fall was to ensure the resident was wearing regular socks and shoes when in their wheelchair. The Care Plan further stated the resident was to remain within line of sight of staff and to not be placed in a recliner in the [LOCATION]. In an interview and observation on 2/22/24 at 10:20 a.m. with Licensed Nurse C and Resident #15 while the resident was in a recliner in the [LOCATION], they stated they were treated well and the rest of the conversation was unintelligible. After the conversation with Resident #15, Licensed Nurse C stated some of the interventions they had in place to prevent Resident #15 from falling again, were to do checks every 15 minutes and to keep them in the [LOCATION] so staff could have them within their line of sight. The [LOCATION] was not within line of sight from the [LOCATION] and went against the intervention noted in the Care Plan.
§ 51.120 (b) (3) Activities of daily living. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, hydration, grooming, personal and oral hygiene, mobility, and bladder and bowel elimination. **Level of Harm** – No Actual Harm, with potential for more than minimal harm	Based on observations, interviews and record review, the facility failed to ensure one (1) of one (1) resident reviewed, who was unable to carry out activities of daily living (ADLs), was provided incontinent care and fluids (Resident #10). The findings include: The facility did not provide a policy for Activities of Daily Living for dependent residents when asked.

Residents Affected – Few	Resident #10 was admitted to the facility on [DATE] with diagnoses that included Dementia, Alzheimer's Disease, Type 2 Diabetes Mellitus, and Contracture- unspecified hand. Review of the Quarterly Minimum Data Set (MDS) Assessment dated [DATE] identified the resident's Brief Interview for Mental Status (BIMS) was completed by staff and indicated that the resident was severely impaired for daily decision making. The resident was dependent on two (2) staff for ADLs for toileting and one (1) staff for eating. The resident was always incontinent of bladder and bowel. Review of the Care Plan revised on [DATE] identified the resident required assistance with ADLs related to Alzheimer's Disease, Dementia, Impaired Balance, and Inability to Ambulate. The interventions included the resident was dependent with toileting hygiene. The Care Plan revised [DATE] identified the resident received Level 2 mildly thick or nectar thick consistency for fluids and staff assisted the resident at mealtime. The interventions included staff were supposed to offer water or liquids every four (4) hours for hydration and give four (4) to six (6) ounces of liquid while awake. 1. Observation during the initial tour on 2/20/24 at 11:32 a.m., revealed the resident was reclined in a Broda chair with eyes closed in the hallway in front of the window; there was another resident in the same area. There was a strong odor of urine during the observation. At 12:12 p.m., the resident was in the same area and in the same position and the strong odor of urine continued. At 12:33 p.m., the resident was in the same area, sitting up in the Broda chair. There was a Certified Nurse Aide who assisted the resident with their lunch meal, while a strong odor of urine continued. During a continuous observation on 2/21/24 from 8:36 a.m. to 1:15 p.m. the resident was in the [LOCATION] to the [LOCATION]. The resident was taken to their room at 8:39 a.m. as two (2) Certified Nurse Aides exited the room, one (1) carried a clear bag that had an adult brief. The resident remained in their room until 10:54 a.m., when two (2) Certified Nurse Aides used a mechanical lift to transfer the resident from their bed to the Broda chair. The Certified Nurse Aides did not check or change the resident's brief prior to transferring the resident. The resident was taken to the same area near the [LOCATION]. From 12:18 p.m. to 1:03 p.m. Certified Nurse Aide B assisted the resident with their lunch meal. Upon completion of the meal, the resident remained in the same area. Certified Nurse Aide B did not take the resident back to their room to check or change

