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: Hollidaysburg Veterans Home

Location: 536 Municipal Drive, Duncansville, PA 16635

Onsite / Virtual: Onsite

Dates of Survey: 6/6/22-6/9/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 257

Census on First Day of Survey: 151

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from June 6, 2022, through June 9, 2022, at the Hollidaysburg Veteran Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§51.70(c)(6) Assurance of financial security The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Many	Based on record review and staff interview, the facility failed to provide evidence that a surety bond or other assurance approved by the Under Secretary for Health was secured for the security of all personal funds of residents deposited with the facility. This deficient practice affected all residents whose funds were managed by the facility. The findings include: On 6/8/22 at approximately 9:19 a.m., an inquiry was made to Administrative Staff A and facility staff, regarding the status of the facility's surety bond. In an interview on 6/8/22 at 2:54 p.m., Administrative Staff B confirmed that their alternative to a surety bond was still awaiting approval from the Under Secretary.
§51.100(a)(b) Quality of Life A facility management must care for its residents in a manner and in an environment that promotes	Based on observation, staff interviews, review of Resident #103's medical record and the facility's policy, the facility failed to promote the dignity of Resident #103 when care was

maintenance or enhancement of each resident's quality of life. (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. (b) Self-determination and participation. The resident has the right to— (1) Choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; (2) Interact with members of the community both inside and outside the facility; and (3) Make choices about aspects of his or her life in the facility that are significant to the resident. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	provided. This deficient practice affected Resident #103, one (1) of 32 sampled residents. The findings include: Review of Resident #103's medical record revealed the resident was admitted to the facility in [DATE] with diagnoses of Dementia and Alzheimer's Disease. Review of Resident #103's Annual Minimum Data Set dated [DATE] revealed the resident was not able to complete the interview to assess his cognitive status. On 6/6/22 at approximately 11:43 a.m., a surveyor was in the hallway near Resident #103's room. The surveyor overheard someone say "Sit up" in a demanding, harsh tone. The door to Resident #103's room was opened, and Resident #103 was observed in a sit-to-stand lift device wearing only a brief. Certified Nurse Aide A continued to speak to Resident #103 in a demanding, harsh tone while they assisted the resident with toileting. Certified Nurse Aide A was overheard stating, "For someone who wants to go to the bathroom you sure are making this difficult." Another Certified Nurse Aide, Certified Nurse Aide B, was overheard instructing Resident #103 in a non-demanding tone, to "push it through." Certified Nurse Aide A was overheard using profanity. Certified Nurse Aide B came to the door area and noticed the surveyor standing outside of the door. Certified Nurse Aide B greeted the surveyor, while Certified Nurse Aide A asked who was at the door while they remained in the resident's bathroom. An interview was conducted with Licensed Nurse A on 6/6/22 at approximately 11: 50 a.m. Licensed Nurse A was informed of the surveyor's observation that occurred in Resident #103's room. Licensed Nurse A stated that they needed to get their supervisor and start an investigation. During an interview with Certified Nurse Aide A and Certified Nurse Aide B on 6/6/22 at approximately 11:49 a.m., Certified Nurse Aide A denied using profanity. An interview was conducted with Licensed Nurse A and Licensed Nurse B on 6/6/22 at approximately 11:54 a.m. Both Licensed Nurse A and Licensed Nurse B were informed of the surveyor's observations. Licensed Nurse A and Licensed Nurse B stated that they would start an immediate investigation per the facility's policy and procedure.
§51.100(i)(1) – Environment The facility management must provide—	Based on observation and staff interview, the facility management failed to provide a safe, clean, homelike environment for residents isolated together in the [LOCATION].

