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: Idaho State Veterans Home – Lewiston

Location: 821 21st Ave, Lewiston, ID 83501

Onsite / Virtual: Onsite

Dates of Survey: 7/9/24 – 7/11/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 66

Census on First Day of Survey: 47

VA Regulation Deficiency	Findings
	A VA Annual Survey was conducted from July 9, 2024, through July 11, 2024, at the Idaho State Veterans Home – Lewiston. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.120 (i) Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, record review, and review of facility policy, the facility failed to implement effective and individualized interventions for the prevention of falls for one (1) of six (6) residents reviewed for falls (Resident #5). The findings include: Review of the facility policy titled, "Incident Reporting," with no date, revealed: "Details: Immediate Action Taken. In this section you will document what you did immediately following the incident. Resident assessment (ROM [range of motion], Pain, Skin condition, Neuros). Any immediate interventions i.e., non-skid footwear etc. [etcetera]." The policy also revealed: "100 Fall Interventions. This list is created to assist facilities in choosing fall interventions. It is by no means an all-inclusive list and interventions should be applied on an individual's needs and capabilities." Review of Resident #5's clinical record listed the admission date of [DATE], and diagnoses included: Dementia, Emphysema,

	Aphasia, Neuropathy, Repeated Falls, Major Depressive Disorder, and Anxiety Disorder. Review of Resident #5's Quarterly Minimum Data Set (MDS), Assessment Review Date (ARD) of [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was an eight (8), which indicated the resident had moderately impaired cognition. Resident #5 was independent with bed mobility, transfers, and toilet use, and required supervision with walking and locomotion. Per the MDS, Resident #5 was not steady, but was able to stabilize without staff assistance when moving from a seated to standing position, walking, turning around and facing the opposite direction while walking, moving on and off the toilet, and surface to surface transfers. The MDS revealed the resident did not use a mobility device, had two (2) or more non-major injury falls, and did not receive therapy or restorative services. Review of Resident #5's Care Plan revealed a focus area for Altered Mobiity, and listed interventions in place on [DATE], as follows: resident was full weight bearing; staff were directed to keep items the resident used frequently within easy reach when possible; staff were to keep the resident's pathways clear and free from clutter, keep the resident's room well lit, and environmental layout consistent. Per the Care Plan, staff were to ensure the resident wore proper fitting, non-skid footwear, and non-skid socks while in bed, as the resident allowed. The Care Plan also revealed staff were to ensure the call light was properly placed within the resident's reach when the resident was in bed and or in their room chair, and staff were instructed to follow facility fall protocol when a fall occurred. Review of Resident #5's Progress Notes, Fall Investigations, and Care Plan revealed the following 22 falls occurred from [DATE], to [DATE]: • [DATE], at 7:20 p.m. – Certified Nurse Aide saw the resident fall to the floor in the hallway. The resident sustained an abrasion to the right elbow. Staff encouraged the resident to use a cane. • [DATE], at 8:44 p.m. – resident stepped away from the [LOCATION] and fell onto their left knee. Staff again encouraged resident to use their cane. • [DATE], at 5:45 p.m. – staff found the resident on the floor at the foot of the bed. The resident sustained a bruise to their left arm. Per the note, Resident #5 had severe cognitive impairment based on their BIMS score of six (6), noted as completed on [DATE]. • [DATE], at 8:45 p.m. – Certified Nurse Aide heard yelling and found the resident on the floor in their room. The

resident sustained a 0.1-centimeter (cm) scratch to their right eyelid that bled.

- [DATE], at 6:45 p.m. – staff heard the resident yelling and found the resident on the floor with their feet under the bed, and the walker and wheelchair on the opposite side of the bed. On [DATE], it was noted that PT (physical therapy) was to evaluate the resident and make recommendations; staff were to encourage the resident to use a front wheeled walker (FWW) and to wear nonskid socks. The resident's BIMS was a five (5) as of [DATE], which indicated severe cognitive impairment.
- [DATE], at 6:30 a.m. – Certified Nurse Aide alerted the licensed nurse that the resident was found sitting on the floor between beds. Per the note, on [DATE], staff encouraged the resident to wear nonskid socks and use their FWW. Underbed lighting was to be checked to ensure it was working properly.
- [DATE], at 12:45 p.m. – staff found the resident sitting against the frame of their bed on the floor by the bed. The mattress was slightly pushed off the bed and the FWW was between the beds.
- [DATE], at 8:25 p.m. – staff found the resident sitting on the floor in their room. The resident sustained an abrasion to the left knee and the left lower leg. Per the note, staff were to encourage the resident to use their FWW. Per the note, it was revealed, on [DATE], the fall committee reviewed the fall that occurred on [DATE], and the resident was moved to a room closer to the [LOCATION]. The resident had been working with Physical Therapy (PT).
- [DATE], at 6:15 p.m. – the resident, who was agitated, fell while walking with a licensed nurse and hit their head on a table. The resident sustained a 1.5 cm scalp wound, to which staff applied steri-strips. Per a note entered on [DATE], staff were to encourage resident to use their wheelchair for mobility. Per a note entered on [DATE], the resident's medications were also adjusted.