	the resident. The resident had not been checked or changed from 8:39 a.m. until the end of observation at 1:15 p.m. During an interview on 2/22/24 at 3:08 p.m., Certified Nurse Aide B stated the staff completed two (2) hour checks for dependent residents who needed to be checked and changed. They stated they checked and changed Resident #10 every two (2) hours unless they were up for meals. Certified Nurse Aide B stated they laid them down between 8:00 a.m. and 9:00 a.m. and up for lunch between 10:00 a.m. and 11:00 a.m., back to lay down between 1:00 p.m. and 2:00 p.m., and last check at 2:45 p.m. before shift change. Certified Nurse Aide B stated they did not know how often they were checked on [DATE]. They stated that they did not check the resident after lunch and said they should have been checked and changed before lunch. During an interview on 2/23/24 at 10:34 a.m. Licensed Nurse A stated dependent residents were supposed to be checked and changed every two (2) hours. Licensed Nurse A stated that they did not know how often Resident #10 was checked or changed on [DATE] but it was supposed to be completed every two (2) hours. Licensed Nurse A stated it was important to make sure the resident did not have skin breakdown and check on them in general. During an interview on 2/23/24 at 11:25 a.m. Administrative Nurse A explained the process of toileting a dependent resident. They stated the toileting program was to be completed after meals and before bed. Administrative Nurse A stated totally dependent residents were checked and changed every two (2) hours. Further clarification was stated as when the residents got up, after meals and during the evening shift before and after supper, at least checking them. Administrative Nurse A stated all of the residents were a little bit different depending on personal needs. They stated that it was important to check and change residents for comfort and maintain skin integrity. 2. Observation during the initial tour on 2/20/24 at 11:32 a.m. revealed Resident #10 was not in their room, there were two (2) containers of unopened thickened water on the nightstand to the right of the bed. The resident was reclined in a Broda chair with eyes closed in the hallway in front of the window and there was no water on the table in front of the resident. During a continuous observation on 2/21/24 from 8:36 a.m. to 1:15 p.m. the resident was in the [LOCATION] next to the [LOCATION]. The resident was taken to their room at 8:39 a.m. and transferred to their bed. There were two (2) containers of unopened thickened water on the nightstand to the right of the bed. The Certified Nurse Aide did not offer water to the resident at the time of transfer. The staff was not observed to offer water

	to the resident from 8:36 a.m. until 12:18 p.m. when the resident was assisted with their meal. Certified Nurse Aide B requested water, cranberry juice, and tea for the resident, all thickened. They assisted the resident with drinking the beverages. The resident drank all the water and tea, they did not appear to care much for the cranberry juice. During an interview on 2/22/24 at 3:08 p.m., Certified Nurse Aide B stated the staff completed two (2) hour checks for dependent residents which included offering water. They stated that there was a water pitcher or thickened beverages at the bedside of all residents. Certified Nurse Aide B stated the resident did drink the water and tea that was offered during the lunch meal on 2/21/24 but did not know if water was offered when the resident was in their room. Certified Nurse Aide B stated it was important for residents to drink water for overall health. During an interview on 2/23/24 at 10:34 a.m., Licensed Nurse A stated the residents received water when staff completed their rounds. They stated the staff was supposed to offer the residents something to drink at mealtime and medication pass. Licensed Nurse A stated the staff was supposed to pass water to the residents to have at bedside, if they did not require thickened liquids or if they did not have difficulty swallowing. They stated jug and ice was passed in the morning, at 10:00 a.m. and again at 3:00 p.m. Licensed Nurse A said, “Resident #10 was supposed to have been offered water during rounds because obviously [they] cannot do it [themselves].” They stated it was important to offer water to prevent dehydration, keep hydrated and prevent skin problems. During an interview on 2/23/24 at 11:25 a.m. Administrative Nurse A explained that dependent residents were supposed to receive fluids between breakfast and lunch 9:30 a.m. and 10:00 a.m. and then 2:00 p.m. and 3:00 p.m., during the evening before bedtime between 7:00 p.m. and 8:00 p.m. and during the night and offer fluids if residents were awake. They stated that included all forms of liquids, “because I am on thickened does not mean I should not be offered fluids.” Administrative Nurse A stated it was important to offer fluids for hydration and comfort purposes.
§ 51.140 (d) Food. Each resident receives and the facility provides— (1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	Based on observation, interview and record review, the facility failed to provide one (1) resident with food in the appropriate form in order to allow them to adequately feed themselves (Resident #24). The findings include:

(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** – Few	Review of the facility's policy, "Menu Policy", dated 4/6/22 revealed "Policy: All meals served will be adequate according to Recommended Dietary Allowances. A contract an RDLD will prepare menus and recipes for the agency. The providers will order appropriate diet based on initial/ongoing assessments and outside consults. The agency has liberalized all residents to improve quality of life. The menus will provide texture modifications only… Procedure: Regular and texture modified meals are prepared and served on the front and back serving lines. Dietary will verify and issue tray cards with picture identification to all residents prior to serving on the front and back serving line." [sic] An observation of the resident back serving tray line on 2/21/24 at 11:04 a.m. revealed a tray ticket for Resident #24 which stated they were to receive finger foods. The resident's meal consisted of chicken teriyaki with rice, egg roll, mixed vegetables and bread pudding. Further observation revealed the only finger foods available on the tray line were the egg rolls. In an interview on 2/21/24 at 11:30 a.m., Resident #24 stated they hardly ever received finger foods from the [LOCATION]. They stated they bought their own food and ordered food out frequently. They further stated they could not depend on the [LOCATION] to supply finger foods, so they bought their own foods. Resident #24 also stated they could not use utensils secondary to their hand tremors and it was impossible to eat using utensils.
§ 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 maintain safe and sanitary conditions in the [LOCATION] related to storing foods, taking food temperatures prior to serving the food to residents and obtaining the food temperatures in an appropriate manner. This affected all residents in the facility who consumed food from the [LOCATION]. The findings include: Review of the facility's policy titled, "Back Serving Line Policy", dated 4/6/22 revealed, "**Policy:** Meal service for residents **NOT** attending meals in the [LOCATION] will be served on units. Meals will be prepared by personnel assigned to the back serving line. Meals will be prepared and temped according to standardized menu and recipes. Each resident tray is *required* to have a personalized diet card with diet order, preferences, allergies and resident picture to ensure accuracy. **Procedure:** Cooks temp foods and record temps as they prepare and again prior to beginning the serving line…When getting additional

	foods from the warmer or cooler check temperature, perform hand hygiene, and change gloves." [sic] 1. An observation and interview on 2/20/24 at 9:46 a.m. with Dietary Staff A and Dietary Staff B revealed dented cans in the [LOCATION]. When one (1) #10 can of pinto beans, three (3) 50-ounce (oz.) cans of cream of celery soup and one (1) #10 can of tropical fruit salad were found by the surveyor, Dietary Staff A and Dietary Staff B verified the cans were dented and pulled them from stock. 2. An observation and interview on 2/20/24 at 9:59 a.m. with Dietary Staff B, revealed approximately 15 10-pound (lb.) chubs or tubes of ground beef in the walk-in cooler were contained in a white tub without labels or dates on them. When asked what the process was for managing the ground meat, Dietary Staff B stated they didn't really have a process to determine when the meat was placed in the cooler or when it should be discarded. There was also a plastic container of chicken next to the ground beef, without labels or dates. During the same observation and interview period, there were approximately eight (8) white dinner rolls in the freezer without a label or date and had visible freezer burn on them. 3. During an observation of the resident tray line in the [LOCATION] on 2/21/24 that began at 10:46 a.m., Dietary Staff C was observed taking temperatures of the food on the tray line. Temperatures were not taken of all the food items. Temperatures were missed for the whole egg rolls, chopped vegetables, chopped egg rolls and bread pudding. None of the temperatures were observed to be recorded on a log. While taking the temperatures, Dietary Staff C was asked if their thermometer touched the bottom of the steam table pan. They pulled the thermometer away from the bottom of the pan and readjusted it to ensure it touched the bottom of the pan. 4. An observation on 2/21/24 at 11:48 a.m. revealed [LOCATION] staff replenishing the resident tray line and pulled hot foods from the warmer and placed them on the steamtable. No temperatures were observed to be taken prior to service. These items were replenished from the previous tray line service. Trayline service began at 11:55 a.m. At 12:05 p.m. [LOCATION] staff brought whole egg rolls to the steamtable and placed them in the steamtable pan. No temperature was taken of the whole egg rolls. At 12:13 p.m. Dietary Staff C brought more ground chicken and rice from the warmer to refill the steamtable pans. No temperatures were taken prior to service of these food items.