(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible; Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Some	The laminated covering on multiple pieces of furniture (e.g., bedside tables, dressers, and wardrobes) was noted to be peeling away and/or was absent from the faces of the furniture, leaving behind curled and/or rough edges of laminate and uncleanable surfaces of the underlying composite material. This condition was found in 10 of 12 occupied rooms observed on [LOCATION]. The census on [LOCATION] was 20. The findings include: Observations were made of all occupied resident rooms in the [LOCATION], on the afternoons of 6/6/22 and 6/7/22. Both tours were conducted in the presence of Administrative Nurse A. In 10 of 12 occupied rooms on this unit, one (1) or more individual pieces of furniture were found to be in a state of disrepair due to the peeling away of the laminate covering from the underlying composite material used to construct the furniture. An example is as follows: A 4-drawer dresser with light wood-tone laminate was found in one (1) room occupied by four (4) female residents. The face of the top drawer was missing a large, irregularly shaped swathe of laminate from the upper left-hand corner, exposing the underlying composite material. The face of the second drawer was missing almost half of the laminate covering, extending from the left edge to the middle of the drawer. Irregular edges of the remaining laminate were noted to be curling up from the underlying composite material both above and below the drawer pull. The exposed composite material was unsealed and presented a porous surface that cannot be effectively cleaned or sanitized. The affected items, when counted on 6/7/22, included 19 bedside sides, 11 dressers, and seven (7) wardrobes. The affected rooms were [LOCATIONS]. These observations were confirmed by Administrative Nurse A.
§51.120(f) Range of motion Based on the comprehensive assessment of a resident, the facility management must ensure that - (1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	Based on observations, interviews, record review, and review of facility policy it was determined the facility failed to provide restorative services as planned for one (1) resident with a decrease in range of motion (ROM) (Resident #116). The findings include: Review of the facility policy titled, “Restorative Services,” dated May 2021, documented, “It is the policy of the Hollidaysburg Veterans Home to assist residents in achieving their optimal functioning through rehabilitative services or Restorative Nursing…Procedure: 11. Nurse Aide (NA) implements

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	restorative programs as per the care plan and therapy staff training. 12. NA documents resident's restorative programming and performance electronically under RESTORATIVE in Care Tracker (computer program utilized by the NAs). 13. NA documents refusals of Restorative Nurse Program (RNP) in Care Tracker and notifies the licensed nurse on the unit of resident refusals and functional changes/significant observations regarding restorative program performance." Review of Resident #116's clinical record revealed an admission date of [DATE] and the diagnoses included Dementia with Behavior Disturbances, Anxiety and Depression. Review of Resident #116's Physician Order dated [DATE] revealed an order to utilize a palm guard on the left hand at all times, except during care, skin checks and passive ROM. Skin checks to be completed after removing the palm guard and prior to applying one (1) time per shift. Review of Resident #116's Quarterly Minimum Data Set (MDS) Assessment dated [DATE] revealed the Brief Interview for Mental Status (BIMS) score of 99, indicating the resident could not complete. The MDS documented that the resident had short and long-term memory problems, severely impaired decision-making skills, and did not display behaviors. Resident #116's MDS documented the resident required extensive assistance of two (2) people for bed mobility and personal hygiene and was totally dependent on two (2) people for transfers, toilet use, and bathing. The resident had no limitation in range of motion (ROM) and did not receive therapy or restorative services. The Care Plan dated [DATE] listed the interventions: will participate in RNP for active assisted ROM at least four (4) out of seven (7) days. Review of the documentation of the RNP in the Care Tracker lacked documentation regarding the use of the palm guard to the left hand. Review of the "Occupational Therapist's Quarterly Screen," dated [DATE] at 2:05 p.m. documented Resident #116 continued to tolerate the palm guard on the left hand at all times, except for during care, skin checks and passive ROM. Observation of Resident #116 on 6/6/22 at 12:08 p.m. revealed that the resident sat in a Broda chair and that the left hand was partially drawn inward and there was no palm guard on the left hand.

	Observation of Resident #116 on 6/7/22 at 8:57 a.m. revealed the resident sat in a Broda chair and there was no palm guard on the left hand. Observation of Resident #116 on 6/7/22 at 12:12 p.m. revealed the resident sat in a Broda chair and there was no palm guard on the left hand. In an interview with Licensed Nurse C on 6/9/22 at 8:39 a.m., they stated that Resident #116 could not do anything independently and staff should maintain the palm guard in the left hand. In an interview with Certified Nurse Aide C on 6/9/22 at 9:06 a.m., they stated that Resident #116 required total care and the palm guard was too round, so staff were using a rolled washcloth. In an interview with Licensed Nurse D on 6/9/22 at 10:43 a.m., they stated that the therapy department ran the restorative program. Licensed Nurse D stated that they did not re-evaluate the program but tried to observe the program being completed one (1) time a month.
§51.120(l) Special needs The facility management must ensure that residents receive proper treatment and care for the following special services: (1) Injections; (2) Parenteral and enteral fluids; (3) Colostomy, ureterostomy, or ileostomy care; (4) Tracheostomy care; (5) Tracheal suctioning; (6) Respiratory care; (7) Foot care; and (8) Prostheses. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Some	Based on observation, staff interview, and review of the facility's policies, the facility management failed to ensure oxygen humidifiers were labeled with the date and time opened, to ensure this equipment was changed weekly for five (5) residents of random opportunity and one (1) sampled resident (Resident #128, Resident #129, Resident #130, Resident #131, Resident #132, and Resident #120). The findings include: The facility's policy titled, "Oxygen Administration," with a revision date of 12/19, documented, "4. Care and use of humidifiers: … g. Label humidifier with date and time opened. 5. Weekly, 11-7 shift will change and date oxygen equipment, masks, tubing and cannulas." On 6/6/22 from 4:30 p.m. to 5:48 p.m., observations were made of all 20 residents who tested positive for SARS-CoV-2 and were isolated together in the [LOCATION]. Of those 20 residents, five (5) residents (Resident #128, Resident #129, Resident #130, Resident #131, Resident #132) were noted to be actively using supplemental oxygen with humidifier bottles and tubing that were not dated. These observations were confirmed by Administrative Nurse A, who was present throughout this tour.