Review of a Significant Change MDS Assessment, dated [DATE], revealed Resident #5 had short and long-term memory impairment and modified independent decision-making skills. Resident #5 required supervision to touching assistance with sitting to lying, lying to sitting, sitting to standing, chair to bed, and bed to chair activities. The MDS revealed the resident used a walker and wheelchair, and had two (2) or more non injury falls and two (2) or more non-major injury falls.

	• [DATE], at 12:50 p.m. – staff responded to a loud noise and screaming and found the resident on the floor. • [DATE], at 11:00 a.m. – resident fell while outside with staff and had an abrasion to their left elbow and wrist. Staff were to conduct frequent checks. • [DATE], at 8:00 p.m. – staff found the resident on the floor up against the window in their room. Their wheelchair was between the sink and bed, and their walker was in front of them. Staff were to continue to provide close observations. • [DATE], at 9:08 p.m. – staff found the resident lying on the floor with their wheelchair at the end of their bed. No injuries were noted. • [DATE], at 8:20 p.m. – staff found the resident on the floor in the doorway of their room. Staff had placed the resident in bed around 7:30 p.m. Per the note, a 0.4 cm (centimeter) laceration was found on the resident's right lateral eyebrow. Staff would again apply nonskid socks and conduct more frequent checks. • [DATE], at 8:55 p.m. – staff found the resident flat on their back on the floor in the hallway. Staff were to complete a three (3) day bowel/bladder toileting program and continue to monitor. • [DATE], at 7:30 p.m. – staff responded to the resident yelling and found the resident on the floor next to the bed. The staff placed the resident in bed at 7:00 p.m. The staff were to continue with frequent checks. • [DATE], at 9:20 p.m. – resident was at the [LOCATION]. Staff saw the resident's wheelchair roll back. The resident yelled, and staff found the resident on the floor. Staff noted the anti-rollback brakes were not working. Staff were to lay the resident down when they were slouching in the chair. • [DATE], at 4:30 p.m. – staff found the resident on the floor. A Certified Nurse Aide stated the resident fell from their wheelchair. Staff were educated to offer the resident rest after lunch. • [DATE], at 10:58 a.m. – resident was at the [LOCATION]. Two (2) staff saw the resident slide out of their wheelchair, and the two (2) Certified Nurse Aides assisted the resident to the floor. • [DATE], at 2:30 p.m. – resident was in their room. Staff observed the resident sliding out of their wheelchair and assisted the resident to the floor. The facility were to have therapy evaluate the resident for wheelchair positioning or the possible use of a Broda chair. • [DATE], at 8:50 p.m. – the staff found the resident on the floor in front of their wheelchair. Staff used the Hoyer lift to transfer the resident from the floor. The resident began to flail around and then fell from the Hoyer sling.

	Staff were to receive "refresh education" on sling placement during a Hoyer transfer, and were to inspect the sling for any issues. Review of the Restorative Notes, dated [DATE], listed the resident received restorative services from Omnicycle for bilateral lower extremity up to 15 minutes per day for six (6) days per week. The documentation revealed the restorative services started on [DATE]. Observation, on 7/9/24, at 10:39 a.m., revealed Resident #5 sat in a Broda chair in the TV area. Observation, on 7/10/24, at 12:13 p.m., revealed Resident #5 sat in a Broda chair at the [LOCATION] table, and staff fed the resident. Observation, on 7/11/24, at 8:22 a.m., revealed the resident laid in bed with the head of their bed elevated 75 degrees. The resident kept reaching for the edge of the mattress and then would stop. No transfer bars/siderails noted. In an interview with Licensed Nurse A, on 7/11/24, at 8:28 a.m., it was revealed the underbed lighting was no longer used. Licensed Nurse A stated it was used when the resident could transfer themselves. In an interview with Administrative Nurse A, on 7/11/24, at 9:24 a.m., they stated Monday through Friday, during the daily meetings, the staff discussed the falls that occurred since the previous meeting. The staff present tried to determine the root cause and review what type of assistance the resident required. Administrative Nurse A stated Resident #5 had a decline in function due to their dementia. They also stated the staff initiated the Broda chair on [DATE]. In an interview with Licensed Nurse B, on 7/11/24, at 10:41 a.m., they stated to prevent falls, the staff kept the resident in high visual areas and in their Broda chair. In an interview with Consultant Staff A, on 7/11/24, at 10:56 a.m., they stated Resident #5's orientation had decreased in the last year. The resident was unable to follow cues and required the use of a Hoyer lift. Consultant Staff A stated the resident received restorative therapy six (6) days per week and used the Omnicycle.
§ 51.120 (j) Nutrition. Based on a resident's comprehensive assessment, the facility management must ensure that a resident—	Based on observations, interviews, record review, and review of facility policy, the facility failed to implement effective interventions and failed to provide interventions as planned for