	In an interview on 2/22/24 at 9:27 a.m., when asked to see the temperature logs for the resident tray line from 2/21/24, Dietary Staff A and Dietary Staff B stated Dietary Staff C must have forgotten to write them down. A review at that time of the temperature log revealed not all food items (different consistencies) had a place to record temperatures on the log, just the main or unaltered forms of the food items had a place to be logged. Dietary Staff A agreed that each item needed a place on the log to record the temperatures prior to service.
§ 51.200 (a) Life safety from fire. 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	**Means of Egress Requirements** 1. Based on observation and interview, the facility failed to maintain delayed egress doors and provide the required signage. The deficient practice affected zero (0) of 15 smoke compartments in the [LOCATION], zero (0) of four (4) smoke compartments in the [LOCATION], two (2) of four (4) smoke compartments the [LOCATION] and zero (0) of one (1) smoke compartments in the [LOCATION], staff, and 23 residents. The facility has a capacity for 148 beds with a census of 132 on the day of the survey. The findings include: Observation on 2/22/24 at 11:05 a.m. revealed the exit door to the stairway in the [LOCATION] was equipped with delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating they were delayed egress, and the delay function of the door was not working, as required by section 7.2.1.6.1.1 (3) and (4) of NFPA 101, Life Safety Code. Interview on 2/22/24 at 11:05 a.m. with Maintenance Staff A about the delayed egress on [LOCATION] revealed they were not aware of the missing signage and delay not working. Observation on 2/22/24 at 11:17 a.m. revealed the exit door to the stairway in the [LOCATION] was equipped with delayed egress locking system. Testing revealed that the delay function of the door was not working, as required by section 7.2.1.6.1.1 (3) of NFPA 101, Life Safety Code. Interview on 2/22/24 at 11:17 a.m. with Maintenance Staff A about the delayed egress on [LOCATION] stated it should be working. Observation on 2/22/24 at 11:31 a.m. of the [LOCATION] door on the [LOCATION] revealed it was very hard to open.

	Interview on 2/22/24 at 11:31 a.m. with Maintenance Staff A before the door was opened stated you must knock it hard to open it. The census of 132 was verified by Administrative Staff B 2/22/24 at 10:27 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 2/23/24 at 3:15 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.2.2.2 Doors.** **19.2.2.2.1** Doors complying with 7.2.1 shall be permitted. **19.2.2.2.4** Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following: (1) Locks complying with 19.2.2.2.5 shall be permitted. (2) *Delayed-egress locks complying with 7.2.1.6.1 shall be permitted. (3) *Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. (4) Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted. (5) Approved existing door-locking installations shall be permitted. **7.2.1.4.5.1** The forces required to fully open any door leaf manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf (133 N) to set the leaf in motion, and 15 lbf (67 N) to open the leaf to the minimum required width, unless otherwise specified as follows: (1) The opening forces for interior side-hinged or pivoted-swinging door leaves without closers shall not exceed 5 lbf (22 N). (2) The opening forces for existing door leaves in existing buildings shall not exceed 50 lbf (222 N) applied to the latch stile. (3) The opening forces for horizontal-sliding door leaves in detention and correctional occupancies shall be as provided in Chapters 22 and 23. (4)The opening forces for power-operated door leaves shall be as provided in 7.2.1.9. **7.2.1.6.1** Delayed-Egress Locking Systems. **7.2.1.6.1.1** Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with

	Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met: (1) The door leaves shall unlock in the direction of egress upon actuation of one of the following: (a) Approved, supervised automatic sprinkler system in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism. (3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1⁄8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTILALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS (5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9. **<u>Smoke Barriers and Sprinklers</u>** 2. Based on observation and interview, the facility failed to maintain the kitchen cooking hood ventilation systems in accordance with the code. The deficient practice affected zero (0) of 15 smoke compartments in the [LOCATION], zero (0) of four (4) smoke compartments in the [LOCATION], zero (0) of four (4) smoke compartments the [LOCATION] and one (1) of one (1) smoke compartments in the [LOCATION], staff, and no residents. The facility has a capacity for 148 beds with a census of 132 on the first day of the survey. The findings include:

	Observation on 2/22/24, at 1:46 a.m. kitchen hoods revealed the following. Hood #1 had two (2) bent grease baffles leaving 2-inch gaps between them. Hood #2 was missing two grease baffles. Hood #3 had a 3-inch gap between the two (2) grease baffles. Grease laden air would not all flow though the grease baffle as required by section 6.2.3 of NFPA 96, Standard for Ventilation Control and Fire Protections of Commercial Cooking Operations. The interior seams of the three (3) kitchen hoods had not been made grease tight, as required by section 5.1.4 of NFPA 96, Standard for Ventilation Control and Fire Protections of Commercial Cooking Operations Interview with Maintenance Staff A on 2/22/24 at 1:48 p.m. revealed the facility had intended to replace the missing grease baffles but not the damaged one. Maintenance Staff A was not aware that the interior seams of the kitchen hood had to be made grease tight. Observation on 2/22/24, at 1:52 p.m. of the three (3) kitchen hood suppression systems revealed the following. The tags for kitchen hood suppression systems dated September 23 had no check initials or checkmarks on the back indicating that the facility was performing the monthly owner's inspection, as required by section 8.2 of NFPA®17A Standard for Wet Chemical Extinguishing Systems. Interview with Maintenance Staff A on 2/22/24 at 1:52 p.m. about the monthly inspection revealed the facility was not aware of the requirement. The census of 132 was verified by Administrative Staff B 2/22/24 at 10:27 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 2/23/24 at 3:15 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012) 19.3.2.5 Cooking Facilities.** **19.3.2.5.1** Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4. **19.3.2.5.2*** Where residential cooking equipment is used for food warming or limited cooking, the equipment shall not be required to be protected in accordance with 9.2.3, and the presence of the equipment shall not require the area to be protected as a hazardous area. **9.2.3** Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service.

	Actual NFPA Standard: NFPA 96, Standard for Ventilation Control and Fire Protections of Commercial Cooking Operations (2011) **5.1 Construction.** **5.1.4*** Internal hood joints, seams, filter support frames, and appurtenances attached inside the hood shall be sealed or otherwise made grease tight. **6.2.3 Grease Filters.** **6.2.3.2** Grease filters shall be of rigid construction that will not distort or crush under normal operation, handling, and cleaning conditions. **6.2.3.3** Grease filters shall be arranged so that all exhaust air passes through the grease filter. **10.2.6** Automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable: **(1) NFPA12** **(2) NFPA13** **(3) NFPA17** **(4) NFPA17A** **8.2 Owner's Inspection**. **8.2.1** On a monthly basis, inspection shall be conducted in accordance with 8.2.2 and the owner's manual. **8.2.1.1** The system owner shall maintain the design and installation documents and maintenance manual or owner's manual on the premises and shall make them available for review, upon request, by the authority having jurisdiction. **8.2.2** At a minimum, the inspection shall include verification of the following: 1. The extinguishing system is in its proper location. 2. The manual actuators are unobstructed. 3. The tamper indicators and seals are intact. 4. The maintenance tag or certificate is in place. 5. No obvious physical damage or condition exists that might prevent operation. 6. The pressure gauge(s), if provided, has been inspected physically or electronically to ensure it is in the 7. operable range. The nozzle blowoff caps, where provided, are intact and undamaged. 8. The hazard has not changed, including replacement, modification, and relocation of protected equipment. **8.2.3** If any deficiencies are found, appropriate corrective action shall be taken immediately. **8.2.3.1** Where the corrective action involves maintenance, it shall be conducted by a service technician as outlined in 8.3.1.

	8.2.4 Personnel making inspections shall keep records for those extinguishing systems that were found to require corrective actions. **8.2.5** At least monthly, the date the inspection is performed and the initials of the person performing the inspection shall be recorded. **8.2.6** The records shall be retained for the period between the semiannual maintenance inspections.
§ 51.210 (h) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section. (2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. (3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed services and will notify the veteran or the authorized representative of the veteran. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on record review and interview, it was determined the facility failed to obtain a Sharing Agreement for Mental Health Services for 52 residents who received mental health services. The findings include: Review of facility records revealed that the facility did not have a sharing agreement for Mental Health services. During an interview on 2/20/24 at 3:43 p.m. Administrative Staff A confirmed that the facility did not have a sharing agreement. Administrative Staff A stated that a sharing agreement for Mental Health services was still in negotiations with the Oklahoma City (OKC) Veterans Administration Medical Center (VAMC).