	Administrative Nurse A also confirmed that the facility's policy was to have the 11-7 shift staff change out oxygen equipment (e.g., humidifier bottles, nasal cannulas, and tubing) every Monday and that, because there was no date on these items, there was no way to confirm when they were last changed. Review of Resident #120's clinical record revealed an admission date in [DATE] and diagnoses included: Traumatic Brain Injury, Schizoaffective Disorder, Hypertension, Atherosclerotic Heart Disease, and Morbid Obesity. Review of Resident #120's Quarterly Minimum Data Set (MDS) dated [DATE] listed a Brief Interview for Mental Status (BIMS) score of eight (8) with a score of eight (8) to 12 indicating moderately impaired cognition. The MDS revealed the resident used oxygen (O2). Review of Resident #120's Physician Order dated [DATE] listed an order for O2 continuously via nasal cannular at two (2) liters per minute (l/min). Observation on 6/6/22 at 12:28 p.m. revealed Resident #120 lying in bed and receiving O2. Further observation revealed the O2 tubing attached to the oxygen concentrator dated [DATE]. Observation on 6/7/22 at 9:04 a.m. revealed Resident #120 sitting in a Broda chair in the hallway and receiving O2 via the portable cannister. Further observation revealed the O2 tubing attached to the portable cannister dated [DATE]. Observation on 6/8/22 at 2:50 p.m. revealed Resident #120 receiving O2 via the concentrator and the O2 tubing dated [DATE] and humidifier bottle also dated [DATE]. Further observation revealed the O2 tubing attached to the portable O2 cannister dated [DATE]. In an interview with Licensed Nurse E on 6/8/22 at 3:16 p.m. they stated that the O2 tubing and humidifier bottles should be changed every Saturday on the third shift. An interview and observation with Administrative Nurse A on 6/9/22 at 11:04 a.m., confirmed Resident #120's O2 tubing on the portable cannister was still dated [DATE].
§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, temperature testing, staff interview, and review of the facility's policies, the facility management failed to ensure food about to be served to one (1) resident of random opportunity (Resident #126) was at the proper temperature for palatability. 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	The facility's policy titled, "Temperature Guidelines," with no effective date or revision date given, documented, "The following temperature standards will be used as a guide by the Hollidaysburg Veterans Home Dietary Department. (See attached)." Attached was a table with column headings for Food Item, Serving Temp F (Fahrenheit), and Palatable Eating Temp F. Under the heading Food Item was Vegetables and the corresponding Palatable Eating Temp F was a range of 110-140 F. On 6/6/22 beginning at 11:56 a.m., observations were made of the noon meal service in the dining room for the [LOCATION]. The first plates served to residents seated in this dining room came out at about 12:00 p.m. Observation at about 12:05 p.m. found a meal tray had been prepared for a resident who had not yet arrived in the dining room. The plate was covered with an insulated dome lid, but there was no insulated base or heating pellet present to aid in maintaining the temperature of the food on the plate; the meal tray was sitting on a cart next to the tray line. The tray ticket indicated this meal was for Resident #126. At approximately 12:20 p.m., staff brought Resident #126 into the dining room and pushed their wheelchair up to a table in the center of the room. When Certified Nurse Aide D went to deliver their tray to them, this surveyor stopped Certified Nurse Aide D and asked Dietary Staff A to measure the temperatures of the hot food items on Resident #126's plate. At 12:24 p.m., the pork chop was 117.7 degrees F, the potato cake was 97.3 degrees F, and the broccoli was 105.2 degrees F. At 12:27 p.m., Dietary Staff A plated hot foods for Resident #126 and handed it to Certified Nurse Aide D to be served. On 6/9/22 at 10:59 a.m., when informed of the tray held for Resident #126 and of the temperatures of Resident #126's vegetables when tested immediately prior to service on 6/6/22, Dietary Staff B said, "They should have made another tray for him." When informed that a replacement plate was served to him, Dietary Staff B said there was no need to have made a tray for them in advance – staff should have waited to prepare it after Resident #126 arrived in the dining room. Review of Resident #126's medical record, on 6/9/22, found he was assessed on [DATE] as being moderately cognitively impaired. Resident #126 may not have known that they could ask for a replacement tray if they found the hot food items to be not palatable due to low temperatures.
§51.140(g) Assistive devices	Based on observation, staff interview, and record review, the facility management failed to ensure residents received special eating equipment and utensils in accordance with their