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when a nutritional deficiency is identified **Level of Harm** – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	the prevention of a significant weight loss for one (1) of two (2) residents reviewed for weight loss (Resident #5). The findings include: Review of the facility policy titled, "Resident Weights/Nutritional Evaluation," dated 4/22, revealed: "Evaluation: Although a resident's weight loss or gain can be identified through obtaining weights there are other means to help identify those residents who might be at nutritional risk. The following are examples of conditions that may warrant further referral/consultation: 1. Review of meal percentages indicates a decrease in consumption either universal or consistent with a specific meal(s). 2. Resident's clothing appears looser, baggier than previously. 3, Resident complaints of problems that may impact ability to consume food e.g., sore gums, ill-fitting dentures, nausea, and poor appetite. 4. Resident has a newly diagnosed medical condition that may contribute to weight loss/gain such as CHF [Congestive Heart Failure], dysphagia, cancer, diabetes, CVA [Cerebral Vascular Accident], decubitus ulcer, abnormal lab values, etc. [etcetera]." Review of Resident #5's clinical record listed the admission date of [DATE], and the diagnoses which included: Dementia, Emphysema, Aphasia, Gastroesophageal Reflux Disease (GERD), Major Depressive Disorder, and Anxiety Disorder. Review of Resident #5's Quarterly Minimum Data Set (MDS), Assessment Review Date (ARD) of [DATE], revealed the resident's Brief Interview for Mental Status (BIMS) score was an eight (8), which indicated the resident had moderately impaired cognition. Per the MDS, the resident was independent with eating with one (1) person assist, weighed 231 pounds, had no or unknown weight loss, and received a therapeutic diet. Review of Resident #5's Care Plan listed the interventions, which were in place on [DATE], as follows: a diabetic snack at bedtime and Dietary Staff A to evaluate and make diet change recommendations as needed (prn). Review of Resident #5's Weight List and clinical record revealed: [DATE] – 236.6 pounds (lbs.) [DATE] – 231.4 lbs. Review of the Nutrition Review, dated [DATE], revealed Dietary Staff A made no nutritional recommendations. [DATE] – 233.8 lbs. [DATE] – 235.4 lbs. [DATE] – 230.6 lbs.

	Review of Resident #5's Annual Nutrition Evaluation, dated [DATE], revealed the resident received a reduced concentrated sweet diet, regular texture, and thin liquids. The resident had minimal weight loss and no peripheral edema. Dietary Staff A made no new recommendations. [DATE] – 226.6 lbs. [DATE] – 226.2 lbs. [DATE] – 226.6 lbs. Review of the Nutrition Evaluation, dated [DATE], revealed resident #5 continued to receive a reduced concentrated diet, regular textured, and with thin liquids. Dietary Staff A had made no new nutritional recommendations and would follow up prn. [DATE] – 224.2 lbs. Resident #5's clinical record revealed the staff started the resident on a regular diet with regular texture on [DATE]. Resident #5's Physician Orders, dated [DATE], revealed an order for Magic Cup one (1) time a day. Which added 290 calories to the resident's diet. [DATE] – 209.6 lbs. Resident #5's weight review consisted of a 25.8 lb., or 10.96%, weight loss from [DATE], to [DATE], or a 14.6 lb., or 6.5%, weight loss from [DATE], to [DATE]. Continued review of Resident #5's Weight list revealed: [DATE] – 206.4 lbs. Review of Resident #5's Nutrition Review, dated [DATE], revealed the resident received a soft and bite sized textured diet. [DATE] – 203.5 lbs. [DATE] – 197.2 lbs. Resident #5's clinical record revealed the staff added fortified foods with fats on [DATE]. Review of Resident #5's Weight List revealed a continued loss of weight: [DATE] – 197 lbs. [DATE] – 191 lbs., for a total of 45.6 lbs., or 19.27 % since [DATE].

