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: Lawton/Ft. Sill Veterans Center

Location: 501 S.E. Flower Mound Road, Lawton, OK 73501

Onsite / Virtual: Onsite

Dates of Survey: 11/5/24 – 11/8/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 200

Census on First Day of Survey: 163

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from November 5, 2024 – November 8, 2024, at the Lawton/Ft. Sills Veterans Center in Lawton, Oklahoma. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes. On 11/5/24, a determination was made that a situation in which the facility's noncompliance with one (1) or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment, or death to residents. Administrative Staff A and Administrative Staff B were informed of the immediate jeopardy on 11/5/24 at 5:05 p.m. The noncompliance related to immediate jeopardy was identified to have existed on 10/22/24. The immediate jeopardy continued through 11/5/24 and was removed on 11/5/24. The facility implemented a Plan of Removal related to the immediate jeopardy on 11/5/24. The immediate jeopardy is outlined as follows: Resident #6 was sent to the hospital on [DATE], and was diagnosed with Legionella Pneumonia. Resident #6 was re-admitted to the facility on [DATE]. The facility notified the Oklahoma State Department of Health on [DATE], of the positive Legionella within the facility. Recommendations were provided to the facility from the Oklahoma State Department of Health on [DATES]. The facility failed to ensure that all

	recommendations for immediate removal of Legionella bacteria within the facility was completed from 10/22/24 – 11/5/25. Interviews with staff within the facility identified that no education was provided on Legionnaire's disease, and no instruction had been provided on an increase in infection control measures with a positive Legionnaire's disease diagnosis within the facility. Administrative Staff A and Administrative Staff B were informed on 11/8/24 at 9:30 a.m., that an Immediate Jeopardy was identified for Administration. The facility failed to ensure that all facility policies and procedures were reviewed annually, failed to ensure an effective infection control program that monitored infections, implemented interventions to prevent the spread of disease, educate staff on infection control processes, and ensure Licensed Nurse D received required infection control training. The facility also failed to evaluate and assess residents to prevent future falls. The noncompliance related to immediate jeopardy for Administration was identified to have existed on 10/22/24. The immediate jeopardy continued through 11/5/24 and was removed on 11/8/24. The facility implemented a Plan of Removal related to the immediate jeopardy on 11/8/24.
§ 51.40 Basic per diem rates. (a) Basic rate. Except as provided in §51.41, VA will pay per diem for care provided to an eligible veteran at a State home at the lesser of the following rates: (1) One-half of the daily cost of the care for each day the veteran is in the State home, as calculated under paragraph (b) of this section. (2) The basic per diem rate for each day the veteran is in the State home. The basic per diem rate is established by VA for each fiscal year in accordance with 38 U.S.C. 1741(a) and (c). **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Many	The facility was unable to demonstrate that per diem rate was properly calculated each month. The findings include: The facility leadership did not respond to multiple requests for documentation necessary for assessment of regulatory compliance. The facility leadership did not provide evidence to demonstrate that the facility management computes the direct and indirect costs monthly.
§ 51.41 (c) (2) Payments under State home care agreements. (2) The State home shall not charge any individual, insurer, or entity (other	The facility was unable to demonstrate that no individual, insurer, or entity (other than VA) was charged for the nursing home care paid for by VA under a VA provider agreement was not provided identifying third-party vendors.

than VA) for the nursing home care paid for by VA under a State home care agreement. Also, as a condition of receiving payments under paragraph (c), the State home must agree not to accept drugs and medicines from VA provided under 38 U.S.C. 1712(d) on behalf of veterans covered by this section and corresponding VA regulations (payment under this paragraph (c) includes payment for drugs and medicines). **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Many	The findings include: The facility leadership did not respond to multiple requests for documentation necessary for assessment of regulatory compliance. The facility leadership did not provide evidence to demonstrate that all third-party vendor contracts were provide for review to determine the facility had paid the costs for Prevailing Rate Veterans in receipt of required services.
§ 51.70 (c) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on record review and interview, the facility failed to conduct a timely final accounting upon the death of residents with funds deposited in a trust account for two (2) of eight (8) sampled accounts (Resident #24 and Resident #29). The findings include: Review of the facility policy titled, “Disbursement of Deceased Resident Assets for Lawton Veterans Center,” Effective Date 1/31/22, revealed: “The individual(s) designated on ODVA Form No. 490, Designation of Property, will be contacted to receive the resident's property. Arrangements shall be made for the release of the property at their earliest possible convenience. The initial contact may be made verbally. If verbal contact is unable to be made, written notice shall be sent to the designated individual(s). Such notice shall contain a list of the resident's remaining personal property and shall include ODVA Form 490A, Affidavit, for the designated individual(s) to complete at the time the individual(s) retrieves the property from the Veterans Center. The date of the first written notice shall begin the sixty (60) day notice process (90 days for conveyance of funds); (90 days to claim).” A review of Resident #24’s records revealed the Resident expired on [DATE]. The Resident’s representatives did not receive the entirety of the Resident’s funds within the 90 days as per regulatory standards. A review of Resident #29’s records revealed the Resident expired on [DATE]. The Resident’s representatives did not receive the entirety of the Resident’s funds within the 90 days as per regulatory standards.

	During an interview, on 11/7/24, at approximately 12:19 p.m., Administrative Staff E stated that of the eight (8) residents sampled, there were two (2) residents' funds which were still pending Central Office approval for release.
§ 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 minimal harm **Residents Affected** – Many	Based on interview and record review, the facility failed to assure financial security of residents' personal funds per regulatory guidelines. The findings include: On 11/6/24 at approximately 11:00 a.m., a review of the facility's fiscal documentation revealed the facility had not purchased a surety bond to assure the security of residents' personal funds deposited with the facility. During an interview on 11/7/24 at approximately 2:00 p.m., Administrative Staff E presented the survey team a document. Upon further inspection, the document presented was an insurance policy and not a surety bond.
§ 51.70 (e) (1) – (3) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. (1) Residents have a right to personal privacy in their accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility management to give a private room to each resident. (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident's right to refuse release of personal and clinical records does not apply when— (i) The resident is transferred to another health care institution; or (ii) Record release is required by law. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, record review, and policy review, the facility failed to ensure personal privacy for two (2) of 32 sampled residents. Observation revealed Resident #9 was not afforded privacy during the administration of indwelling Foley catheter care, and Resident #10 was not afforded privacy for wound care treatment; these incidents were observed on one (1) occasion for each observation. The findings include: Review of the facility policy titled, "Quality of Life-Dignity," Nursing Services Policy and Procedure Manual for Long-Term Care 2001 Med -Pass, revised August 2009, revealed: "Policy Interpretation and Implementation…10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." Record review revealed Resident #9 was admitted to the facility on [DATE], with active diagnoses of Retention of Urine, Congested Heart Failure, Type Two (2) Diabetes Mellitus, and Chronic Obstructed Pulmonary Disease. Review of Resident #9's Annual Minimum Data Set (MDS) Assessment, dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. On 11/5/24, beginning at 11:45 a.m., Certified Nurse Aide D was observed as they were setting up for Resident #9's

	indwelling Foley catheter care procedure. During this procedure, the vertical curtains to the window next to Resident #9's bed were not closed, and this window looked directly onto the outside sidewalk. At the end of this observation, an inquiry regarding the procedure and resident privacy was made. Certified Nurse Aide D confirmed that the vertical curtains to the window next to Resident #9's bed should have been closed, and they further stated: "I should have closed the curtains to the window in the residents room while providing care." During an interview, at 12:20 p.m., on 11/7/24, Administrative Nurse A, when informed of the above observations, reported it was their expectation that the resident should have been afforded privacy when they received their indwelling Foley catheter care procedure by closing the window curtains to the window of Resident #9's room. Record review revealed Resident #10 was admitted to the facility on [DATE], with active diagnoses of Pressure Ulcer Left Buttock Stage 4 (four), Bilateral Above the Knee Amputee, Diabetes Mellitus, and Obstructed Uropathy. Review of Resident #10's Quarterly MDS Assessment, dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. On 11/6/24, beginning at 11:00 a.m., Licensed Nurse C, and Certified Nurse Aide F were observed as they were setting up for Resident #10's wound care procedure. During this procedure, the vertical curtains to the window next to Resident #10's bed were not closed, and this window looked directly into the outside smokers' courtyard. At the end of this observation of Resident #10's wound care, an inquiry regarding the procedure and resident privacy was made. Licensed Nurse C confirmed that the vertical curtains to the window next to Resident #10's bed should have been closed, and they further stated: "I realize I failed to close the curtains to the window in the resident's room." During an interview, at 12:40 p.m., on 11/7/24, Administrative Nurse A, when informed of the above observations, reported it was their expectation that the resident should have been afforded privacy when they received their wound care procedure by closing the window curtains to the window of Resident #10's room.