The facility management must provide special eating equipment and utensils for residents who need them. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Physician Orders for one (1) sampled resident (Resident #113) and two (2) residents of random opportunity (Resident #126 and Resident #127) who took their noon meals in the dining room for [LOCATION] on 6/6/22. This affected three (3) of three (3) residents in the dining room with notations on their tray tickets to receive adaptive equipment for eating. The findings include: On 6/6/22 beginning at 11:56 a.m., observations were made of the noon meal service in the dining room for the [LOCATION]. At 12:37 p.m., after all residents in the dining room had been served, a review of a stack of meal tray tickets left next to the tray line revealed the following residents had notations to receive special adaptive eating equipment and utensils with their meals: - Resident #113 – Kennedy cup; weighted built-up utensils, and plate guard - Resident #126 – Kennedy cup - Resident #127 – Kennedy cup A Kennedy cup is a light-weight, spill-proof drinking cup with a handle, a screw-on lid, and a hole in the center of the lid for a straw. Observations of Resident #126 and Resident #127 found their beverages had been served in regular drinking cups, without handles, lids and were not spill-proof. Observation of Resident #113 found a plate guard in place; however, their beverages had been served in regular drinking cups and they were provided with regular eating utensils. When interviewed about the Kennedy cups, Dietary Staff A pointed to cupboards located across the dining room near the hand sink and stated if there were any Kennedy cups, they would be in one (1) of the cupboards, and that nursing staff was responsible for serving beverages in those cups to residents needing them. Examination of the cupboards identified by Dietary Staff A found no Kennedy cups present. When this was brought to their attention, Dietary Staff A stated that since it was Monday, they must have been taken to the Dietary Department to be washed (a weekly process they referred to as the “Purge”). Review of Resident #126’s Physician Order found an active order, dated [DATE], documenting, “Resident to utilize Kennedy cup with all meals.”

	Review of Resident #127's Physician Order found an active order, dated [DATE], documenting, "Kennedy cup for drinks." Review of Resident #113's Physician Order found the following active orders: - 2/23/22 – "Resident to utilize built up utensils for all meals." - 4/11/22 – "Kennedy cups, built up utensils." - 4/11/22 – "Recommend plate guards for meals."
§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 – Some	Based on observation, staff interview, and review of the U.S. Food & Drug Administration Food Code 2017, the facility management failed to ensure food was served under sanitary conditions to all residents receiving meatball sub sandwiches and chicken patties on hamburger buns prepared in the dining room of the [LOCATION] for the noon meal on 6/7/22. The findings include: The U.S Food & Drug Administration Food Code 2017 found: "3-304.11 Food Contact with Equipment and Utensils. Pathogens can be transferred to food from utensils that have been stored on surfaces which have not been cleaned and sanitized. They may also be passed on by consumers or employees directly, or indirectly from used tableware or food containers. Some pathogenic microorganisms survive outside the body for considerable periods of time. Food that comes into contact directly or indirectly with surfaces that are not clean and sanitized is liable to such contamination. The handles of utensils, even if manipulated with gloved hands, are particularly susceptible to contamination. … The Food Code defines gloves as a 'utensil' and therefore gloves must meet the applicable requirements related to utensil construction, cleaning, and storage… 3-304.15 Gloves, Use Limitation. Refer to the public health reason for § 3-304.11. Gloves used in touching ready-to-eat food are defined as a 'utensil' and must meet the applicable requirements related to utensil construction, good repair, cleaning, and storage. Multiuse gloves, especially when used repeatedly and soiled, can become breeding grounds for pathogens that could be transferred to food. Soiled gloves can directly contaminate food if stored with ready-to-eat food or may indirectly contaminate food if stored with articles that will be used in contact with food." Observation of the tray line in the dining room of [LOCATION], beginning at 12:00 p.m. on 6/7/22, found Dietary Staff C using their gloved hands to prepare and plate meatball sub sandwiches.