	Review of the Diet Breakout Menu for the lunch meal on 7/9/24, revealed the Fortified Diet consisted of one (1) tablespoon of margarine added to the mashed potatoes and green beans, whipped cream on the fruited gelatin, and eight (8) ounces (oz) of whole milk. Observation of Resident #5's lunch meal, on 7/9/24, at 12:25 p.m., revealed the resident did not receive whipped cream on the fruited gelatin and did not receive the eight (8) oz of whole milk. Review of the Diet Breakout Menu for the lunch meal on 7/10/24, revealed the Fortified Diet consisted of one (1) tablespoon of margarine added to the fried rice, sauteed red cabbage, and assorted bread. Resident #5 should also have received topping for the ice cream and eight (8) oz of whole milk. Observation of Resident #5's lunch meal, on 7/10/24, at 12:10 p.m., revealed the resident did not receive the bread, the additional topping for the ice cream, or the eight (8) oz of whole milk. Further observation revealed staff served the resident cranberry juice and cola. The resident ate approximately 95% of the rice, 90% of the chicken, and none of the red cabbage. In an interview with Dietary Staff B, on 7/11/24, at 8:20 a.m., it was revealed that Dietary Staff A came every week. Dietary Staff B could also email or text Dietary Staff A if they needed something. Dietary Staff B stated that Administrative Staff A scheduled who Dietary Staff A assessed at each visit. In an interview with Administrative Staff A, on 7/11/24, at 8:26 a.m., they stated Dietary Staff A told them who they were going to assess each day. Dietary Staff A assessed all the new admissions, residents scheduled for an MDS assessment, and those who triggered for weight loss. Administrative Staff A stated that after Dietary Staff A assessed the residents, they were discussed in the Nutrition at Risk (NAR) meeting. They also stated one (1) time a month they reviewed the residents' weights. Additional interview with Dietary Staff B, on 7/11/24, at 9:06 a.m., revealed one (1) tablespoon of margarine added 102 calories to the resident's diet. In an interview with Dietary Staff A, on 7/11/24, at 9:11 a.m., it was revealed they had been at the facility two (2) times, as they were filling in for the usual Dietary Staff A. They stated they reviewed the monthly weights, residents with wounds, new admissions, and residents scheduled for a MDS assessment.

	In an interview with Administrative Nurse A, on 7/11/24, at 9:24 a.m., they stated Dietary Staff A, Administrative Nurse A, Administrative Staff A, and Dietary Staff B attended the NAR meeting. The meeting consisted of reviewing residents with weight loss or gain, and residents with pressure ulcers. The group also reviewed the monthly weights. Dietary Staff A made recommendations, and the staff followed up with the resident's physician as needed.
§ 51.120 (n) Medication Errors. The facility management must ensure that— (1) Medication errors are identified and reviewed on a timely basis; and (2) strategies for preventing medication errors and adverse reactions are implemented. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interviews, record review, and review of facility policy, the facility failed to administer medications as ordered for four (4) of 34 medications observed involving one (1) resident (Resident #10). The findings include: Review of the facility policy titled, "Medication Administration and Medication Orders," dated4/24, revealed: "Medication Administration…4. Administration of Metered Dose Inhalers (MDI) a) The nurse will wait at least one (1) minute between inhaler puffs of same medication and five (5) minutes between different medications, b) Administer MDI in proper sequence if more than one (1) type is used bronchodilator-Anticholinergic-Miscellaneous-Corticosteroids. c) When using a steroid MDI, then following completion of inhalation then instruct the resident to gargle or rinse their mouth. d) each order will specify who will administer the MDI order, e.g., resident or nurse…10. Nasal Spray administration a) The nurse will obstruct the opposing nare during administration. b) The nurse will wait 1 [one] minute between inhalations of same medication in same nare." Observation, on 7/10/24, at 8:32 a.m., revealed Licensed Nurse B prepared medications for Resident #10. Observation revealed Licensed Nurse B handed the resident their Spiriva inhaler (bronchodilator) and their Ipratropium nasal spray (used to decrease mucous), and then Licensed Nurse B left the room. Resident #10 administered two (2) sprays of the Ipratropium into each naris without waiting between the sprays, and did not hold the opposite naris when they administered the nasal spray. Resident #10 then administered one (1) dose of the Spiriva inhaler, but did not rinse their mouth afterwards. Licensed Nurse B reentered the room with Resident #10's oral medications, Fluticasone nasal spray (corticosteroid) and Fluticasone Diskus inhaler (corticosteroid). Resident #10 administered two (2) nasal sprays of the Fluticasone into each naris without waiting between the sprays, and did not hold the opposite naris when they administered them. Resident #10 then administered two (2) doses of the Fluticasone Diskus. The resident did not rinse their mouth after they administered the inhalers.