§ 51.120 (i) Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. **Level of Harm** – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	Based on observation, interviews, record reviews, and facility policy reviews, the facility failed to evaluate, assess, and identify causes of falls for one (1) of four (4) sampled residents (Resident #12) to prevent the recurrence of 11 falls from [DATE] to [DATE]. This failure had the potential for Resident #12 to incur repeated falls with injuries. The findings include: A review of the facility's policy titled, "Assessing Falls and Their Causes," dated 03/18, revealed: "Purpose. The purposes of this procedure are to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall…Steps in the procedure. After a fall: 1. If a resident has just fallen or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities. 2. Obtain and record vital signs as soon as it is safe to do so. 3. If there is evidence of injury, provide appropriate first aid and/or obtain medical treatment immediately. 4. If an assessment rules out significant injury, help the resident to a comfortable sitting, lying, or standing position, and then document relevant details …6. Observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall and will document findings in the medical record. 7. Document any observed signs or symptoms of pain, swelling, bruising, deformity and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings. 8. Complete an incident report for resident falls no later than 24 hours after the fall occurs…Identifying causes of a Fall or Fall Risk: 1. Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident-specific evidence including medical history, known functional impairment, etc. 2. Evaluate chains of events or circumstances preceding a recent fall, including: a. Time of day of the fall; b. Time of the last meal; c. What the resident was doing; d. Whether the resident was standing, walking, reaching, or transferring from one position to another; e. Whether the resident was among other persons or alone; f. Whether the resident was trying to get to the toilet; g. Whether any environmental risk factors were involved (e.g. slippery floor, poor lighting, furniture or objects in the way); and/or; h. Whether there is a pattern of falls for this resident. 3. Continue to collect and evaluate information until the cause of falling is identified or it is determined that the cause cannot be found." A review of the facility's policy titled, "Falls and Fall Risk, Managing," dated 3/18, revealed: "Policy Statement, based on

	previous evaluations and current data, the staff will identity interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling…Monitoring subsequent falls and fall risk: 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling…3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change the current interventions." A review of the facility's policy titled, "Falls-Clinical Protocol," dated 9/12, revealed: "Assessment and Recognition…2. In addition, the nurse shall assess and document/report the following: a. Vital sings; b. Recent injury, especially fracture or head injury; c. Musculoskeletal function, observing for change in normal range of motion, weight bearing, etc.; d. Change in condition or level of consciousness; e. Neurological status; f. Pain." A review of the facility's policy titled, "Urinary Incontinence – Clinical Protocol," dated 9/12, revealed: "Assessment and Recognition: 1. As part of the initial assessment, the physician will help identify individuals with impaired urinary continence, i.e. reduced ability to maintain urine in a socially appropriate manner…Treatment/Management…4. As appropriate, based on assessment of the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual's continence status." A review of the Resident #12's "Admission Record," dated [DATE], revealed that the resident was admitted to the facility on [DATE], with diagnosis included age-related physical debility, generalized muscle weakness, Diabetes Mellitus, and Hypertension. A review of the Resident #12's "Admission Minimum Data Set," (MDS), dated [DATE], revealed that the resident had a Brief Interview for Mental Status (BIMS) of 15, which indicated intact cognition. Further review of the MDS revealed that the resident had bilateral upper extremity impairment and was occasionally incontinent of bladder and bowel. A review of the Resident #12's "Care Plan," revealed the following: "I am at risk for falls R/T (related to) unsteady balance, HX (history) of falls, and use of medications that increase the risk for falls, DX (diagnosis) of dementia, unable to remember physical limitations, safety interventions at times, DX sinus syndrome. [They have] cut their bed alarm. -[DATE] unwitnessed fall with minor injury at 10:38 a.m.

	-[DATE] OOP (out on pass) reported fall, admitted to hospital with right hip fracture. -[DATE] unwitnessed fall with minor injury at 7:47 a.m. -[DATE] unwitnessed fall with minor injury at 12:15 a.m. -[DATE] unwitnessed fall with minor injury at 8:27 a.m. -[DATE] fall X1 (times one) minor injury -[DATE] unwitnessed fall no injury at 2:36 p.m. -[DATE] unwitnessed fall no injury at 11:45 p.m. -[DATE] unwitnessed fall no injury at 11:30 a.m. -[DATE] unwitnessed fall minor injury at 3:57 a.m. -[DATE] unwitnessed fall -[DATE] unwitnessed fall minor injury 9:42 p.m." Further review of the Resident #12's Care Plan revealed: "Goal: the resident will be free of falls/injury from falls through increased staff awareness and supervision on a daily basis for the next 92 days." Further review of the Resident #12's Care Plan interventions revealed the following: "-[DATE], medication review/changes, pending effectiveness. -[DATE] refused ER (emergency room) transfer for eval (evaluation), recent hip FX (fracture), PT (physical therapy) and OT (occupational therapy) evals completed [DATE], foam mattress removed. -[DATE] sent to ER for eval, acute illness, add transfer orders, educated regarding requesting assistance for transfers. -[DATE] X-rays ordered, removed 4WW (four-wheeled walker), continue frequent checks and keep door open. -[DATE] review of 2 (two) falls, 1st fall educated about turning off alarm. 2nd fall [they] cut [their] alarm and was observed in floor, provided urinal at bedside, offer toileting with each round. -[DATE] add anti-roll backs. -[DATE] corner protectors for bedside table. -[DATE] review of falls X2 (times 2), labs were drawn yesterday, note of decline in cognition as well as mobility after hip FX [DATE], labs ordered to R/O (rule out) acute illness, review safety order, remove 4WW and add hipsters, consider possible need for pain medication." A review of the Resident #12's "Fall Risk Assessment," revealed the following: 1. [DATE] – high risk at 55 (51 or greater) moderate risk (25 to 50) Low (0-24) 2. [DATE] – 55 Actual Post fall assessment 3. [DATE] – 65 Actual Post fall assessment 4. [DATE] – 80 post fall 5. [DATE] – 65 post fall 6. [DATE] – 75 post fall 7. [DATE] – 75 post fall

	8. [DATE] – 75 post fall 9. [DATE] – 75 post fall 10. [DATE] – 75 post fall A concurrent observation and interview, on 11/5/24, at 2:20 p.m., outside of Resident #12's room, revealed that Resident #12 was sitting on their wheelchair, with steri-strips to the right side of their neck, on their forehead, and on top of their head. When asked what happened to them, Resident #12 stated that they fell last night, and recently came back from the ER. Further interview with the resident revealed that they remembered stepping on their trash can while getting out of the bed to go to the bathroom. An interview, on 11/7/24, at 12:00 p.m., with Administrative Nurse A, revealed that the resident had 11 fall incidents since admission on [DATE]. Administrative Nurse A stated that they had a root cause analysis (RCA); however, it was only discussions that were placed as interventions in the resident's Care Plan. Further interview with Administrative Nurse A revealed that there was no documentation that they discussed the patterns of falls, such as identification of causes and how to prevent the recurrence of falls. Administrative Nurse A confirmed that the resident's (RCA) interventions were not effective because the resident kept falling. A concurrent interview and record review occurred on 11/7/24, at 1:20 p.m., with Administrative Nurse A, in the presence of Administrative Staff D. Resident #12's "Fall Incident Reports" were reviewed. The resident's fall incident reports revealed no documentation of a neurological check (neuro check-assessment for changes in level of consciousness), no vital signs check, and no post-fall note recorded for the resident's fall incidents on [DATES], and for the two (2) falls on [DATE]. Further interview with Administrative Nurse A revealed that per the facility's policy, there should have been a neuro check, vital signs check, and a post-fall 48 hours' note for each of Resident #12's fall incidents. An interview, on 11/7/24, at 1:30 p.m., with Administrative Staff D revealed that after the resident's unwitnessed fall in the bathroom on [DATE], it would have been beneficial to add the scheduled toileting that would prompt the nursing staff to assist Resident #12 to the bathroom every two (2) hours. Further interview with the Administrative Staff D revealed that they should have started the scheduled toileting per the facility's policy to improve Resident #12's incontinence. Administrative Staff D further revealed that the increased episodes of the resident's incontinence should have been identified in the RCA.

§ 51.190 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** – Immediate Jeopardy to resident health or safety **Residents Affected** – Many	Based on observation, interview, and record review, the facility failed to ensure safe infection control practices were in place to prevent the spread of infection to all residents within the facility. This had the potential to affect all residents, and resulted in Immediate Jeopardy. The findings include: Review of the facility's policy titled, "Legionella Water Management Program," dated July 2017, noted the following: "Policy Statement: Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Policy Interpretation and Implementation: 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. 2. The water management team will consist of at least the following personnel: a. [Licensed Nurse D]; b. [Administrative Staff A]; c. [Administrative Staff C] (or designee); d. [Maintenance Staff A]; and 3. [Maintenance Staff C]. 3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. 4. The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE [the American Society of Heating, Refrigerating and Air-Conditioning Engineers] recommendations for developing a Legionella water program. 5. The water management program includes the following elements: a. An interdisciplinary water management team; b. A detailed description and diagram of the water system in the facility, including the following: (1) Receiving; (2) Cold water distribution; (3) Heating; (4) Hot water distribution; and (5) Waste. c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including: (1) Storage tanks; (2) Water heaters; (3) Filters; (4) Aerators; (5) Showerheads and hoses; (6) Misters, atomizers, air washer and humidifiers; (7) Hot tubs; (8) Fountains; and (9) Medical devices such as CPAP [continuous positive airway pressure] machines, hydrotherapy equipment; etc. d. The identification of situations that can lead to Legionella growth, such as (1) Construction; (2) Water main breaks; (3) Changes in municipal water quality; (4) The presence of biofilm, scale or sediment; (5) Water temperature fluctuations; (6) Water pressure changes; (7) Water stagnation and; (8) Inadequate disinfection. e. Specific measures used to control the introduction and/or spread of legionella (e.g., temperature, disinfectants); f. The control limits or parameters that are acceptable and that are monitored; g. A diagram of where control measures are applied; h. A system to monitor control limits and the effectiveness of control measures; i. A plan for when control limits are not met and/or control measures are not effective; and j. Documentation of the