	For each meatball sub sandwich made, Dietary Staff C used their gloved hand to remove a sub roll from a bag, pry open the roll using both gloved hands, place the roll on a plate, and hold open the roll with one gloved hand while using a spoon in their other gloved hand to place three (3) meatballs across the open roll. While the tray line was in operation, they would use the same gloved hands to handle other serving utensils, open the doors to cupboards, and open the bags for other sub rolls. They did not remove/replace these gloves at any time during the meal service once the tray line began. In addition to handling sub rolls with their gloved hands, they also handled hamburger rolls to prepare chicken patty sandwiches. They did, however, use tongs to remove single slices of bread from baggies when preparing meals without rolls or buns. After all meals were prepared, Dietary Staff C was interviewed. When asked why they used tongs to handle the slices of bread, Dietary Staff C said it was to keep from cross contaminating the food. When asked why they did not use tongs to handle the rolls, they said that they usually lay the rolls open in a pan, but today they left the rolls in their bags so they would not dry out. When asked if they had cross-contaminated the rolls by handling them with their gloved hands, Dietary Staff C said that they didn't think they did so. When the surveyor pointed out that they opened cupboard doors and handled utensils with the same gloves they used to handle the rolls without changing them, Dietary Staff C acknowledged that they had done so.
§51.180(e)(1) Storage of drugs and biologicals In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on observations, interview, and review of the facility policy, the facility failed to keep medications in a locked medication cart for two (2) of eight (8) medication carts. The findings include: Review of the facility policy titled, "Medication Administration," dated April 2022, revealed documented under "Using the Unit Medication Carts… 4. Cart must always be locked and in a locked room except when in use and in clear sight of the nurse responsible." Observation on 6/8/22 at 8:13 a.m. of the [LOCATION] revealed the unlocked medication cart in the hallway and no staff within eyesight of the cart. Licensed Nurse F acknowledged the medication cart was unlocked. Observation on 6/8/22 at 11:25 a.m. of the [LOCATION] revealed an unlocked medication cart with eight (8) insulin vials on top of the cart, and inhalers, eye drops, and ointments in the unlocked drawers. The medication cart was in the hallway and no staff were within eyesight of the cart.

	An interview with Licensed Nurse G on 6/8/22 at 11:30 a.m. confirmed the medication cart was unlocked and they stated that they got busy getting a drink for a resident and did not lock the cart.
§51.190(a) Infection Control The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Many	Based on observation, staff interview, review of the facility's policies, review of guidance from the Pennsylvania Department of Health, and review of material from the Centers for Disease Control and Prevention (CDC), the facility management failed to maintain an infection control program during an active outbreak of COVID-19 as evidenced by: incomplete wearing of personal protective equipment (PPE) by staff performing rapid point-of-care COVID-19 testing; lack of availability of supplies to perform hand hygiene prior to exiting the facility's COVID-19 isolation unit; ineffective wearing of PPE in resident care areas; and cross contamination of wounds during dressing / treatment. The findings include: 1. During the survey entrance conference conducted on the morning of 6/6/22, Administrative Staff A and Administrative Nurse B reported the facility was currently in an active outbreak of COVID-19, with 20 residents who tested positive for COVID-19 being isolated together in the facility's dedicated isolation unit (the Red Zone) on the [LOCATION]. Staff working outside of the Red Zone were to wear personal protective equipment (PPE) based on their vaccination status. All personnel who were up to date with vaccinations were to wear a surgical mask and protective eyewear when in resident care areas. All personnel who were not up to date with vaccinations were to wear an N95 respirator and protective eyewear and were subject to routine testing based on guidance provided by the Pennsylvania Department of Health. 2. At 8:54 a.m. on 6/6/22, two (2) of the surveyors riding together in the same automobile stopped at the security guard station for screening prior to entering the campus. A security guard, who was wearing protective eyewear, a surgical mask, and gloves, approached the driver and offered an ink pen and a clipboard holding a COVID-19 self-screening questionnaire to be completed by each person entering the campus. After the driver completed the questionnaire, the security guard took the surveyor's temperature using a touchless thermometer and recorded it on the form. The security guard removed the driver's completed questionnaire from the clipboard, walked around to the passenger window, and handed the same clipboard and pen to the passenger for them to use to complete a self-screening questionnaire. Neither the clipboard nor the pen was sanitized between uses.

	Upon arrival at the conference room in [LOCATION] after completing the screening process, a second team of two (2) surveyors who traveled in the same vehicle together reported the security guard had them complete their self-screening questionnaires, one after the other, using the same pen and clipboard without these items being sanitized between uses. At 7:57 a.m. on 6/7/22, two (2) of the surveyors riding together in the same automobile stopped at the security guard station for screening prior to entering the campus. One (1) of the two (2) security guards at the station, who was wearing protective eyewear, an N95 respirator, and gloves, approached the driver and offered them an ink pen and a clipboard holding a COVID-19 self-screening questionnaire to be completed by each person entering the campus. After the driver completed the questionnaire, the security guard took their temperature using a touchless thermometer and recorded it on the form. The security guard removed the driver's completed questionnaire from the clipboard, walked around to the passenger window, and offered the same clipboard and pen to the passenger for them to use to complete a self-screening questionnaire. Again, neither the clipboard nor the pen was sanitized between uses. 3) The facility's policy titled, "COVID-19 Testing Requirements for Residents and Staff for the State Veterans Homes (SVH)," with a revision date of 4/13/22, documented, "4. Collecting and handling specimens correctly and safely is imperative to ensure the accuracy of test results and prevent any unnecessary exposures. … b. During specimen collection, SVHs will maintain proper infection control and use recommended personal protective equipment (PPE), which includes a NIOSH (National Institute of Occupational Safety and Health) approved N95 or equivalent or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens." At 7:57 a.m. on 6/7/22, two (2) of the surveyors riding together in the same automobile stopped at the security guard station for screening prior to entering the campus. During the screening process, the security guard asked if any surveyors had been on the [LOCATION] the previous day, as a resident on that unit had newly tested positive for COVID-19. When one (1) of the surveyors responded in the affirmative, the security guard informed the surveyors that COVID testing was available if desired. The surveyors drove to the COVID-19 testing site on campus and were met by Licensed Nurse H. Licensed Nurse H, who was wearing a surgical mask, approached the automobile to discuss the rapid point-of-care COVID-19 testing that would be

	done, then they offered a clipboard to each surveyor to gather information prior to being swabbed. When Licensed Nurse H reapproached the automobile with two (2) opened packages, each containing a swab for specimen collection, they were still wearing only a surgical mask – no gloves, gown, N95 respirator, or protective eyewear or face shield. While holding both opened packages in one (1) ungloved hand, they swabbed one (1) surveyor, inserted the used swab back into the open package, walked around the automobile, swabbed the second surveyor, inserted the used swab into the second open package, and informed them they would be notified of the test results via telephone as soon as they were available. Administrative Nurse B, during the debriefing conference on the afternoon of 6/7/22, confirmed that all staff were now expected to wear N95 respirators, and that N95s were readily available to staff throughout the facility. 4) The facility's policy titled, "FUNDAMENTALS OF ISOLATION PRECAUTIONS," with a revision date of 9/20/11, documented: "Hand Hygiene is the most important measure to reduce the transmission of microorganisms between staff and residents. Perform hand hygiene with a hand sanitizer when hands are not visibly soiled. … Gloves are worn to provide a protective barrier and prevent gross contamination of the hands when touching blood, body fluids, secretions, mucous membranes and non-intact skin; to reduce the transmission of microorganisms present on the hands of personnel to residents during resident care/ procedures [*sic*]; to reduce the likelihood that hands of personnel contaminated with microorganisms from a resident ... will transmit these microorganisms to another resident. Gloves must be changed between resident contacts and hands washed after gloves are removed." The "PENNSYLVANIA DEPARTMENT OF HEALTH 2021 – PAHAN – 563 – 04-09-UPD UPDATE: Interim Infection Prevention and Control Recommendations for Healthcare Settings during the COVID-19 Pandemic," with an effective date of 4/9/20, documented: "II. RECOMMENDED INFECTION PREVENTION AND CONTROL (IPC) PRACTICES WHEN CARING FOR A PATIENT EXPOSED TO COVID-19 OR WITH COVID-19 INFECTION … C. Personal Protective Equipment HCP (health care personnel) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection…

	Hand Hygiene - HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. HCP should perform hand hygiene by using ABHS (alcohol-based hand sanitizer) with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS. Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location." From 4:30 p.m. to 5:48 p.m. on 6/6/22, a tour was conducted of the facility's dedicated isolation unit, the Red Zone, for residents who had tested positive for COVID-19. Upon leaving the resident care area and entering the doffing station (the area designated for removal of PPE prior to exiting the Red Zone), observation found no hand sink available for performing hand washing and only a gallon jug of alcohol-based hand sanitizer with no dispensing pump. Administrative Nurse A, who was present during this tour, verified there were no hand hygiene supplies readily available for personnel to use after removing their PPE and prior to exiting the Red Zone and returning to the rest of the facility. 5) An undated CDC handout titled, "SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)," presented by Administrative Nurse B at 11:00 a.m. on 6/9/22, documented, "2. MASK OR RESPIRATOR: Secure ties or elastic bands at middle of head and neck. Fit flexible band to nose bridge. Fit snug to face and below chin. Fit-check respirator." Educational material from the CDC titled, "How to Use Your N95 Respirator," updated on 3/16/22, documented: "Always inspect the N95 for damage before use. If it appears damaged, dirty, or damp, do not use it. … Your N95 must form a seal to your face to work properly. Your breath must pass through the N95 and not around its edges. … Replace the N95 when the straps are stretched out and it no longer fits snugly against your face or when it becomes wet, dirty, or damaged." Upon entering the dining room on [LOCATION] at 11:52 a.m. on 6/7/22, observation found Certified Nurse Aide E verbally alerting their coworkers to the arrival of this surveyor. Further observation found Dietary Staff C and Certified Nurse Aide F wearing N95 respirators on their chins as they conversed with each other while standing on either side of the serving station. Dietary Staff C was wearing protective eyewear, and Certified

	Nurse Aide F was wearing a face shield, but neither had their nose or mouth covered by their N95. Both individuals were noted to have subsequently adjusted their N95s to cover their noses and mouths. During the course of the meal service, observations found Certified Nurse Aide E wearing both straps of their N95 at the neck, and the N95s worn by both Dietary Staff C and Certified Nurse Aide F each only had a single strap, which was also worn at the neck. Upon questioning Dietary Staff D and Dietary Staff C about their PPE at 12:10 p.m., Dietary Staff D confirmed that all staff were now to be wearing N95s and that they had been fit-tested for them. Both Dietary Staff D and Dietary Staff C were unable to recall the last time that they were fit-tested, but both agreed this had occurred within the past year. At 12:18 p.m., Certified Nurse Aide E (who was wearing her N95 with both straps at the neck) was asked when they were last fit-tested for their respirator; they could not recall. When observed again at 12:21 p.m., Certified Nurse Staff E was now wearing their N95 with one strap across the middle of their head and the other strap at the neck. When interviewed in the dining room at 12:35 p.m. about their N95 missing a strap, Dietary Staff C reported that they broke it and that they would need to get a new one. When informed that they were seen earlier with their N95 down, they had no further comments. When interviewed in the hallway near the nursing station at 12:38 p.m. about when they were last fit-tested for their N95, Certified Nurse Aide F could not recall an exact date but acknowledged that this took place “a couple of months ago.” When asked about their N95 missing a strap, they said that they broke it “a little bit ago” and needed to get another one; that they had one in their car. Administrative Nurse B, during the debriefing conference on the afternoon of 6/7/22, confirmed that all staff were now expected to wear N95s, and that N95s were readily available to staff throughout the facility. 6) The facility policy titled, “ISOLATION PRECAUTION,” with a revision date of 4/16/20, documented: “TIER 1 – STANDARD PRECAUTIONS … Gloves are to be worn when handling or touching resident equipment that is visibly soiled or potentially contaminated with blood, body fluids, secretions, excretions, or infectious organisms, and other potentially infected material. Put on clean gloves just before touching non intact skin and mucous

	membranes. Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms." Observation, beginning at 11:25 a.m. on 6/8/22, found Licensed Nurse I accompanied by a Licensed Nurse J, who was a wound care consultant. Licensed Nurse I gathered supplies for a treatment to be performed on Resident #123. They carried a gallon-size, resealable plastic bag containing the treatment materials into Resident #123's room and placed the bag on the resident's bedside stand. The outside of the plastic bag was visibly smudged with what appeared to be fingerprints from repeated handling of the bag. Licensed Nurse I closed the privacy curtain, and both Licensed Nurse I and Licensed Nurse J washed their hands and donned gloves. The resident was assessed for pain, the old dressing was removed, and Licensed Nurse J measured the wound. Licensed Nurse J reported the wound as being a fistula that opened to the outside of the resident's abdomen, likely caused by an emergency repair of an inguinal hernia that used mesh in the procedure. As Licensed Nurse J removed their gloves and washed their hands, Licensed Nurse I used their gloved hands to handle the outside of the plastic bag as they removed and prepared their supplies, and they proceeded to describe their actions as they performed the treatment. Licensed Nurse I flushed the wound with sterile saline, treated the peri-wound area, retrieved a length of Iodoform gauze from a bottle, gathered up the gauze in the palm of their gloved hand, and prepared it to pack the open wound. This surveyor intervened by suggesting that Licensed Nurse I change their gloves, as they were in contact with the outside of the plastic bag, which was visibly smudged.
51.200 (a) Life Safety from Fire The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.	**<u>Means of Egress</u>** 1. Based on observation and interview, the facility failed to prohibit storage in stairwells. The deficient practice affected three (3) of 31 smoke compartments, staff, and 42 residents. The facility had the capacity for 257 beds with a census of 151 on the day of survey. The findings include: Observation during the building inspection tour on 6/6/22 at 3:40 p.m. revealed storage of paper goods in the stairwell exit adjacent to the [LOCATION] in the [LOCATION] building, as

Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Many	prohibited by sections 7.1.3.2.3 and 7.2.2.5.3 of NFPA 101, Life Safety Code. An interview at that time with the Maintenance Staff A revealed that the paper goods were being stored in in the area outside the stairwell for a carnival for the residents. The census of 151 was verified by Administrative Staff A on 6/6/22. The finding was acknowledged and verified by Administrative Staff A during the exit interview on 6/9/22. **Actual NFPA Standard: NFPA 101, Life Safety Code** **19.2 Means of Egress Requirements.** **19.2.1** General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. **7.1.3.2.3*** An exit enclosure shall not be used for any purpose that has the potential to interfere with its use as an exit and, if so designated, as an area of refuge. (See also 7.2.2.5.3.) **7.2.2.5.3*** Usable Space. Enclosed, usable spaces within exit enclosures shall be prohibited, including under stairs, unless otherwise permitted by 7.2.2.5.3.2. **7.2.2.5.3.1** Open space within the exit enclosure shall not be used for any purpose that has the potential to interfere with egress. **Smoke Barriers and Sprinklers** 2. Based on observation and interview, the facility failed to install Alcohol Based Hand Rub (ABHR) dispensers in accordance with the code. The deficient practice affected three (3) of 31 smoke compartments, staff, and 30 residents. The facility had a capacity for 257 beds with a census of 151 on the day of the survey. The findings include: Observation during the building inspection tour on 6/7/22 at 11:07 a.m. in the kitchen of the in the [LOCATION] revealed an ABHR dispenser installed above an electrical outlet, as prohibited by section 19.3.2.6 (8) of NFPA 101, Life Safety Code. An interview at that time with Maintenance Staff B revealed the facility was not aware the dispenser was installed above the electrical outlet. Observation during the building inspection tour on 6/7/22 at 1:40 p.m. revealed an ABHR dispenser installed above an electrical outlet in corridor of the [LOCATION], as prohibited by section 19.3.2.6 (8) of NFPA 101, Life Safety Code. An interview at that time with the Maintenance Staff B revealed the facility was not aware the dispenser was installed above the electrical outlet.

	Observation during the building inspection tour on 6/7/22 at 2:07 p.m. in the [LOCATION] unit in the [LOCATION] revealed an ABHR dispenser installed above an electrical outlet by room BG-7, as prohibited by section 19.3.2.6 (8) of NFPA 101, Life Safety Code. An interview at that time with Maintenance Staff B revealed the facility was not aware the dispenser was installed above the electrical outlet. The census of 151 was verified by Administrative Staff A on 6/6/22. The findings were acknowledged and verified by Administrative Staff A during the exit interview on 6/9/22. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.2.6*** Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met: (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source
§ 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	Based on interview and record review, the facility didn't have a written sharing agreement with Veterans Administration (VA) for psychological services. The facility was also unable to provide evidence of a provider agreement in relation to primary care services. The findings included: An interview with the Administrative staff was conducted on 6/6/22 at approximately 9:30 a.m. during the entrance conference. The staff confirmed that they had residents who went to VA for mental health services and noted that they had a sharing agreement. The facility Administrative Staff A also confirmed that the facility has a contract with a local primary care provider group but that Veterans who are eligible to receive care from the VA go to the local VA to see a primary care provider. Review of the Provider Agreement (effective date February 2, 2013), signed by the Administrative Staff A revealed that the document did not meet the requirements to be considered a Sharing Agreement. The facility was unable to demonstrate that they have a written sharing agreement between the facility and the local VA for either mental health or primary care services.

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	