	Review of Resident #10's Physician Orders listed the following orders: [DATE] - Ipratropium Bromide Solution 0.06 percent (%) two (2) sprays in both nostrils three (3) times a day. Plug opposing nostril during administration. [DATE] – Fluticasone Propionate Suspension 50 micrograms/activation (MCG/ACT) one (1) spray in both nostrils two (2) times a day. Plug opposing nostril during administration. [DATE] - Spiriva Respimat Inhalation Aerosol Solution 2.5 MCG/ACT one (1) inhalation in the morning, wait five (5) minutes between inhaled medications and rinse mouth after use. [DATE] - Fluticasone-Salmeterol Inhalation Aerosol 250-50 MC/ACT, two (2) puffs inhaled orally two (2) times a day, wait one (1) minute between puffs, rinse mouth after use. In an interview with Licensed Nurse B, on 7/10/24, at 8:42 a.m., they stated they had instructed Resident #10 to hold the opposite naris when they administered the nasal spray, but the resident did their own thing. In an interview with Administrative Nurse A, on 710/24, at 3:10 p.m., they stated the staff needed to follow the Physician Orders when they administered the medications. The staff should have held the opposite naris when they administered nasal spray, and should have assisted the resident to rinse their mouth out after taking Sprivia. Administrative Nurse A stated they did not know what the order for two (2) puffs of the Fluticasone Inhalation meant. They would get the order clarified. Administrative Nurse A also stated that if the resident administered their own nasal spray and/or inhalers, the licensed nurse should have observed and instructed the resident on the correct way to self-administer them.
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. **Level of Harm** – No Actual Harm, with potential for more than minimal harm	Based on observation, interview, record review, and facility policy review, the facility failed to ensure resident meals had been stored, prepared, and served in a sanitary condition to prevent cross contamination and potential illness. The findings include: A review of the facility policy and procedure manual titled, "Food and Nutrition Services in Healthcare Facilities," dated 2021, revealed: "Employee Sanitary Practices, subtitled Sanitation and Infection Control, identified Policy: Employees will wash hands as frequently as needed throughout the day using proper hand washing procedures…Procedure: Hand an exposed portions of arms (or surrogate prosthetic devices) should be washed

Residents Affected – Many	immediately before engaging in food preparation. 1. When to wash hands: …f. After handling soiled equipment or utensils. g. During food preparation, as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks…i. Before donning disposable gloves for working with food and after gloves are removed. j. After engaging in other activities that contaminate the hands…General Food Preparation and Handling...5. Equipment a. All food service equipment should be cleaned, sanitized, air dried, and reassembled after each use…Employee Sanitary Practices Policy: All food and nutrition services employees will practice good personal hygiene and safe food handling procedures. Procedure: All employees will: …2. Wash hands before handling food, using posted hand-washing procedures…10. Equipment and work areas should be cleaned and sanitized after use." Section three (3) included identification of hazardous analysis critical control points (HACCP's), and indicated development of a prevention plan must follow all steps of food preparation that needed to be monitored, such as proper hand washing to prevent food borne contamination. A review of the facilities data sheet titled, "Clean Quick Broad Range Quaternary Sanitizer," not dated, revealed: "This is an EPA- [Environmental Protective Agency] registered as a broad range, liquid quaternary sanitizer. It is EPA approved for food contact sanitizing from 150 to 400 ppm [parts per million]." Additionally, the "Sanitizer Bucket Fact Sheet," provided with the data sheet, revealed: "Sanitizer Solutions…Quaternary Ammonia (QUAT)…Stable at high temperatures up to 100 F [Fahrenheit]…Longer contact time is needed with this sanitizer, since it is slow-acting against some common spoilage bacteria." This product should be tested when in use by using the quaternary test strips (QT-40 or equivalent). Review of the facility followed Idaho Diet Manual, twelfth (12) edition – 2020, revealed that hands were a critical factor in the transmission of organisms, and hands must be properly washed, and washed often. When to wash hands included immediately prior to engaging in food establishment operations, before handling food, food content surfaces, equipment, or utensils. An observation, on 7/10/24 at 11:46 a.m., Dietary Staff C was preparing hamburgers from the oven, and grease and food particles were observed on the food preparation surface. Dietary Staff C used a wet cloth that was removed from a bucket of liquid which was labeled "Sanitization Bucket." They wiped the entire preparation surface using the same cloth, then

	returned the cloth back into the sanitation bucket. When asked how long it had been since the sanitation bucket solution was changed or tested, Dietary Staff C stated within the last thirty (30) minutes. They was asked to evaluate the solution utilizing the proper test strips for "Clean Quick Broad Range Quaternary Sanitizer." The test identified there was a reading of zero ppm of sanitizer for the solution in the bucket. Dietary Staff C stated that the solution must be changed, and followed up by retesting the solution to get an acceptable range of 400 ppm. However, Dietary Staff C continued to utilize the food preparation table without re-sanitizing the surface after the sanitization bucket solution was changed and tested. During an observation of the meal serving line, on 7/10/24, at 11:50 a.m., Dietary Staff C brought food pans to the steam table line multiple times. Just prior to the beginning of meal service, Dietary Staff C was observed approaching the steam table utilizing oven mittens. Dietary Staff C removed the oven mittens and began serving food from the tray line, but had not washed their hands prior to serving residents food. Dietary Staff C prepared food for every resident in the facility from this tray line without washing their hands to prevent cross contamination. During an observation, on 7/10/24, at 12:14p.m., of Dietary Staff B, they approached the meal tray line and reached over the table to prepare a bowl of vegetables and passed it off the line to the dietary staff. Dietary Staff B had been observed in several areas of the [LOCATION], prior to approaching the line, and was never observed to have washed their hands. During an interview, on 7/10/24, at 1:05 p.m., with Dietary Staff C, they stated that they had changed the sanitation bucket solution every hour for the past 8 hours. However, Dietary Staff C further stated they did not test the sanitation buckets but twice during this shift, and they tested within range. Dietary Staff C stated that 30 minutes before the observation of their wiping down the food preparation table area, the sanitation solution was changed, but not tested. Dietary Staff C stated the chemical was supposed to come out at the right amount from the preparation sink. They then stated that their concern over the observation was the potential spread of food borne illness (virus, germs, Covid) to all the residents due to there being no sanitation in the bucket. Dietary Staff C stated they remembered bringing a pan of hamburgers to the steam table and removing their gloves, but they did not wash their hands and went directly to the steam table and started serving. They stated that they knew they had touched the top of some of plates while plating the food, and should have been more careful so as to not contact any resident food surfaces while serving. Dietary Staff C stated that cross contamination of the