	program. 6. The Water Management Program will be reviewed at least once a year, or sooner if any of the following occur: a. The control limits are consistently not met; b. There is a major maintenance of water service change; c. There are any disease cases associated with the water system; or d. There are changes in laws, regulations, standards or guidelines" [sic]. Review of the facility's policy and procedure titled, "Legionella Surveillance and Detection," revised September 2022, noted the following: "Policy Statement: Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Legionnaire's disease is included as part of our infection surveillance activities. Policy Interpretation and Implementation: 1. Legionella can grow in parts of building water systems that are continually wet (e.g., pipes, faucets, water, storage tanks, decorative fountains), and certain devices can spread contaminated water droplets via aerosolization. 2. Legionellosis outbreaks are generally linked to locations where water is held or accumulates, and pathogens can reproduce. Transmission from these water systems to humans occurs when the water is aerosolized (i.e., converted into a spray/mist in the air). Legionella is less commonly spread by aspiration of drinking water or ice. 3. As part of the infection prevention and control program, all cases of pneumonia that are diagnosed in residents >48 [greater than] hours after admission are investigated for possible Legionnaire's disease. 4. Clinical staff are trained on the following signs and symptoms associated with pneumonia and Legionnaire's: a. Cough; b. Shortness of breath; c. Fever; d. Muscle aches; e. Headache; and f. Diarrhea, nausea and confusion associated with Legionnaire's disease. 5. Risk factors for developing Legionnaire's Disease include: a. Age >50 years; b. Smoking (current or historical); c. Chronic lung disease, such as emphysema or COPD [Chronic Obstructive Pulmonary Disease]; d. Immune system disorders due to disease or medication; e. Systemic malignancy; and f. Underlying illness, such as diabetes, renal failure, or hepatic failure. 6. If pneumonia or Legionnaire's disease is suspected, the nurse will notify the physician or practitioner immediately. 7. Residents who have signs and symptoms of pneumonia may be placed on transmission-based (droplet) precautions, although person-to-person transmission is rare. 8. Diagnosis of Legionnaire's disease is based on a culture of lower respiratory secretions and urinary antigen testing (concurrently). 9. Depending on the severity of illness, a hospital transfer may be initiated. 10. If Legionella is detected in one or more residents, the [Licensed Nurse D] will: a. initiate active surveillance for Legionnaire's diseases; b. notify the water management team; c. notify the local health department; and d. notify [Administrative Staff A] and the [Administrative Nurse A]" [sic].

	Review of the medical record for Resident #6 was conducted on 11/5/24, and noted Resident #6 was admitted to the facility on [DATE], and had diagnoses of Obesity, Vascular Dementia, Type II Diabetes, History of Urinary Tract Infections, Paraplegia, and a History of COVID-19. An interview was conducted, on 11/5/24, at 12:35 p.m., with Administrative Staff A. Administrative Staff A stated Resident #6 was not feeling well and was sent to [Hospital] Emergency Room on [DATE]. Administrative Staff A stated Resident #6 was hospitalized. Administrative Staff A stated Resident #6 was re-admitted to the facility on [DATE]. Administrative Staff A stated a floor nurse had reviewed the hospital discharge summary and identified the diagnosis of Legionnaires' Pneumonia. Administrative Staff A stated the facility contacted the Oklahoma State Department of Health on [DATE]. Administrative Staff A stated the Oklahoma State Department of Health came into the facility and took water samples. Administrative Staff A stated two (2) out of three (3) sinks tested positive for Legionnaires, and two (2) units ([LOCATION]) were still pending results. An interview was conducted, on 11/5/24, at 1:30 p.m., with Licensed Nurse D. They stated Resident #6 was re-admitted to the facility on [DATE]. Licensed Nurse D stated the hospital physician and the facility's Licensed Nurse E had a verbal report via phone, and the hospital's physician did not let the facility know, in that verbal report, that Resident #6 had tested positive for Legionnaires' Pneumonia. Licensed Nurse D stated a floor nurse reviewed the hospital discharge summary for Resident #6, dated [DATE], on [DATE], and noted that the summary included the diagnosis of Legionnaires' Pneumonia. A review of the medical record for Resident #6 was conducted on 11/5/24, and noted the following Progress Note, dated [DATE], at 11:30 a.m.: "Resident leaving unit via stretcher accompanied by 4 [four] EMT [Emergency Medical Technician] personnel for transport to [HOSPITAL]] ER [Emergency Room]. Paperwork given to EMT personnel that include resident's current height and weight. Attempted to call report and left on hold until EMT arrived for resident" [sic]. A review of the medical record for Resident #6 was conducted on 11/5/24, and noted the following Progress Note, dated [DATE], at 8:12 p.m.: "Spoke w/ [with] [HOSPITAL] ER. Confirmed that resident is going to be admitted to [LOCATION] for complicated UTI [urinary tract infection], lactic acidosis, and chronic hemocytic anemia." [sic] A review of the medical record for Resident #6 was conducted on 11/5/24 and noted the following: Progress Note, dated

	[DATE], at 12:06 p.m.: "resident continues at [HOSPITAL] on [LOCATION]. resident admitted for pneumonia. [They are] also getting treated for a bacteria in urine. Resident is doing well and vital signs are stable. nurse did ask for resident wound care treatments. Writer went over those with nurse" [sic]. A review of the medical record for Resident #6 was conducted on 11/5/24, and noted the following Consultation Report from [HOSPITAL], dated [DATE], which stated the following: "Laboratory Results: LEGIONELLA ANTIGEN URINE…Detected. Problem List…Legionella pneumonia…I was asked to see this patient for: Legionella pneumonia…History of Present Illness – [Resident #6] with paraplegia presented to the emergency department from the VA [Veterans Affairs] with a nonproductive cough, shortness of breath, and fever and chills for 2 days" [sic]. A review of an Incident Report to the Oklahoma State Department of Health was conducted on 11/5/24, and noted that the facility filed a written report to the Oklahoma State Department of Health on [DATE]. The written reported noted the following: "Incident Date: [DATE]…Incident Location: [LOCATION]…Resident(s)/Client(s) Involved: [Resident #6]…Incident Type: Communicable Disease…Description of Incident. Resident admitted to [HOSPITAL] for Pneumonia on [DATE], Returned to ODVA [Oklahoma Department of Veterans Affairs]-Lawton/Ft Sill on [DATE]. Provider to Provider call was made and [HOSPITAL] failed to mention this on the call. It was found by ODVA staff in the return orders. [Administrative Nurse A] notified the Acute Disease Service…It is unknown if [Resident #6] contracted this from the ODVA Home or it came from somewhere else. At this time the resident will remain in [their] private room, and orders for care will be followed per [HOSPITAL]." A review of facility correspondence from the Oklahoma State Department of Health, dated [DATE], at 8:47 p.m., noted the following: "First, we wanted to thank you again for having our Oklahoma State Department of Health and Department of Environmental Quality teams into your facility. You and your maintenance staff were extremely helpful and accommodating. I've included below a summary of what we discussed today and the visit and some resources. We informed you of three [3] Legionellosis cases reported to us in the last 12 months that are/were residents at your facility (one in 2021 as well). We discussed an overview of legionella and why it is a concern to your residents. You confirmed with me that there have been no additional cases that you are aware of, and that you are testing residents with similar symptoms and recent hospitalizations. We completed the Legionella Environmental Assessment Form (LEAF) with your team and toured your facility to assess water

	sources and devices for potential sampling sites. We agreed to meet on [DATE] at 7:30 a.m. to conduct sampling on water sources and devices. We recommended that you develop a water management program (WMP) to help reduce the risk of legionella growth and spread within your facility. Resources: Below is information on developing a WMP, I have attached a WMP toolkit (PDF) to this email as well…Below is the CDC's (Centers for Disease Control and Prevention) page on clinic guidance for Legionnaires disease if you or your providers would like to look through any further information. I have attached a PDF fact sheet on legionella as well" [sic]. A review of facility correspondence from the Oklahoma State Department of Health, dated [DATE], at 12:35 p.m., noted the following: "Again, we wanted to thank you for having our Oklahoma State Department of Health and the Department of Environmental Quality teams into your facility this past week. I've included a summary below of what we accomplished yesterday at our visit and the recommendations that were provided to you. Our team completed environmental sampling on the potable water system (hot water heaters), and devices served by the potable water system (cooling tower, ice machines, resident showers, congregate whirlpools, and sinks in the [LOCATION]). The samples made it to the Legionella Reference Center this morning and were set up for testing. Our team recommended keeping record of any exposures outside of your facility that your residents have (such as healthcare and or recreational visits), which you are already doing, in case they become sick and are diagnosed with Legionnaires' disease or Pontiac fever. You informed us that one [1] of your employees was diagnosed with Legionnaires' disease back in [DATE]. We discussed that we would let you know the test results of the samples and make necessary recommendations for remediation, if any. We expect results within the next 2 [two] weeks or so." A review of facility correspondence from the Oklahoma State Department of Health, dated [DATE], at 4:02 p.m., noted the following: "We received results on most of the samples we collected. Legionella pneumophila was detected in three [3] samples: the bulk and swab sample from the hair wash sink in the [LOCATION] (samples 2514630 and 2514673) and the bulk sample from the sink in the [LOCATION] (sample 2514643). Three [3] samples are still pending: water heater in the [LOCATION], and two [2] samples from separate resident showers in the [LOCATION]. All other samples were negative. For your records, I have attached the positive results and will send the others when they become available. Remediation and follow-up testing post-remediation is recommended to be performed by a third-party legionella consultant company. Additionally, they can help you develop a water management

	program (WMP) that we recommended. We are available to review the suggested remediation plans that the third-party company recommends and provide feedback on whether the plan would be appropriate or possibly too extensive/not extensive enough. Here are some recommendations for you and your consultant company to consider: I know there was some back and forth on which water served the sink in the [LOCATION] (either the [LOCATION] water heater or the heater located in the [LOCATION] behind the [LOCATION]), so confirm which heater serves the [LOCATION] sink that had a positive bulk water sample. When you determine which water heater serves this sink, it should be sampled and tested by your consultant company. Perform device-specific response activities for the [LOCATION] sink that tested positive AND other sinks on the same water loop that it was intended to represent (e.g., other infrequently used devices serviced by the same water heater). This may include removal and sanitization of any aerators, removal of visible debris/biofilm, and implementing a flushing plan. Similarly, perform device-specific response activities for the hair wash sink that tested positive and other sinks on the same loop. This may include replacement of any rubber hosing, sanitization or replacement of the aerator, and implementing a flushing plan. If the [LOCATION] sink and the [LOCATION] are served by the same hot water heater (the [LOCATION] water heater), that indicates that there is Legionella growth at multiple locations along that loop and remediation of that system is indicated. Remediation methods should be determined by a consultant with facility-specific knowledge and could include hyperchlorination. Thermal remediation is contraindicated for potable water systems. Here are some considerations when choosing a legionella consultant company: Working with Legionella Consultants/Controlling Legionella/CDC. If you have trouble finding a company, please let me know. Your consultant should validate remediation activities with roughly the same sample plan that we used. It's important to know that a facility-wide remediation may still be indicated since the pending results represent additional areas and could be indicative of a need for widespread remediation versus loop-specific response activities" [sic]. An interview was conducted on 11/5/24, at 12:35 p.m., with Administrative Staff A. Administrative Staff A stated Resident #6 went to the hospital due to not feeling well, and was admitted to the hospital with pneumonia. Administrative Staff A stated the hospital neglected to inform the facility, via verbal report, that Resident #6 had tested positive for Legionella' Disease. Administrative Staff A stated a floor nurse in the facility was reviewing the hospital discharge summary and noted that Resident #6 was positive for Legionnaires' Disease. Administrative Staff A stated the Oklahoma State Department of

	Health was notified and came into the facility to conduct water samples. Administrative Staff A stated two (2) out of three (3) sinks tested were positive for Legionella and the facility was still waiting for test results to come back on the [LOCATIONS]. Administrative Staff A stated the two (2) sinks that tested positive were in the [LOCATION] and in the facility's [LOCATION]. Administrative Staff A stated the sink the [LOCATION] had not been used in a very long time, but the sink in the [LOCATION] had been used for residents, staff, and visitors. Administrative Staff A stated the water that went into the facility was city water, and that the Lawton City Water Department was in charge of testing the water. Administrative Staff A stated the facility had not tested the water at the facility for Legionella. Administrative Staff A stated the facility would have to start testing the water at the facility moving forward. An interview was conducted, on 11/5/24, at 1:40 p.m., with Certified Medication Aide B. They stated facility staff were currently providing showers to the residents, and made coffee for the residents daily. Certified Medication Aide B stated they were not aware of anything wrong with the facility's water system, and was not aware of any residents within the facility having tested positive for Legionnaires' Disease. Certified Medication Aide B stated they were not familiar with Legionnaires' Disease, and were unfamiliar as to what the signs and symptoms were if a resident were to develop Legionnaires' Disease. An interview was conducted, on 11/5/24, at 1:45 p.m., with Licensed Nurse A. They stated they were not aware of any residents who tested positive for Legionnaires' Disease within the facility, and they had not been provided any education on Legionnaires' Disease. An interview was conducted, on 11/5/24, at 1:49 p.m., with Maintenance Staff B. They stated they were not aware of any resident who tested positive for Legionnaires' Disease, and had not received any education recently on Legionnaires' Disease. Maintenance Staff B stated they did not know what Legionnaires' Disease was, and was not aware of what the signs and symptoms were for Legionnaires' Disease. Maintenance Staff B stated they were not asked to increase cleaning functions, or to use any special cleaning products recently. An interview was conducted on 11/5/24, at 2:00 p.m., with Certified Nurse Aide A. They stated they were not advised by the facility of any residents who tested positive for Legionnaires' Disease, and was not provided any education on Legionnaires' Disease. Certified Nurse Aide A stated they were not familiar

	with Legionnaires' Disease, and was unaware of what the signs and symptoms were of Legionnaires' Disease. An interview was conducted, on 11/5/24, at 2:09 p.m., with Licensed Nurse B and Certified Medication Aide A. Licensed Nurse B stated they were aware that a resident within the facility had tested positive for Legionnaires' Disease, but was not advised by the facility to do anything differently, and they had not received any training on Legionnaires' Disease. Certified Medication Aide A stated the residents still received showers, and received coffee and water from the sink during the day. Certified Medication Aide A stated that they were unaware of any residents who tested positive for Legionnaires' Disease within the facility, and had not received any education recently on Legionnaires' Disease. An interview was conducted, on 11/5/24, at 2:15 p.m., with Certified Nurse Aide B, Certified Nurse Aide C, and Certified Nurse Aide E. Certified Nurse Aide B stated that they, Certified Nurse Aide C, and Certified Nurse Aide E were students from [COLLEGE], and were scheduled to be at the facility 11/4/24, 11/5/24, and 11/6/24. Certified Nurse Aide C stated the teacher of their certified nurse aide program would let them know if there were any infectious outbreaks within the facility, and they had not been informed of any residents who tested positive for Legionnaires' Disease within the facility. Certified Nurse Aide E stated they had not received any education from the facility on Legionnaires' Disease, and was not informed of any residents who tested positive for Legionnaires' Disease within the facility. A review of facility correspondence from the Oklahoma State Department of Health, dated [DATE], at 7:41 a.m., noted the following: "We received the results on two [2] of the pending samples. The water heater in the green wing was negative and the resident shower in [LOCATION] detected Legionella pneumophila. For your records I have attached the positive result and will send all the negative results as soon as we receive a result on the final pending sample (resident shower in [LOCATION]). Given that Legionella was detected in multiple water loops of the facility, including showers, it's important that you work with a consultant to implement remediation activities throughout the entire potable water system within the facility. Additionally, we recommended that you implement immediate control measures as soon as possible on all showers and other fixtures that spray water to prevent additional illness" [sic]. An interview was conducted, on 11/6/24, at 11:45 a.m., with both Administrative Staff A and Licensed Nurse D. Licensed Nurse D stated they had just started the Licensed Nurse D position in [DATE], and had not completed the Infection Control Training by the CDC, and had not completed any other infection

	control training. Licensed Nurse D stated they had not been monitoring waterborne illnesses until now, and did not know they were supposed to. Licensed Nurse D stated the hospital did not report any residents who tested positive for Legionnaires' Disease to the facility when a resident had tested positive while in the hospital, so they did not know they had a concern with Legionella in the water system. Licensed Nurse D stated the hospital would report it to the state agency, but not to the facility. Administrative Staff A stated they would be having a call with the hospital to discuss concerns, but had not done that as of today. Licensed Nurse D stated the facility had not yet developed a WMP at the request of the Oklahoma State Department of Health, as noted in the correspondence dated [DATE], and did not have a good reason for not having it done. Licensed Nurse D stated the facility had not completed the recommendations by the Oklahoma State Department of Health as noted in correspondence provided. Licensed Nurse D stated the facility had not met in the past to discuss Legionnaires' within the facility, and had not ever before, prior to yesterday, implemented a Plan of Correction to prevent the spread of Legionnaires' Disease within the facility. Administrative Staff A stated they had a call out to a 3rd party Legionella consultant company, but had not yet heard back from the company. Administrative Staff A stated they notified the Lawton City Water Department on [DATE], and reported the positive Legionnaires' Disease case. Administrative Staff A stated an official from the Lawton City Water Department came into the facility during the evening hours to start an investigation. A phone interview was conducted on 11/7/24, at 10:00 a.m., with Consultant Staff A at the Oklahoma State Department of Health (OSDH). Consultant Staff A confirmed the positive Legionnaires case as noted, and stated the facility was contacted by the OSDH and recommendations were provided to the facility as noted in the correspondence. Consultant Staff A stated the facility had contacted the OSDH on [DATE], via phone, and had advised the OSDH that the facility had been instructed to shut down all the water within the facility to remove the immediacy of a Legionnaire's outbreak. Consultant Staff A stated this was contradictory to the education that was provided to the facility by the OSDH, as noted in the correspondence. An interview was conducted, on 11/7/24, at 10:13 a.m., with both the Administrative Staff B and Licensed Nurse D. They stated that they had spoken verbally to Consultant Staff A on the evening of [DATE], in attempts to get outstanding water testing results, as the facility had currently shut the water off due to the facility receiving an Immediate Jeopardy for Legionella in the facility's water system. Administrative Staff B stated the facility had met as a team on 11/5/24, after they were notified of the Immediate Jeopardy, and the facility's administration team

	made the decision to shut the water off in the facility to remove potential further spread of infection to all residents within the facility. An interview was conducted, on 11/7/24, at 11:45 a.m., via phone, with Administrative Staff C. They stated they were informed of Resident #6's positive Legionnaires' diagnosis at the end of the month in [DATE]. Administrative Staff C stated they were informed that the Oklahoma State Department of Health would be coming to the facility to complete testing of the facility's water system and air conditioning systems. Administrative Staff C stated that facility policies and procedures were reviewed every quarter if something new was to be discussed. Administrative Staff C stated that they had never reviewed the facility's policy and procedure on Legionnaires' due to never having a positive case before. Administrative Staff C stated that they were never provided with copies of the correspondence from the Oklahoma State Department of Health, as noted above, and was not aware of the guidance that was provided to the facility on the removal of Legionella within the facility by the Oklahoma State Department of Health.
§ 51.190 (a) Infection control program. The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection control program. The facility management must establish an infection control program under which it— (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on interviews and record reviews, the facility failed to ensure that the facility's infection control program was effective in preventing the spread of illness to all residents within the facility. The facility failed to ensure that all infections were closely monitored, interventions were implemented, education on infection control was provided to all staff within the facility, and to ensure that Licensed Nurse D received appropriate education on infection control. This had the potential to affect all residents within the facility. The findings include: Review of facility policy titled, "Surveillance for Infections," dated September 2017, noted the following: "Policy Statement: [Licensed Nurse D] will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions. Policy Interpretation and Implementation: 1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections. 2. The criteria for such infections are based on the current standard definitions of infections…4. Infection may be considered in surveillance include those with limited transmissibility in a healthcare environment; and/or limited prevention strategies. 5. Nursing staff will monitor residents for

	signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and will document and report suspected infections to the [Licensed Nurse F] as soon as possible. 6. If a communicable disease outbreak is suspected, this information will be communicated to [Licensed Nurse F] and [Licensed Nurse D] immediately. 7. When infection or colonization with epidemiologically important organisms is suspected, cultures may be sent, if appropriate, to a contracted laboratory for identification or confirmation. Cultures will be further screened for sensitivity to antimicrobial medications to help determine treatment measures. 8. [Licensed Nurse F] will notify the Attending Physician and [Licensed Nurse D] of suspected infections. a. [Licensed Nurse D] and the Attending Physician will determine if laboratory tests are indicated, and whether special precautions are warranted. b. [Licensed Nurse D] will determine if the infection is reportable. c. The Attending Physician and interdisciplinary team will determine the treatment plan for the resident. 9. If transmission-based precautions or other preventative measures are implemented to slow or stop the spread of infection, [Licensed Nurse D] will collect data to help determine the effectiveness of such measures" [sic]. Review of facility policy titled, "Infection Control Guidelines for All Nursing Procedures," dated August 2012, noted the following: "Purpose: To provide guidelines for general infection control while caring for residents. Preparation: 1. Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on general infection and exposure control issues, including: a. The facility protocols for isolation (standard and transmission-based) precautions…d. The facility exposure control plan; and…2. Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on managing infections in residents, including: a. Types of Healthcare-Associated Infections; b. Methods of preventing their spread; c. How to recognize and report signs and symptoms of infection; and d. Prevention of the transmission of multi-drug resistant organisms" [sic]. Review of the facility policy titled, "Legionella Water Management Program," dated July 2017, noted the following: "Policy Statement: Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Policy Interpretation and Implementation: 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. 2. The water management team will consist of at least the following personnel: a. [Licensed Nurse D]; b. [Administrative Staff A]; c. [Administrative Staff C] (or designee); d. [Maintenance Staff A]; and 3. [Maintenance Staff C]. 3. The purposes of the water management program are to identify

	areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. 4. The water management program used by our facility is based on the Centers for Disease Control and Prevention…recommendations for developing a Legionella water management program. 5. The water management program includes the following elements: a. An interdisciplinary water management team; b. A detailed description and diagram of the water system in the facility, including the following: (1) Receiving; (2) Cold water distribution; (3) Heating; (4) Hot water distribution; and (5) Waste. c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including: (1) Storage tanks; (2) Water heaters; (3) Filters; (4) Aerators; (5) Showerheads and hoses; (6) Misters, atomizers, air washers and humidifiers; (7) Hot tubs; (8) Fountains; and (9) Medical devices such as CPAP [continuous positive airway pressure] machines, hydrotherapy equipment; etc. d. The identification of situations that can lead to Legionella growth, such as (1) Construction; (2) Water main breaks; (3) Changes in municipal water quality; (4) The presence of biofilm, scale or sediment; (5) Water temperature fluctuations; (6) Water pressure changes; (7) Water stagnation and; (8) Inadequate disinfection. e. Specific measures used to control the introduction and/or spread of legionella (e.g., temperature, disinfectants); f. The control limits or parameters that are acceptable and that are monitored; g. A diagram of where control measures are applied; h. A system to monitor control limits and the effectiveness of control measures; i. A plan for when control limits are not met and/or control measures are not effective; and j. Documentation of the program. 6. The Water Management Program will be reviewed at least once a year, or sooner if any of the following occur: a. The control limits are consistently not met; b. There is a major maintenance of water services change; c. There are any disease cases associated with the water system; or d. There are changes in laws, regulations, standards or guidelines" [sic]. Review of the facility policy and procedure titled, "Legionella Surveillance and Detection," dated September 2022, noted the following: "Policy Statement: Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Legionnaire's disease is included as part of our infection surveillance activities. Policy Interpretation and Implementation: 1. Legionella can grow in parts of building water systems that are continually wet (e.g., pipes, faucets, water, storage tanks, decorative fountains), and certain devices can spread contaminated water droplets via aerosolization. 2. Legionellosis outbreaks are generally linked to locations where water is held or accumulates, and pathogens can reproduce. Transmission from these water systems to humans occurs when the water is aerosolized (i.e., converted into a spray/mist in the

	air). Legionella is less commonly spread by aspiration of drinking water or ice. 3. As part of the infection prevention and control program, all cases of pneumonia that are diagnosed in residents >48 [greater than] hours after admission are investigated for possible Legionnaire's disease. 4. Clinical staff are trained on the following signs and symptoms associated with pneumonia and Legionnaire's: a. Cough; b. Shortness of breath; c. Fever; d. Muscle aches; e. Headache; and f. Diarrhea, nausea and confusion associated with Legionnaire's disease. 5. Risk factors for developing Legionnaire's Disease include: a. Age >50 years; b. smoking (current or historical); c. Chronic lung disease, such as emphysema or COPD [Chronic Obstructive Pulmonary Disease]; d. Immune system disorders due to disease or medication; e. Systemic malignancy; and f. Underlying illness, such as diabetes, renal failure, or hepatic failure. 6. If pneumonia or Legionnaire's disease is suspected, the nurse will notify the physician or practitioner immediately. 7. Residents who have signs and symptoms of pneumonia may be placed on transmission-based (droplet) precautions, although person-to-person transmission is rare. 8. Diagnosis of Legionnaire's disease is based on a culture of lower respiratory secretions and urinary antigen testing (concurrently). 9. Depending on the severity of illness, a hospital transfer may be initiated. 10. If Legionella is detected in one or more residents, the [Licensed Nurse D] will: a. initiate active surveillance for Legionnaire's diseases; b. notify the water management team; c. notify the local health department; and d. notify [Administrative Staff A] and the [Administrative Nurse A]" [sic]. Review of the medical record for Resident #30 was conducted and noted that Resident #30 was admitted to the facility on 5/29/24, and had diagnoses of Anxiety, Lobar Pneumonia, Respiratory Failure, and Tobacco Use. A review of the infection control monthly line listing for [DATE] was conducted on 11/6/24, and noted the following: - Resident #30 was diagnosed with pneumonia on [DATE]. Review of the medical record for Resident #30 was conducted from [DATES], and noted the following: No investigation was identified within the medical record to rule out Legionnaires' Disease upon diagnosis of pneumonia on [DATE]. Review of the Nursing Progress Notes for Resident #30 was conducted and noted the following: - Progress Note, dated [DATE], at 6:45 a.m.: "I was called into resident room by [certified nurse aide]… resident is having a hard time breathing. This resident is sitting on the side of the bed leaning on [their] bedside table Oxygen in via nasal cannula in [their] nose. O2 sat

	[oxygen saturation] at 78% [they] did not use [their] c-pap at all last night refused each time we encouraged [them] to use it. We got resident to scoot over in the middle of the bed and lay back [they] came right back up stated [they] cannot breathe [they had] to sit up. I asked if [they] would like to go to Er [emergency room], [they] refused. I contacted house supervisor they state [they need] to go out for evaluation [they state] NO I'm not going. VS 152/98 24 resp, 97.9 temp pulse 88 02 [oxygen] 86%. I notified [their] [family members] via phone that we are trying to get [them] sent out to local ER [emergency room] for evaluation. at 0642 [HOSPITAL] EMS [emergency medical services] arrived resident refused right off with them they talked with [them] over [their] history tried talking [them] into going for evaluation [they] still declined. [HOSPITAL] staff did vs [vital signs] and assessment asked [them] multiple times to let them take [them] to checked out [they] continued to decline. Resident sat is at 92% [they continue] to sit on the side of the bed call light in reach. EMS left at 0655 House sup [supervisor] notified that [they] refused to be transported to the hospital for evaluation" [sic]. - Progress Note, dated [DATE], at 13:56 p.m.: "[Licensed Nurse] notified this nurse resident was ready to go to the ER for further eval [evaluation], this nurse notified [Administrative Staff A] on call" [sic]. - Progress Note, dated [DATE], at 13:54 p.m.: "[Resident #30] returned via EMS on a stretcher. this resident is being very verbally combative with staff. this resident is to be on continuous o2 [oxygen] @ 4lnc [liters per nasal canula] but resident refuses to keep [their] o2 on because [they are] outside smoking, I explained to the need for oxygen and [them] being ordered continuous in order to keep [their] sats between 90-92%. this resident yelled that [they] did not have to be on o2 all the time. this resident is out to smoke and is very winding. resident self reports that [they] had a bowel movement in the hospital. I notified that the house supervisor…of this residents returns. resident reports that [they are] to have one to one care and we explained to [them] that will help with [their] adl [activities of daily living] care when [they call]" [sic]. - Progress Note, dated [DATE], at 7:35 a.m., by Administrative Staff C: "Late Entry: Note Text: Resident seen this morning by [physician] for hospital re-admission [DATES] for SOB [shortness of breath]. Treated with steroids and Mucinex. DX [diagnosis] of

	PNE [pneumonia]. Taking Cefdinir and reports feeling better. Encouraged Resident to continue wearing is O2 [oxygen]. [They] agreed [they] would comply. Resident is stable. No c/o [concerns of] voiced. No new orders" [sic]. Review of facility infection control documents was conducted on 11/6/24, and noted the following: - Hand Hygiene and Contact Precautions observations sheets, undated, completed on the [LOCATION], revealed three [3] observations of staff, names not provided, did not complete hand hygiene as required per facility policy and procedure and did not wear gloves or gowns per facility's policy and procedure. The observation sheet did not state education and training were provided to staff members observed to prevent future errors from occurring. - Hand Hygiene and Contact Precautions observations sheets, undated, completed on the [LOCATION], revealed three [3] observations of staff, staff names not provided, did not complete hand hygiene as required per facility policy and procedure and did not wear gloves or gowns per facility's policy and procedure. The observation sheet did not state education and training were provided to staff members observed to prevent future errors from occurring. An interview was conducted, on 11/5/24, at 1:40 p.m., with Certified Medication Aide B. They stated that facility staff were currently providing showers to the residents and making coffee for the residents daily. Certified Medication Aide B stated they were not aware of anything wrong with the facility's water system, and was not aware of any residents within the facility who tested positive for Legionnaires' Disease. Certified Medication Aide B stated they were not familiar with Legionnaires' Disease, and was unfamiliar as to what the signs and symptoms were if a resident were to develop Legionnaires' Disease. An interview was conducted, on 11/5/24, at 1:45 p.m., with Licensed Nurse A. They stated that they were not aware of any residents who tested positive for Legionnaires' Disease within the facility, and they had not been provided any education on Legionnaires' Disease. An interview was conducted, on 11/5/24, at 1:49 p.m., with Maintenance Staff B. They stated they were not aware of any resident who tested positive for Legionnaires' Disease, and had not received any education recently on Legionnaires' Disease.

	Maintenance Staff B stated they did not know what Legionnaires' Disease was, and was not aware of what the signs and symptoms were for Legionnaires' Disease. Maintenance Staff B stated that they were not asked to increase cleaning functions or to use any special cleaning products recently. An interview was conducted, on 11/5/24, at 2:00 p.m., with Certified Nurse Aide A. They stated that they were not advised by the facility of any residents who tested positive for Legionnaires' Disease, and was not provided any education on Legionnaires' Disease. Certified Nurse Aide A stated that they were not familiar with Legionnaires' Disease, and was unaware of what the signs and symptoms were of Legionnaires' Disease. An interview was conducted, on 11/5/24, at 2:09 p.m., with Licensed Nurse B and Certified Medication Aide A. Licensed Nurse B stated that they were aware that a resident within the facility had tested positive for Legionnaires' Disease, but was advised by the facility not to do anything differently, and they had not received any training on Legionnaires' Disease. Certified Medication Aide A stated that the residents still received showers, and received coffee and water from the sink during the day. Certified Medication Aide A stated they were unaware of any residents who tested positive for Legionnaires' Disease within the facility, and had not received any education recently on Legionnaires' Disease. An interview was conducted, on 11/5/24, at 2:15 p.m., with Certified Nurse Aide B, Certified Nurse Aide C, and Certified Nurse Aide E. Certified Nurse Aide B stated that they, Certified Nurse Aide C, and Certified Nurse Aide E were students from the [COLLEGE] and were scheduled to be at the facility on 11/4/24, 11/5/24, and 11/6/24. Certified Nurse Aide C stated that the teacher of their certified nurse aide program would let them know if there were any infectious outbreaks within the facility, and they had not been informed of any residents who tested positive for Legionnaires' Disease within the facility. Certified Nurse Aide E stated that they had not received any education from the facility on Legionnaires' Disease, and was not informed of any residents who tested positive for Legionnaires' Disease within the facility. An interview was conducted, on 11/6/24, at 11:45 a.m., with Licensed Nurse D. They stated that they had just started in the Licensed Nurse D position in [DATE], and had not completed the Infection Control Training by the CDC, and had not completed any other infection control training. Licensed Nurse D stated that they had not been monitoring waterborne illnesses until now, and did not know they were supposed to. Licensed Nurse D stated that the facility had not yet developed a water-

	management program (WMP) at the request of the Oklahoma State Department of Health, as noted in the correspondence dated [DATE], and did not have a good reason for not having it done. Licensed Nurse D stated that the facility did not complete the recommendations by the Oklahoma State Department of Health as noted in their correspondence. Licensed Nurse D stated that the facility had not met in the past to discuss Legionnaires' Disease within the facility, and had not ever before, prior to yesterday, implemented a Plan of Correction to prevent the potential spread of Legionnaires' Disease within the facility. An interview was conducted, on 11/6/24, at 3:48 p.m., with Administrative Staff B and Licensed Nurse D. Licensed Nurse D stated that they had not been conducting investigations within 48 hours of all residents who had been diagnosed with pneumonia to rule out Legionnaires' Disease. Licensed Nurse D stated that they were not aware of the facility's policy and procedure for Legionnaires,' and was not aware that an investigation was required within 48 hours to rule out Legionnaires' if a resident was tested positive for pneumonia. Administrative Staff B stated the above noted Hand Hygiene and Contact Precautions Observation sheets for both the [LOCATIONS] should have identified the staff members who were being observed, and education should have been documented as being completed when it was identified that hand hygiene, gloves, or gowns were not being followed per infection control policy and procedure. Licensed Nurse D stated that staff received education on infection control processes annually during the facility's skills fair, and upon hire. Licensed Nurse D stated that no formal education was done on infection control during the year. Licensed Nurse D stated that they were not aware that the facility had a Legionnaires' policy and procedure as noted above. An interview was conducted, on 11/7/24, at 1:26 p.m., with Administrative Staff A. Administrative Staff A stated that they did not remember reviewing the above noted Legionnaire's policy and procedure, and was not aware that the facility was required to complete an investigation within 24 hours after a resident was diagnosed with pneumonia. Administrative Staff A stated they did not have a system in place to ensure that all policies and procedures were reviewed, and that all policies and procedures came from the central office, which was not located at the facility.
§ 51.200 (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.	**Smoke Barriers and Sprinklers** 1. Based on record review, observation, and interview, the facility failed to test the sprinkler system in accordance with the code. The deficient practice affected 20 of 20

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	smoke compartments, staff, and all residents. The facility had a capacity for 200 beds with a census of 163 on the first day of the survey. The findings include: Records review, on 11/5/24, at 1:05 p.m., of the facility's annual sprinkler report from 9/11/24, revealed in the section titled, "Sprinklers – Piping," the following in section 3, "Sprinklers using Fast-Response Elements have been installed for 20 years or older? (NFPA25-2008, 2011, 2014. 2017. and 2020 Editions)" was marked "No." In section 4, "Sprinklers Manufactured using Fast-Response Elements, except for ESFR and CMSA, have been installed for 25 years or older? (NFPA 25-2023 Edition)" was marking "No." Nothing on sprinkler inspection reports for the past two years indicated that quick response sprinklers were present in the facility and, if so, had they been tested or replaced as required by section 5.3.1.1.1.3 of NFPA Standard: NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Observation during the tour of the facility, on 11/5/24, from 2:11 p.m., through 3:00 p.m., revealed quick response sprinklers, dated 2001, in the following areas: 1. In [LOCATION], [LOCATION]. 2. In [LOCATION], [LOCATION] by [LOCATION]. 3. In [LOCATION], [LOCATION]. 4. In [LOCATION], [LOCATION] one spare sprinkler box; the replacement sprinkler was dated 2001. Observation during the tour of the facility on 11/6/24, from 9:30 a.m., through 11:04 p.m., revealed quick response sprinklers dated 2000, and 2001, in the following areas: 1. In the riser room off the [LOCATION], in the spare sprinkler box the replacement sprinklers were dated 2001. 2. In [LOCATION] in [LOCATION]. 3. In [LOCATION], [LOCATION], in the spare sprinkler box the replacement side mount sprinkler was dated 2001. 4. In [LOCATION], [LOCATION]. During the facility tour, on 11/5/24, and 11/6/24, revealed that quick response sprinklers were located throughout the facility. During an interview with Maintenance Staff A, on 11/6/24, at 1:17 p.m., they were asked if the 20-year testing had been done

	on the quick response sprinklers; they stated that they didn't know of any testing or replacement of the fire sprinklers. An additional interview revealed Maintenance Staff A was not aware of the 20-year testing requirement for quick response sprinklers. The census of 163 was verified by Administrative Staff A on 11/5/24, at 9:15 a.m. The findings were acknowledged by Administrative Staff A and Maintenance Staff A during the exit interview on 11/6/24, at 4:00 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.3.5 Extinguishment Requirements.** **19.3.5.1** Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. **9.7.5 Maintenance and Testing.** All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. **Actual NFPA Standard: NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011)** **4.3 Records.** **4.3.1*** Records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. **4.3.2** Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. **4.3.3*** Records shall be maintained by the property owner. **5.3 Testing.** **5.3.1 * Sprinklers.** **5.3.1.1 *** Where required by this section, sample sprinklers shall be submitted to a recognized testing laboratory acceptable to the authority having jurisdiction for field service testing. **5.3.1.1.1** Where sprinklers have been in service for 50 years, they shall be replaced or representative samples from one or more sample areas shall be tested. **5.3.1.1.1.1** Test procedures shall be repeated at 10-year intervals. **5.3.1.1.1.2** Sprinklers manufactured prior to 1920 shall be replaced. **5.3.1.1.1.3 *** Sprinklers manufactured using fast-response elements that have been in service for 20 years shall be replaced, or representative samples shall be tested and then retested at 10-year intervals.

	5.3.1.1.1.4 * Representative samples of solder-type sprinklers with a temperature classification of extra high [325°F (163°C)] or greater that are exposed to semicontinuous to continuous maximum allowable ambient temperature conditions shall be tested at 5-year intervals. **5.3.1.1.1.5** Where sprinklers have been in service for 75 years, they shall be replaced or representative samples from one or more sample areas shall be submitted to a recognized testing laboratory acceptable to the authority having jurisdiction for field service testing and repeated at 5-year intervals. **5.3.1.1.1.6 *** Dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals. **5.3.1.1.2 *** Where sprinklers are subjected to harsh environments, including corrosive atmospheres and corrosive water supplies, on a 5-year basis, either sprinklers shall be replaced or representative sprinkler samples shall be tested. **5.3.1.1.3** Where historical data indicate, longer intervals between testing shall be permitted. **5.3.1.2 *** A representative sample of sprinklers for testing per 5.3.1.1.1 shall consist of a minimum of not less than four sprinklers or 1 percent of the number of sprinklers per individual sprinkler sample, whichever is greater. **5.3.1.3** Where one sprinkler within a representative sample fails to meet the test requirement, all sprinklers within the area represented by that sample shall be replaced. **5.3.1.3.1** Manufacturers shall be permitted to make modifications to their own sprinklers in the field with listed devices that restore the original performance as intended by the listing, where acceptable to the authority having jurisdiction. **Electrical Systems** 2. Based on records review, observation, and interview, the facility failed to maintain documentation of inspections on the Patient-Care Related Electrical Equipment (PCREE). The deficient practice affected 20 of 20 smoke compartments, staff, and all residents. The facility had a capacity for 200 beds with a census of 163 on the day of the survey. The findings include: Records review, on 11/5/24, at 1:05 a.m., revealed there was no documentation of testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. An interview, on 11/5/24, at 1:05 p.m., with Maintenance Staff A revealed the facility was not aware of the testing requirements.

	Maintenance Staff A asked Administrative Nurse A about the testing and maintenance of patient care related electrical equipment (PCREE) in the facility. Administrative Nurse A was not aware of any testing being performed on the PCREE. Observations during the building inspection tour, on 11/5/24, from 1:30 p.m., to 3:00 p.m., and on 11/6/24, from 9:30 a.m., to 11:04 a.m., revealed that the facility provided electric beds for all residents and that PCREE, such as vital sign monitors, portable suction units, nebulizers, concentrators, air pumps for air mattresses, and other medical equipment was present at the facility. During an additional interview, on 11/5/24, at 2:52 p.m., Maintenance Staff A stated all the PCREE in the building was owned by the facility, and that the facility provided electric beds to all residents. The census of 163 was verified by Administrative Staff A on 11/5/24, at 9:15 a.m. The findings were acknowledged by Administrative Staff A and Maintenance Staff A during the exit interview on 11/6/24, at 4:00 p.m. **Actual NFPA Standard: NFPA 99, Health Care Facilities Code (2012)** **3.3.137 Patient-Care-Related Electrical Equipment.** Electrical equipment appliance that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care vicinity. **10.3 Testing Requirements — Fixed and Portable.** **10.3.1* Physical Integrity.** The physical integrity of the power cord assembly composed of the power cord, attachment plug, and cord-strain relief shall be confirmed by visual inspection. **10.3.2* Resistance.** **10.3.2.1** For appliances that are used in the patient care vicinity, the resistance between the appliance chassis, or any exposed conductive surface of the appliance, and the ground pin of the attachment plug shall be less than 0.50 ohm under the following conditions: **(1)** The cord shall be flexed at its connection to the attachment plug or connector. **(2)** The cord shall be flexed at its connection to the strain relief on the chassis. **10.3.2.2** The requirement of 10.3.2.1 shall not apply to accessible metal parts that achieve separation from main parts by double insulation or metallic screening or that are unlikely to become energized (e.g., escutcheons or nameplates, small screws). **10.3.3* Leakage Current Tests.** **10.3.3.1 General.**

	10.3.3.1.1 The requirements in 10.3.3.2 through 10.3.3.4 shall apply to all tests. **10.3.3.1.2** Tests shall be performed with the power switch ON and OFF. **10.3.3.2 Resistance Test**. The resistance tests of 10.3.3.3 shall be conducted before undertaking any leakage current measurements. **10.3.3.3*** Techniques of Measurement. The test shall not be made on the load side of an isolated power system or separable isolation transformer. **10.3.3.4* Leakage Current Limits.** The leakage current limits in 10.3.4 and 10.3.5 shall be followed. **10.3.4 Leakage Current — Fixed Equipment.** **10.3.4.1** Permanently wired appliances in the patient care vicinity shall be tested prior to installation while the equipment is temporarily insulated from ground. **10.3.4.2** The leakage current flowing through the ground conductor of the power supply connection to ground of permanently wired appliances installed in general or critical care areas shall not exceed 10.0 mA (ac or dc) with all grounds lifted. **10.3.5 Touch Current — Portable Equipment.** **10.3.5.1* Touch Current Limits.** The touch current for cord connected equipment shall not exceed 100 µA with the ground wire intact (if a ground wire is provided) with normal polarity and shall not exceed 500 µA with the ground wire disconnected. **10.3.5.2** If multiple devices are connected together and one power cord supplies power, the leakage current shall be measured as an assembly. **10.3.5.3** When multiple devices are connected together and more than one power cord supplies power, the devices shall be separated into groups according to their power supply cord, and the leakage current shall be measured independently for each group as an assembly. **10.3.5.4** Touch Leakage Test Procedure. Measurements shall be made using the circuit, as illustrated in Figure 10.3.5.4, with the appliance ground broken in two modes of appliance operation as follows: **(1)** Power plug connected normally with the appliance on **(2)** Power plug connected normally with the appliance off (if equipped with an on/off switch) **10.3.5.4.1** If the appliance has fixed redundant grounding (e.g., permanently fastened to the grounding system), the touch leakage current test shall be conducted with the redundant grounding intact. **10.3.5.4.2** Test shall be made with Switch A in Figure 10.3.5.4 closed. **10.3.6* Lead Leakage Current Tests and Limits — Portable Equipment.**

	10.3.6.1 The leakage current between all patient leads connected together and ground shall be measured with the power plug connected normally and the device on. **10.3.6.2** An acceptable test configuration shall be as illustrated in Figure 10.3.5.4. **10.3.6.3** The leakage current shall not exceed 100 µA for ground wire closed and 500 µA ac for ground wire open. **10.5.2.1 Testing Intervals.** **10.5.2.1.1** The facility shall establish policies and protocols for the type of test and intervals of testing for patient care–related electrical equipment. **10.5.2.1.2** All patient care–related electrical equipment used in patient care rooms shall be tested in accordance with 10.3.5.4 or 10.3.6 before being put into service for the first time and after any repair or modification that might have compromised electrical safety. **10.5.2.5* System Demonstration.** Any system consisting of several electric appliances shall be demonstrated to comply with this code as a complete system. **10.5.3 Servicing and Maintenance of Equipment.** **10.5.3.1** The manufacturer of the appliance shall furnish documents containing at least a technical description, instructions for use, and a means of contacting the manufacturer. **10.5.3.1.1** The documents specified in 10.5.3.1 shall include the following, where applicable: **(1)** Illustrations that show the location of controls **(2)** Explanation of the function of each control **(3)** Illustrations of proper connection to the patient or other equipment, or both **(4)** Step-by-step procedures for testing and proper use of the appliance **(5)** Safety considerations in use and servicing of the appliance **(6)** Precautions to be taken if the appliance is used on a patient simultaneously with other electric appliances **(7)** Schematics, wiring diagrams, mechanical layouts, parts lists, and other pertinent data for the appliance **(8)** Instructions for cleaning, disinfection, or sterilization **(9)** Utility supply requirements (electrical, gas, ventilation, heating, cooling, and so forth) **(10)** Explanation of figures, symbols, and abbreviations on the appliance **(11)** Technical performance specifications **(12)** Instructions for unpacking, inspection, installation, adjustment, and alignment **(13)** Preventive and corrective maintenance and repair procedures **10.5.3.1.2** Service manuals, instructions, and procedures provided by the manufacturer shall be considered in the development of a program for maintenance of equipment.

	10.5.6 Record Keeping — Patient Care Appliances. **10.5.6.1 Instruction Manuals.** **10.5.6.1.1** A permanent file of instruction and maintenance manuals shall be maintained and be accessible. **10.5.6.1.2** The file of manuals shall be in the custody of the engineering group responsible for the maintenance of the appliance. **10.5.6.1.3** Duplicate instruction and maintenance manuals shall be available to the user. **10.5.6.1.4** Any safety labels and condensed operating instructions on an appliance shall be maintained in legible condition. **10.5.6.2* Documentation.** **10.5.6.2.1** A record shall be maintained of the tests required by this chapter and associated repairs or modifications. **10.5.6.2.2** At a minimum, the record shall contain all of the following: **(1)** Date **(2)** Unique identification of the equipment tested **(3)** Indication of which items have met or have failed to meet the performance requirements of 10.5.6.2 **10.5.6.3 Test Logs.** A log of test results and repairs shall be maintained and kept for a period of time in accordance with a health care facility's record retention policy. **10.5.8 Qualification and Training of Personnel.** **10.5.8.1*** Personnel concerned for the application or maintenance of electric appliances shall be trained on the risks associated with their use. **10.5.8.1.1** The health care facilities shall provide programs of continuing education for its personnel. **10.5.8.1.2** Continuing education programs shall include periodic review of manufacturers' safety guidelines and usage requirements for electrosurgical units and similar appliances. **10.5.8.2** Personnel involved in the use of energy-delivering devices including, but not limited to, electrosurgical, surgical laser, and fiberoptic devices shall receive periodic training in fire suppression. **10.5.8.3** Equipment shall be serviced by qualified personnel only.
§ 51.200 (b) Emergency power. (1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination. (2) The system must be the appropriate type essential electrical system in	**<u>Electrical Systems</u>** Based on records review, observation, and interview, the facility failed to inspect and test the emergency generator in accordance with the code. The deficient practice affected 20 of 20 smoke compartments, staff, and all residents. The facility had a capacity for 200 beds with a census of 163 on the day of the survey. The findings include:

accordance with the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. (3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Health Care Facilities Code. (4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Records review, on 11/5/24, at 11:19 a.m., of the monthly emergency generator inspection for the facility's two generators and testing records, dating back 12 months prior to the survey revealed there was no documentation of monthly specific gravity testing or conductance testing for the lead-acid batteries, as required by section 8.3.7.1 of NFPA 110, Standard for Emergency and Standby Power Systems. An interview, on 11/5/24, at 11:19 a.m., with Maintenance Staff D revealed that they were only checking a charging panel on both the generators. Maintenance Staff D stated that they only looked to see if the panels were indicating green. The facility was not aware of the monthly generator battery testing requirements for "sealed" or "maintenance free" generator batteries. Observation of the Generator sets, on 11/6/24, at 1:29 a.m., revealed both emergency generators were equipped with sealed lead acid batteries. An additional interview with Maintenance Staff A, 11/6/24, at 1:31 a.m., revealed the battery conductance testing was only being done with the yearly generator maintenance performed by a vender. The census of 163 was verified by Administrative Staff A on 11/5/24, at 9:15 a.m. The findings were acknowledged by Administrative Staff A and Maintenance Staff A during the exit interview on 11/6/24, at 4:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.5 Building Services.** **19.5.1 Utilities.** **19.5.1.1** Utilities shall comply with the provisions of Section 9.1. **9.1.3 Emergency Generators and Standby Power Systems.** Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. **9.1.3.1** Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. **Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems (2010)** **8.3.7 *** Storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. **8.3.7.1** Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity.

	Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. **8.4** Operational Inspection and Testing. **8.4.1 *** EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. **8.4.1.1** If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, providing the same record as required by 8.3.4. **8.4.2 *** Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: **(1)** Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer **(2)** Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating
§ 51.210 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. **Level of Harm** – Immediate Jeopardy to resident health or safety **Residents Affected** – Many	Based on interviews and record reviews, the facility failed to ensure that all resources were effectively utilized to ensure that residents who resided in the facility received the necessary care to promote safety and to attain and maintain their highest physical and mental well-being. This affected all residents and resulted in an Immediate Jeopardy. The findings include: Review of facility Administrative Staff A job description titled, "Veterans Center [Administrative Staff A]," received 11/8/24, and undated, revealed the following: "Basic Purpose: Positions in this job family perform highly independent work in directing and coordinating the operations and activities of one [1] of the state veterans centers involving long-term health care or other medical services for eligible veterans. The centers serve as fully functional health care facilities and include on-site laboratory and x-ray facilities, pharmacy and full-time physicians on staff. These positions are located only at one [1] of the state veterans centers and will be assigned overall responsibility for the operation of the designated center, including staff and budgetary matters, coordination of program requirements with other state and federal programs, compliance with various accreditation requirements and insuring that quality medical care and treatment is provided to all eligible veterans. Administrative direction will be provided to medical and nursing directors and other staff in meeting program goals and objectives" [sic]. Review of facility records revealed Resident #6 had tested positive for Legionnaires' Pneumonia on [DATE]. The facility contacted the Oklahoma State Department of Health and was

	provided with written guidance for the removal of the Legionella in order to protect all residents within the facility. The facility failed to ensure the guidance was followed, and that protection of all residents within the facility was conducted, which resulted in an Immediate Jeopardy. Reference § 51.190 Infection Control, which has been identified within this report. The facility failed to ensure an effective infection control program that monitored infections, implemented interventions to prevent the spread of disease, educated staff on infection control processes, and Licensed Nurse D received required infection control training. Reference § 51.190 (a) Infection Control Program, which was identified within this report. The facility failed to ensure that all policies and procedures were reviewed, updated, and followed. Reference § 51.210 (a) Governing Body, which was identified within this report. The facility failed to evaluate and assess residents to prevent future falls. Reference § 51.120 (i) Accidents, which was identified within this report. The facility failed to conduct a timely final accounting of residents with funds deposited in a trust for two (2) of eight (8) residents reviewed. Reference § 51.70 (c) (5) Conveyance upon Death, which was identified within this report.
§ 51.210 (a) Governing body. (a) Governing body. (1) The State must have a governing body, or designated person functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and (2) The governing body or State official with oversight for the facility appoints the administrator who is— (i) Licensed by the State where licensing is required; and (ii) Responsible for operation and management of the facility. **Level of Harm** – No Actual Harm, with potential for more than minimal harm	Based on interview and record review, the facility failed to ensure facility policies and procedures were reviewed annually and as needed to ensure the safe operations of the facility. This affected all residents who resided in the facility. The findings include: Review of the facility's policy and procedure titled, "Legionella Surveillance and Detection," revised September 2022, noted the following: "Policy Statement: Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Legionnaire's disease is included as part of our infection surveillance activities. Policy Interpretation and Implementation: 1. Legionella can grow in parts of building water systems that are continually wet (e.g., pipes, faucets, water, storage tanks, decorative fountains), and certain devices can spread contaminated water droplets via aerosolization. 2. Legionellosis outbreaks are generally linked to locations where water is held or accumulates, and pathogens can reproduce. Transmission from these water systems to humans occurs when the water is aerosolized (i.e., converted into a spray/mist in the air). Legionella is less commonly spread by aspiration of drinking water or ice. 3. As part of the infection prevention and

Residents Affected – Many	control program, all cases of pneumonia that are diagnosed in residents >48 [greater than] hours after admission are investigated for possible Legionnaire's disease. 4. Clinical staff are trained on the following signs and symptoms associated with pneumonia and Legionnaire's: a. Cough; b. Shortness of breath; c. Fever; d. Muscle aches; e. Headache; and f. Diarrhea, nausea and confusion associated with Legionnaire's disease. 5. Risk factors for developing Legionnaire's Disease include: a. Age >50 years; b. Smoking (current or historical); c. Chronic lung disease, such as emphysema or COPD [Chronic Obstructive Pulmonary Disease]; d. Immune system disorders due to disease or medication; e. Systemic malignancy; and f. Underlying illness, such as diabetes, renal failure, or hepatic failure. 6. If pneumonia or Legionnaire's disease is suspected, the nurse will notify the physician or practitioner immediately. 7. Residents who have signs and symptoms of pneumonia may be placed on transmission-based (droplet) precautions, although person-to-person transmission is rare. 8. Diagnosis of Legionnaire's disease is based on a culture of lower respiratory secretions and urinary antigen testing (concurrently). 9. Depending on the severity of illness, a hospital transfer may be initiated. 10. If Legionella is detected in one or more residents, [Licensed Nurse D] will: a. initiate active surveillance for Legionnaire's diseases; b. notify the water management team; c. notify the local health department; and d. notify [Administrative Staff A] and [Administrative Nurse A]" [sic]. An interview was conducted, on 11/6/24, at 11:45 a.m., with Licensed Nurse D. They stated that they had just started the Licensed Nurse D position in [DATE], and had not completed the Infection Control Training by the CDC, and had not completed any other formal infection control training. Licensed Nurse D stated that they had not been monitoring waterborne illnesses and did not know they were supposed to. An interview was conducted, on 11/7/24, at 9:39 a.m., with Administrative Staff B. Administrative Staff B stated that the last time the above noted Legionella's policy and procedure was reviewed by the facility in September of 2022. Administrative Staff B stated that the facility reviewed all facility policies and procedures annually and as needed. Administrative Staff B stated the facility's Legionella Surveillance and Detection Policy and Procedure had not been reviewed annually, and they were not aware that the facility had a policy and procedure for Legionella. Administrative Staff B stated that Administrative Staff A was responsible for reviewing all policies and procedures annually, and as needed. An interview was conducted on 11/7/24, at 11:45 a.m., via phone, with Administrative Staff C. They stated they had never

	reviewed the facility's policy and procedure on Legionnaires,' due to never having had a positive case before. An interview was conducted, on 11/7/24, at 1:26 p.m., with Administrative Staff A. They stated that they did not remember reviewing their Legionnaires' policy and procedure. Administrative Staff A stated that they did not have a system in place to ensure that all policies and procedures for the facility were reviewed annually, and as needed, and that all policies and procedures came from the central office, which was not located at the facility.
§ 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** – Some	Based on record review and interviews, the facility's management failed to obtain a sharing agreement that governed mental health services and dental services provided to 35 residents by the Veterans Administration Medical Center (VAMC). The findings include: Review of documents provided by the facility revealed there was no sharing agreement with the Veterans Administration to provide mental health and dental services for 35 out of 163 residents. During an interview, on 11/5/24, at 10:00 a.m., Administrative Staff A reported that their state agency had requested a sharing agreement for the residents who received mental health and dental services from the VAMC on October 14, 2024.