	food, and no sanitization solution in the bucket, could have caused a serious food borne pathogen outbreak in the facility. During an interview with Dietary Staff B, on 7/10/24, at 12:44 p.m., They stated that they expected the staff to change the sanitation solution out every two (2) hours, and more often if needed. Dietary Staff B stated staff should always test each time to verify the proper sanitation solution was within the 200-400 ppm range per manufactures guidelines. They stated that they felt the water temperature only, and it was too hot to stabilize the solution, but they had not tested the temperature. They stated that their concerns were cross contamination, food borne illness, and the spread of bacteria or viruses. Dietary Staff B stated that they were aware that Dietary Staff C had not washed their hands prior entering the tray line after removing their oven mittens. Dietary Staff B further stated they did not stop Dietary Staff C from serving food without washing their hands. Dietary Staff B stated that oven mittens were contaminated inside from multiple uses, and this was the most important reason for hand washing after removing them and before contacting food. They stated they were aware they contacted the steam table by reaching over the table and removing a pair of tongs from inside the hamburger pan, and then prepped a bowl of cabbage by reaching onto the steam table and coming into contact with a ladle that had been in contact with other surfaces in the [LOCATION]. Dietary Staff B acknowledged they had not washed their hands before contacting the food area. Dietary Staff B confirmed there were no residents who required tube feeding, and that all residents had been served by Dietary Staff C, who had not washed their hands prior to, during, or after the completion of the meal service. An interview, on 7/11/24, at 10:45 a.m., with Administrative Staff B revealed that they were surprised the deficient practice occurred; but they were more concerned that staff did not comply with policy. Their concerns included infection control, food borne illness, and cross contamination, which could lead to a facility illness outbreak.
§ 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	Based on observation, interviews, record review, and review of facility policies, the facility failed to provide urinary catheter care using appropriate infection control technique to prevent the spread of infection for one (1) of five (5) residents observed (Resident #2). The findings include: Review of the facility policy titled, “Urinary/Indwelling/Supra-Pubic Catheter Care,” dated 4/22, revealed: “Procedures…10. Along with routine peri care, routine catheter care is performed

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** – Few	Q [every] shift. Use of a washcloth, soap, and water is indicated with routine catheter care. Cleanse the proximal third of the catheter with soap and water, washing away from the insertion site and manipulating the catheter as little as possible to avoid trauma to the urethra." Review of the facility policy titled, "Using Gloves," dated 4/24, revealed: "Purpose: …1. Equipment And Supplies…g. Disposable (single use) gloves must be replaced as soon as practical when contaminated or as soon as feasible if they are torn or punctured and when they exhibit signs of deterioration or when their ability to function as a barrier is compromised." Review of Resident #2's clinical record listed the admission date of [DATE], with diagnoses which included: Hemiplegia, Hemiparesis, Dementia, Neuromuscular Dysfunction of the Bladder, and Obstructive and Reflux Uropathy. Review of Resident #2's Annual Minimum Data Set (MDS), Assessment Reference Dated (ARD) [DATE], revealed the resident had short and long-term memory problems, was dependent for toileting hygiene, and had a urinary catheter. Review of Resident #2's Care Plan for their urinary catheter, dated [DATE], listed the intervention was to provide catheter care every shift and as needed. Observation, on 7/10/24, at 3:11 p.m., while Certified Nurse Aide A provided catheter care revealed Certified Nurse Aide A used a wet washcloth to clean the genitals, and then wiped the catheter tubing away from the genitals, but continued to wipe the catheter tubing back towards the genitals without changing the position of the washcloth. Certified Nurse Aide A then cleanse the groin area by wiping several times without changing the position of the washcloth. Certified Nurse Aide A then placed the used washcloth on the overbed table prior to using a dry washcloth to dry the groin area. Certified Nurse Aide A, without changing gloves, used the bed controls to raise the head of the bed, pulled the covers up over the resident, and then touched the resident's cheek with the same used gloves. In an interview with Administrative Nurse A and Licensed Nurse C, on 7/11/24, at 9:48 a.m., they stated the staff should wipe away from the entry of the catheter and should change position of the washcloth/wipe with each swipe. They also stated the staff should have put the used washcloth into a trash bag and not on the resident's overbed table. Administrative Nurse A and Licensed Nurse C stated the staff should have removed their gloves prior to touching the resident's environment or the resident.

§ 51.200 (a) Life safety from fire. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	**Smoke Barriers and Sprinklers** 1. Based on records review and interview, the facility failed to test and inspect the Fire Alarm in accordance with the code. The deficient practice affected four (4) of four (4) smoke compartments, staff, and all residents. The facility had the capacity for 66 beds with a census of 47 on the first day of the survey. The findings include: Record review, on 7/9/24, at 10:00 a.m., of the fire alarm testing and inspection records for the 12-month period prior to the survey revealed there was no documentation of semi-annual visual inspections of the smoke detectors as required by table 14.3.1 of NFPA 72, National Fire Alarm and Signaling Code. An interview, on 7/9/24, at 10:02 a.m., with Maintenance Staff A revealed the facility was unaware of the requirement to keep documentation of semi-annual visual inspections of the facility smoke detectors. Record review, on 7/9/24, at 10:05 a.m., of the fire alarm testing and inspection records for the 12-month period prior to the survey revealed there was no documentation of semiannual testing of the alarm system battery charger, load voltage, or discharge test for the back-up batteries, as required by table 14.4.5 of NFPA 72, National Fire Alarm and Signaling Code. Further review of alarm system testing and inspection documents revealed the facility last completed required alarm system battery testing on 1/10/23. An interview with Maintenance Staff A, on 7/9/24, at 10:08 a.m., revealed the facility was unaware of the requirements to have charger testing, discharge testing, and load voltage testing completed. The census of 47 was verified by Administrative Staff B on 7/9/24, at 9:00 a.m. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff A during the LSC exit interview on 7/9/24, at 4:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.4.1 General.** Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. **9.6 Fire Detection, Alarm, and Communications Systems.** **9.6.1* General.** **9.6.1.1** The provisions of Section 9.6 shall apply only where specifically required by another section of this Code. **9.6.1.2** Fire detection, alarm, and communications systems installed to make use of an alternative permitted by this Code

	shall be considered required systems and shall meet the provisions of this Code applicable to required systems. **9.6.1.3** A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. **9.6.1.4** All systems and components shall be approved for the purpose for which they are installed. **9.6.1.5*** To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. **4.6.12 Maintenance, Inspection, and Testing.** **4.6.12.1** Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. **4.6.12.2** No existing life safety feature shall be removed or reduced where such feature is a requirement for new construction. **4.6.12.3*** Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. **4.6.12.4** Any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. **10.2 Purpose.** The purpose of fire alarm and signaling systems shall be primarily to provide notification of alarm, supervisory, and trouble conditions; to alert the occupants; to summon aid; and to control emergency control functions. **10.3 Equipment.** **10.3.1** Equipment constructed and installed in conformity with this Code shall be listed for the purpose for which it is used. **Actual NFPA Standard: NFPA 72, National Fire Alarm and Signaling Code (2010)** **14.4.2* Test Methods.** **14.4.2.1*** At the request of the authority having jurisdiction, the central station facility installation shall be inspected for complete information regarding the central station system, including

	specifications, wiring diagrams, and floor plans that have been submitted for approval prior to installation of equipment and wiring. **14.4.2.2*** Systems and associated equipment shall be tested according to Table 14.4.2.2. **14.3 Inspection.** **14.3.1*** Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction. **14.4.5* Testing Frequency.** Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. **Table 14.3.1 Visual Inspection Frequencies** **Table 14.4.5 Testing Schedule Frequencies** 2. Based on observation and interview, the facility failed to properly maintain the smoke barriers. The deficient practice affected three (3) of four (4) smoke compartments, staff, and all residents. The facility had the capacity for 66 beds with a census of 47 on the first day of the survey. The findings include: Observation during the facility tour, on 7/9/24, at 1:00 p.m., of the smoke barrier wall at the [LOCATION] above the lay-in ceiling tiles, revealed four (4) unsealed penetrations. The penetrations consisted of three (3) metal conduits, 1/2 inch in diameter and one (1) 2 ½ inch insulated metal pipe that were not sealed to resist the passage of smoke as required by sections 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code. An interview with Maintenance Staff A, on 7/9/24, at 1:05 p.m., revealed the facility was not aware of the penetration until discovered during the facility tour. Observation during the facility tour, on 7/9/24, at 1:20 p.m., of the smoke barrier wall at the [LOCATION] above the lay-in ceiling tiles, revealed two (2) unsealed penetrations. The penetrations consisted of four (4) gray and two (2) blue data cables that were not sealed to resist the passage of smoke as required by sections 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code. An interview with Maintenance Staff A, on 7/9/24, at 1:25 p.m., revealed the facility was not aware of the penetration until discovered during the facility tour.

	The census of 47 was verified by Administrative Staff B on 7/9/24, at 9:00 a.m. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff A during the LSC exit interview on 7/9/24, at 4:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.7.3** Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1⁄2-hour fire resistance rating, unless otherwise permitted by one of the following: **(1)** This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: **(a)** Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). **(b)** Not less than two separate smoke compartments shall be provided on each floor. **(2) ***Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. **8.5 Smoke Barriers.** **8.5.6 Penetrations.** **8.5.6.1** The provisions of 8.5.6 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations of smoke barriers. **8.5.6.2** Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. **8.5.6.3** Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless the requirements of 8.5.6.4 are met. **8.5.6.4** Where sprinklers penetrate a single membrane of a fire resistance–rated assembly in buildings equipped throughout with an approved automatic fire sprinkler system, noncombustible escutcheon plates shall be permitted, provided that the space around each sprinkler penetration does not exceed 1⁄2 in. (13 mm), measured between the edge of the membrane and the sprinkler. **8.5.6.5** Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be securely set in the smoke barrier, and the space between the item and the sleeve shall be filled with a material capable of restricting the transfer of smoke.

	8.5.6.6 Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: **(1)** It shall be provided on either side of the smoke barrier. **(2)** It shall be designed for the specific purpose. **8.5.7 Joints.** **8.5.7.1** The provisions of 8.5.7 shall govern the materials and methods of construction used to protect joints in between and at the perimeter of smoke barriers or, where smoke barriers meet other smoke barriers, the floor or roof deck above, or the outside walls. The provisions of 8.5.7 shall not apply to approved existing materials and methods of construction used to protect existing joints in smoke barriers, unless otherwise required by Chapters 11 through 43. **8.5.7.2** Joints made within or at the perimeter of smoke barriers shall be protected with a joint system that is capable of limiting the transfer of smoke. **8.5.7.3** Joints made within or between smoke barriers shall be protected with a smoke-tight joint system that is capable of limiting the transfer of smoke. **8.5.7.4** Smoke barriers that are also constructed as fire barriers shall be protected with a joint system that is designed and tested to resist the spread of fire for a time period equal to the required fire resistance rating of the assembly and restrict the transfer of smoke. **8.5.7.5** Testing of the joint system in a smoke barrier that also serves as fire barrier shall be representative of the actual installation suitable for the required engineering demand without compromising the fire resistance rating of the assembly or the structural integrity of the assembly. **Means of Egress** 3. Based on record review, observation, and interview, the facility failed to properly test and inspect illuminated exit signs as required by the code. The deficient practice affected two (2) of four (4) smoke compartments, staff, and residents. The facility had the capacity for 66 beds with a census of 47 on the first day of survey. The findings include: Record review, on 7/9/24, at 11:00 a.m., revealed for the 12-month period from the date of the survey, the facility had no documentation indicating the required testing and inspection of illuminated exit signs was completed, as required by sections 7.10.9.1 and 7.10.9.2 of NFPA 101 Life Safety Code. An interview, on 7/9/24, at 11:05 a.m., with Maintenance Staff A revealed that the facility was unaware that the battery backup illuminated exit signs were present in the facility. Further

	interview revealed the facility was unaware of the requirement to have battery backup illuminated exit signs inspected and tested. Observation during the facility tour, on 7/9/24, at 12:45 p.m., revealed two (2) battery backup illuminated exit signs above the [LOCATION]. Additional observation revealed one battery backup illuminated exit sign above the exit door of the [LOCATION]. Observation during the facility tour, on 7/9/24, at 1:00 p.m., revealed two (2) battery backup illuminated exit signs in the [LOCATION]. Additional observation revealed two (2) battery backup illuminated exit signs located above the exit doors in the [LOCATION]. Additional observation revealed one (1) battery backup illuminated exit sign located above the exit door of the [LOCATION]. The census of 47 was verified by Administrative Staff B on 7/9/24, at 9:00 a.m. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff A during the LSC exit interview on 7/9/24, at 4:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.2 Means of Egress Requirements.** **19.2.1 General.** Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11 **7.10.9 Testing and Maintenance**. **7.10.9.1 Inspection.** Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days or shall be periodically monitored in accordance with 7.9.3.1.3. **7.10.9.2 Testing**. Exit signs connected to, or provided with, a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3. **7.9.3 Periodic Testing of Emergency Lighting Equipment.** **7.9.3.1** Required emergency lighting systems shall be tested in accordance with one of the three options offered by 7.9.3.1.1, 7.9.3.1.2, or 7.9.3.1.3. **7.9.3.1.1** Testing of required emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2)*The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction.

	(3) Functional testing shall be conducted annually for a minimum of 1½ hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the duration of the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction **7.10.4* Power Source**. Where emergency lighting facilities are required by the applicable provisions of Chapters 11 through 43 for individual occupancies, the signs, other than approved self-luminous signs and listed photoluminescent signs in accordance with 7.10.7.2, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration.