Department of Veterans Affairs State Veterans Home Survey Report

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

General Information:

Facility Name: Oklahoma Veterans Center

Location: 1776 East Robinson Street, Norman, Oklahoma 73070

Onsite / Virtual: Onsite

Dates of Survey: 10/31/23 – 11/3/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 301

Census on First Day of Survey: 203

VA Regulation Deficiency	Findings
	Initial Comments A VA Annual Survey was conducted from October 31,2023 through November 3, 2023 at the Oklahoma Veterans Center. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.43 (d) Drugs and medicines for certain veterans VA may furnish a drug or medicine under this section and under §17.96 of this chapter by having the drug or medicine delivered to the State home in which the veteran resides by mail or other means and packaged in a form that is mutually acceptable to the State home and to VA set forth in a written agreement. **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Few	The facility was unable to demonstrate they received only drugs and medicines for veterans who were eligible to receive such medications as implemented by §17.96. The findings include: Based on record review, one (1) of seven (7) sampled Residents was ineligible to have medications furnished by the VA. In an interview on November 3, 2023, the Administrative Staff A reported that the Resident was eligible for VA-furnished medications due to being in receipt of Aid & Attendance. Upon further review, it was identified that the Resident was not currently nor had ever been in receipt of Aid & Attendance and had thus never had eligibility for VA-furnished medications. Prior to survey exit on November 3, 2023, the Administrative Staff A and Consultant Staff A confirmed

	understanding that the facility cannot seek reimbursement for medication costs from the VAMC of jurisdiction for veteran residents who do not meet eligibility criteria.
§ 51.70 (c) (6) Assurance of financial security. The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility**.** **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on record review and staff interview, the facility failed to provide evidence that a surety bond or other assurance was secured for the security of all personal funds of residents deposited with the facility. The findings include: An inquiry was made to Administrative Staff A on 11/4/23, at approximately 11:06 a.m., regarding the facility's surety bond. Administrative Staff A confirmed that the facility did not have a surety bond.
§ 51.70 (n) Self-Administration of Drugs. An individual resident may self administer drugs if the interdisciplinary team, as defines by § 51.110(d)(2)(ii) of this part, has determined that this practice is safe. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, record review, and interviews with staff, the facility failed to assess a resident for self-administration of medication for safe practice for one (1) out of 46 sampled residents (Resident #19). The findings include: A review of the facility's policy and procedure on self-administration of medication, revised 2016, found stated: "Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so." Also, the policy and procedure stated: "As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the [LOCATION]. Nursing will transfer the unopened medication to the resident when the resident requests them." Review of Resident #19's clinical record revealed that there were no assessments related to the resident being able to self-administer medications. Review of the Care Plan did not reveal any goals or interventions addressing monitoring for self-administration of medications or the acquiring of store bought, over-the-counter medications.

	During a tour of the [LOCATION], on 10/31/23, at approximately 10:30 a.m., one (1) bottle of Aleve, one (1) bottle of Garlique, and two (2) bottles of Super Beta Prostate tablets were observed in Resident #19's room. Licensed Nurse A immediately removed the bottles and wrote the resident's name on them. Licensed Nurse B stated that the resident went to [LOCATION] and purchased the items, and stated that the resident liked to go to the store and purchase items.
§ 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, record review, and staff interview, the facility failed to ensure that medications/supplements were given as ordered for one (1) resident resulting in one (1) error out of 33 opportunities observed (Resident #47). The findings include: Record review for Resident #47 revealed the resident was admitted to the facility on [DATE], with the following diagnoses: Viral Hepatitis, Myocardial Infarction, Coronary By-Pass surgery, Major Depressive Disorder, Iron Deficient Anemia, Benign Prostatic Hypertrophy, Gastric Esophageal Reflux Disease (GERD), Nicotine Dependency, Dysphagia, B-12 deficiency, Diabetes, and Osteoarthritis. During Medication Pass observation, on 11/1/23, at 9:51 a.m., the resident received, via the G tube, Prosource provided in a 45 milliliter (ml) packet. Review of the Physician Orders, dated [DATE], revealed an order for Prosource 60 ml twice daily, via G tube. An observation and interview, on 11/1/23, at 12:41 p.m., with Licensed Nurse A revealed that Prosource was supplied in a 45 ml packet and confirmed the Physician Order called for 60 ml twice per day. Licensed Nurse A confirmed that Prosource 45 ml had been given since the Physician Order on [DATE]. Licensed Nurse A could not explain the oversight for the inaccurate Prosource dose. Licensed Nurse A notified Licensed Nurse C at the time of the discrepancy and the order was changed. An interview with Dietary Staff A, on 11/2/23, at 11:35 a.m., revealed that Prosource was supplied by Dietary weekly and was only available in 45 ml packets. Dietary Staff A revealed that Licensed Nurse D had been notified, for this resident, via email, of how the Prosource was supplied. Dietary Staff A provided an email, dated 9/26/23, addressed to Licensed Nurse D, and to Dietary Staff B, stating that: "Prosource comes in a packet and is 45 ml." However, Dietary Staff A confirmed there was not a follow up to clarify Resident #47's Physician Order.

	An interview with Licensed Nurse D was attempted, but they were unavailable on 11/3/23. An interview with Dietary Staff B, on 11/3/23, at 9:48 a.m., revealed that two (2) residents received Prosource, with Resident #47 receiving the wrong dose. Dietary Staff B could not explain how this was overlooked for Resident #47.
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities. (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on observations, interviews, review of the facility documentation, and review of facility policies, the facility failed to ensure food served to residents was stored and served under sanitary conditions. This failure placed 203 residents at potential risk for foodborne illnesses. The findings include: A review of the facility's policy titled, "Dietary," dated 10/16/23, under the "Environmental Safety and Maintenance" section, found stated: "[Dietary Staff C] is responsible for supervising sanitation and housekeeping procedures within the Food Services Department." In addition, the policy required that [Dietary Staff C] ensured: "[Maintenance Staff A] is responsible for routine inspections and care of fans, vents, ducts, and equipment." The "Cleaning Procedures" section of the policy outlined that walk-in freezers should be cleaned "Every Thursday." The cleaning of the walk-in freezers included: "Keep debris off floors…Clean spill on shelving with hot cloth." The facility's dietary policy and procedure further stated under the "First in First Out" section, that: "Milk will be stored in the walk-in refrigerator at 40°F [degrees Fahrenheit (F)], and will be used prior to expiration date." 1. The initial [LOCATION] tour observations were conducted on 10/31/23, at 10:00 a.m. The observations revealed there was a large accumulation of ice buildup located behind the fans in the walk-in freezer. In addition, four (4) boxes of frozen chicken were stored directly underneath the ice buildup. In addition, the observation revealed there was evidence of ice debris on the boxes, shelving, and floors. An interview was conducted with Dietary Staff C on 10/31/23, at 10:00 a.m. During the interview, Dietary Staff C acknowledged the food should not be stored directly under the ice buildup in the freezer, and was observed removing the boxes from the walk-in freezer. In addition, Dietary Staff C stated Maintenance Staff A was responsible for ensuring the ice buildup was removed from the freezer, and provided a work order, dated 8/21/2020, which indicated Dietary Staff C had notified the Maintenance Department of the problem with the walk-in freezer.

	An interview was conducted with Maintenance Staff A of the facility on 11/2/23, at 1:00 p.m. Maintenance Staff A stated the ice buildup in the walk-in freezer was caused by an uninsulated, low-pressure suction line behind the freezer fan. Maintenance Staff A further stated that staff from the Maintenance Department were required to conduct a weekly inspection of the walk-in freezer. However, the weekly inspections did not include checking for the accumulation of ice on the freezer fans, including the lines. 2. A review of the facility's documented procedure for staff working on [LOCATIONS] found stated: "1. It is YOUR responsibility to check the refrigerators before leaving the units (i.e., throw out any outdated or not dated product…)…3. Please check your unit that you are on every day and ensure that these things are being done." During a tour, on 10/31/23, at approximately 11:10 a.m., observations of a nourishment refrigerator on a unit of the facility revealed five (5) single serving containers of 2% milk and five (5) single serving containers of skim milk which were dated 10/30/23. The containers of milk were behind newer containers of milk dated 11/7/23. During an interview, on 10/31/23, at approximately 11:15 a.m., Licensed Nurse A stated the [LOCATION] staff was responsible for maintaining the nourishment refrigerator. During an interview, on 10/31/23, at 2:16 p.m., the evening Dietary Staff D stated that the dietary department was responsible for maintaining the refrigerators, and that everyone from dietary who was staffed on the units should have checked and rotated the inventory in the refrigerator. 3. An observation was made, on 11/2/23, from noon until 12:40 p.m., of dining in one (1) of two (2) [LOCATIONS] on the [LOCATION]. Dietary Staff E began meal service from a steam table with residents who required assistance or cueing with eating. Dietary Staff E plated food without wearing gloves and was not observed to wash or sanitize their hands. After they plated a tray for the hallway, Certified Nurse Aide A asked where the plate cover was, which was needed before the food could leave the [LOCATION]. Dietary Staff E then pulled out a cell phone and called for the [LOCATION] to bring plate covers to the [LOCATION]. Dietary Staff E continued to plate foods without gloves or hand sanitization. Three (3) different individuals brought plate covers to the [LOCATION], and one (1) staff member held the covers directly against their body. Dietary Staff F came to the [LOCATION] to help with meal service, although Dietary Staff F did not wash or sanitize their hands before they began, and did not wear gloves. Dietary

	Staff F was observed to plate large cinnamon rolls, then place them on top of a transport cart, and then adjusted the plates by touching them several times without gloves or sanitizing their hands. Dietary Staff E completed plating the food without washing or sanitizing their hands. Dietary Staff F then asked for the tray line temperatures to record on the sheet. Dietary Staff E said they didn't write them down, due to not having a pen. Dietary Staff E stated, "they were all above 150 degrees, so I'm not worried about it." Dietary Staff E complained throughout the meal service that they had not been trained, didn't like people watching them, and was just there for the money. An interview with Dietary Staff F, on 11/2/23, at 12:40 p.m., revealed that tray line temperatures should always be taken and recorded for all meals prior to service. Dietary Staff F revealed that Dietary Staff E was rather new, but had been trained. An interview with Dietary Staff C, on 11/2/23, at 12:55 p.m., revealed that they had been made aware of the [LOCATION] situation by other staff members. Dietary Staff C stated that Dietary Staff E had training and should have been aware of the procedures, including handwashing, wearing gloves, and recording tray line temperatures. Dietary Staff C felt this was unacceptable and that Dietary Staff E would be trained again, from the beginning. An interview was conducted with Dietary Staff G on 11/2/23, at 12:30 a.m. Dietary Staff G stated in the interview that monthly audits of the [LOCATION] were conducted for sanitary conditions. In addition, Dietary Staff G stated food served to residents in the facility was required to be properly stored and served to residents in a manner that was sanitary and safe. Dietary Staff G acknowledged that improper storage of foods in the walk-in freezer, expired milk products in nutrition refrigerators on the units, and unsafe handling of food during meal service to residents did not meet the expectations of standards for proper storage and service of foods.
§ 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** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	Based on observation, record review, review of facility policies, and staff interview, the facility failed to ensure staff appropriately cleaned and disinfected glucometers between residents, and failed to ensure that licensed staff removed gloves after performing catheter care and pressure ulcer treatment on one (1) of five (5) [LOCATIONS]. The findings include: Review of the facility policy and procedure titled, "Blood Sampling-Capillary (Finger Stick)," with a revised date of September, 2014, revealed: "The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to

	prevent transmission of bloodborne diseases to residents and employees. Equipment and Supplies: …6. Approved Environmental Protection Agency (EPA) registered disinfectant for cleaning of sampling device. General Guidelines: 1. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Steps in the Procedure: …7. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use…10. Replace blood glucose monitoring device in storage area after cleaning." Review of the Policy and Procedure, undated, titled, "Rosie SmartMeter Cleaning and Disinfection," found stated: "Cleaning Procedure: …3. Put on a protective glove (after handwashing) 4. Take a germicidal wipe of the canister (purple top wipes). 5. Wipe entire device until visibly clean. **Always clean SmartMeter before disinfecting, all parts of the device are considered biohazard. Be sure to disinfect all parts thoroughly.** Disinfecting Procedures: 1. Prepare wipes and meter. 2. Take germicidal wipe out of canister (Purple top wipes). 3. Put the moistened wipe on a smooth surface. 4. Display side up. Wipe the device from left to right 3 times slowly. All other sides and surfaces should be wiped in this way. 5. Make sure the meter stays wet for 1 minute. Please DO NOT get disinfectant liquid into the test strip slot. 7. After disinfection, gloves should be discarded, and hands thoroughly washed with soap and water before proceeding to the next patient." Review of the Infection Control guidelines, dated 3/14/23, found that: "Standard Precautions, Policy: It is the policy of this facility to provide precautions to prevent transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and other bloodborne agents between all residents and all healthcare workers who activities involve contact with resident or with blood or body fluids from residents. Gloves: Use proper Hand Hygiene before putting on and after removing gloves. Handwashing is the single most effective deterrent to the spread of infection…2. Gloves must be worn when touching blood-soiled items, body fluids or secretions, as well as the surfaces contaminated with them. 3. All tasks performed for one resident must be completed and hands must be washed with soap and water; dried completely and sanitized with sanitizing gel/foam and re-gloved before performing procedures on another resident." Review of the Centers for Disease Control and Prevention for "Glove use in Healthcare Settings: When and how to wear gloves," found stated: "Change gloves and perform hand hygiene during patient care, if moving from work on a soiled body site to a clean body site on the same patient."

	1.) During an observation of a finger stick blood sugar check, on 10/31/23, at 11:24 a.m., Licensed Nurse E utilized a re-usable glucometer for Resident #42. The observation revealed that Licensed Nurse E did not clean or disinfect the glucometer prior to the procedure. After the procedure, Licensed Nurse E returned to the medication cart and laid the glucometer directly on the medication cart without cleaning or disinfecting the glucometer. 2.) During an interview and observation of a finger stick blood sugar check on 10/31/23, at 11:38 a.m., Licensed Nurse E picked up the glucometer and cleaned the test strip end of the glucometer with an alcohol wipe. Licensed Nurse E stated this was all that was required. Licensed Nurse E then gathered the needed items to check the blood sugar for Resident #43 without disinfecting the glucometer. 3.) Observation of a finger stick blood sugar check for Resident #46 by Certified Medication Aide A, on 11/1/23, at 9:36 a.m., who stated they were a Licensed Nurse, revealed that Certified Medication Aide A removed the glucometer device from the medication cart and did not clean or disinfect the glucometer prior to the procedure. After completing the procedure, Certified Medication Aide A returned to the medication cart, placed the glucometer on the medication cart, and proceeded to draw up insulin coverage for Resident #46. After completing the insulin injection, Certified Medication Aide A returned to the medication cart. When asked what procedures were used for cleaning and disinfecting the glucometer, Certified Medication Aide A stated that nothing was required, although alcohol wipes were available. Certified Medication Aide A checked the medication cart, although the cart did not contain Santi-wipes. Certified Medication Aide A stated that they had not been trained by the facility or in school on the cleaning and disinfecting requirements for glucometers. Certified Medication Aide A stated that they never cleaned or disinfected the glucometers. An interview with Administrative Nurse A, on 11/1/23, at 10:30 a.m., revealed that all staff had been trained upon hire on cleaning and disinfecting the glucometers. A follow up interview, on 11/1/23, at 3:45 p.m., revealed a competency check off for Certified Medication Aide A on hire that included proper cleaning and disinfecting the glucometer. Administrative Nurse A then provided documentation that two (2) of 14 residents who received finger stick blood sugar checks on that

	hallway had a diagnosis of Chronic Hepatitis C. Administrative Nurse A confirmed that all residents used reusable glucometers. Administrative Nurse A began glucometer Cleaning and Disinfection procedure in-services for all staff on the [LOCATIONS]. The in-services were completed on 11/2/23, with sign in sheets provided. An email from Administrative Staff A, dated 11/6/23, clarified that Certified Medication Aide A was not a Licensed Nurse, and Certified Medication Aide A's training included 12 hours of classroom and four (4) hours of clinical for Diabetes-Insulin. 4.) Observation and interview of Suprapubic Catheter Care, on 11/2/23, at 10:12 a.m., for Resident #1 by Licensed Nurse F revealed that a pair of scissors were removed from Licensed Nurse F's pocket to cut the 4 by 4 gauze dressing, without evidence they were disinfected prior to use. After the catheter care was completed, Licensed Nurse F did not remove the soiled gloves and applied a leg bag and strapped it to the resident's leg. Licensed Nurse F then pulled the covers up, picked up the resident call light, which was on the floor, and attached it to the resident's covers before removing the soiled gloves. The scissors were then placed into Licensed Nurse F's pocket and were not disinfected. Licensed Nurse F stated they forgot to change the gloves and was planning on disinfecting the scissors. 5.) During observation of pressure ulcer treatment, on 11/2/23, at 1:00 p.m., for Resident #6 with Licensed Nurse G and Licensed Nurse H, it was revealed that once the new dressing was applied to the resident's right ankle, Licensed Nurse G did not remove their gloves prior to replacing the resident's sock. Licensed Nurse H was standing by Licensed Nurse G with hand sanitizer and new gloves after the new dressing was applied. Licensed Nurse G then removed the resident's left sock, to check the resident's toes, which were healing. Licensed Nurse G then replaced the left sock and applied bilateral booties with the same gloves. Licensed Nurse G stated that the lack of glove change was not an issue, but could understand the surveyor's concern. An interview with Administrative Nurse A, on 11/1/23, at 3:45 p.m., confirmed that both Licensed Nurses should have changed their gloves before moving to a clean area.
§ 51.200 (a) Life safety from fire. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA	**<u>Smoke Barriers and Sprinklers</u>** 1. Based on observation and interview, the facility failed to maintain the kitchen cooking hood ventilation systems in

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	accordance with the code. The deficient practice affected one (1) of ten smoke compartments, staff, and no residents. The facility had a capacity for 301 beds with a census of 203 on the first day of the survey. The findings include: Observation, on 10/31/23, at 10:16 a.m., of the kitchen hoods revealed the following: The kitchen hood for the serving line in the [LOCATION] had grease filters that were not tight fitting leaving a one (1) inch gap between the filters. Kitchen hoods #3, #4, #5, and #6 had gaps between grease filters of one (1) to two (2) inches allowing grease laden vapors to bypass the filters. Kitchen hoods #3, #4, and #5 had interior seams where the material that was used to seam them had fallen out. The facility had failed to ensure that all exhaust air passed through the grease filters, and interior seams in the kitchen hoods had been made grease tight, and not allowing grease to build up in the hoods, as required by sections 5.1 and 6.2.3 of NFPA 96, Standard for Ventilation Control and Fire Protections of Commercial Cooking Operations. An interview with Maintenance Staff B, on 10/31/23, at 3:05 p.m., revealed the facility was not aware that the grease filters were not tight fitting, and that the interior seams of the hood were no longer grease tight. The census of 203 was verified by Administrative Staff A on 10/31/23, at 9:22 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff B during the exit interview on 11/1/23, at 12:50 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.3.2.5 Cooking Facilities.** **19.3.2.5.1** Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4. **19.3.2.5.2*** Where residential cooking equipment is used for food warming or limited cooking, the equipment shall not be required to be protected in accordance with 9.2.3, and the presence of the equipment shall not require the area to be protected as a hazardous area. **9.2.3** Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service. **Actual NFPA Standard: NFPA 96, Standard for Ventilation Control and Fire Protections of Commercial Cooking Operations (2011)**

Chapter 5 Hoods

5.1 Construction.

5.1.4* Internal hood joints, seams, filter support frames, and appurtenances attached inside the hood shall be sealed or otherwise made greasetight.

Chapter 6 Grease Removal Devices in Hoods

6.2.3 Grease Filters.

6.2.3.2 Grease filters shall be of rigid construction that will not distort or crush under normal operation, handling, and cleaning conditions.

6.2.3.3 Grease filters shall be arranged so that all exhaust air passes through the grease filter.

2. Based on observation and interview, the facility failed to properly maintain the sprinkler system. The deficient practice affected one (1) of 10 smoke compartments, staff, and 46 residents. The facility had a capacity for 301 beds with a census of 203 on the first day of the survey.

Observation during the building inspection tour, on 10/31/23, at 2:22 p.m., revealed internet cabling wrapped around and zip tied to the sprinkler pipe in [LOCATION], as prohibited by section 5.2.1.1.2 (5) of NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.

An interview, on 10/31/23, at 2:22 p.m., with Maintenance Staff B revealed the facility was not aware that the sprinkler pipe was being used to support cables.

The census of 203 was verified by Administrative Staff A on 10/31/23, at 9:22 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff B during the exit interview on 11/1/23, at 12:50 p.m.

Actual NFPA Standard: NFPA 101 Life Safety Code (2012) 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) **5.2.2 * Pipe and Fittings.** **5.2.2.2** Sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. 3. Based on observation and interview, the facility failed to maintain the doors located within fire barrier walls to resist the passage of smoke. The deficient practice affected three (3) of 10 smoke compartments, staff, and 124 residents. The facility had a capacity for 301 beds with a census of 203 on the first day of the survey. The findings include: Observation during the building inspection tour, on 10/31/23, at 2:10 p.m., revealed that fire doors leading to [LOCATION], connecting to [LOCATION] and [LOCATION] had a gap between the doors of ¾ of an inch. Observation, on 10/31/23, at 2:45 p.m., of the fire barrier doors to [LOCATION] leading to the [LOCATION] were rubbing on the bottom, and would not fully close without being pulled shut. Additional observation, on 11/1/23, at 9:58 a.m., revealed the fire barrier doors to [LOCATION] leading to the [LOCATION] was not being pulled fully closed by its self-closure. These doors did not meet the requirements of sections 19.3.7.6 and 8.5.4.4 of NFPA 101, Life Safety Code and section 6.3.1.7 NFPA 80: Standard for Fire Doors and Other Opening Protectives. During an interview, on 11/1/23, at 9:58 a.m., with Maintenance Staff B, they acknowledged the problems with the fire barrier doors and stated they were a continuing problem. The census of 203 was verified by Administrative Staff A on 10/31/23, at 9:22 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff B during the exit interview on 11/1/23, at 12:50 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.7 Subdivision of Building Spaces.** **19.3.7.6** Openings in smoke barriers shall be protected using one of the following methods: **(1)** Fire-rated glazing **(2)** Wired glass panels in steel frames **(3)**Doors, such as 1 ¾ in. (44 mm) thick, solid-bonded wood-core doors **(4)** Construction that resists fire for a minimum of 20 minutes.

19.3.7.6.1 * Nonrated factory- or field-applied protective plates, unlimited in height, shall be permitted.

19.3.7.6.2 Doors shall be permitted to have fixed fire window assemblies in accordance with Section 8.5.

8.3.3 Fire Doors and Windows.
8.3.3.1
Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, *Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code.*

8.5 Smoke Barriers.
8.5.4 Opening Protectives.
8.5.4.4* *Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1.*

NFPA 80: Standard for Fire Doors and Other Opening Protectives, 2010 Edition
6.1 Doors.
6.3.1.7 * Clearances.
6.3.1.7.1
*The **clearances** between the top and vertical edges of the door and the frame, and the meeting edges of doors swinging in pairs, shall be 1/8 in. ± 1/16 in. (3.18 mm ± 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18 mm) for wood doors.*

Fire Safety and Operations

4. Based on records review and interview, the facility failed to conduct all required fire drills. The deficient practice affected 10 of 10 smoke compartments, staff, and all residents. The facility had a capacity for 301 beds with a census of 203 on the day of the survey.

The findings include:

Records review, on 10/31/23, at 12:06 p.m.,, revealed that no documentation was present that indicated the facility had conducted any fire drills on the third shift (11:00 p.m., to 7:00 a.m.) during the first or second quarters of 2023, as required by section 19.7.1.6 of NFPA 101, Life Safety Code. In addition, the fire drills for the first shift during the first quarter (7:00 a.m., to

	3:00 p.m.) and the first and second shift during the second quarter did not have any signatures indicating that staff had participated in the drill. An interview with Maintenance Staff B, on 10/31/23, at 12:06 p.m., revealed they were not aware of the missing fire drills or lack of signatures on the drill reports. The census of 203 was verified by Administrative Staff A on 10/31/23, at 9:22 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff B during the exit interview on 11/1/23, at 12:50 p.m. ***Actual NFPA Standard: NFPA 101 (2012) Life Safety Code*** **19.7.1.4*** Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. **19.7.1.5** Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. **19.7.1.6** Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. **19.7.1.7** When drills are conducted between 9:00 p.m. and 6:00 a.m. (2100 hours and 0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. 5. Based on observations and interviews, the facility failed to prohibit the use of portable space heaters that did not meet the requirements of the code. The deficient practice affected one (1) of ten smoke compartments, staff, and no residents. The facility had a capacity for 301 beds with a census of 203 on the day of the survey. The findings include: Observation during the building inspection tour, on 10/31/23, at 2:34 a.m., revealed two portable space heaters were in use in [LOCATION]. An interview, on 10/31/23, at 2:34 a.m., with Maintenance Staff B revealed the facility was not aware of the upper temperature limit of the heating element and did not have documentation showing it did not exceed 212°F (100°C), as required by section 19.7.8 of NFPA 101, Life Safety Code.

	The census of 203 was verified by Administrative Staff A on 10/31/23. The findings were acknowledged by Administrative Saff A and verified by Maintenance Staff B during the exit interview on 11/1/23, at 12:50 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012) 19.7.8 Portable Space-Heating Devices.** Portable space-heating devices shall be prohibited in all health care occupancies, unless both of the following criteria are met: **(1)** Such devices are used only in nonsleeping staff and employee areas. **(2)** The heating elements of such devices do not exceed 212°F (100°C).
§ 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 veterans.	Based on record review and interview, the facility failed to ensure there was a sharing agreement for mental health services provided by the VA Medical Center, and failed to provide a written agreement between the facility and outside agencies for the provision of dental services to the residents of the facility. The findings include: A request and subsequent review of the list of residents who received mental health services revealed there were a total of 35 facility residents who received mental health services via telehealth, and 16 residents who received mental health consultations with a psychiatrist with the Veterans Affairs (VA). A request for, and subsequent review of, the list of residents who received dental services revealed there were a total of 74 facility residents who received dental health services. During an interview, on 11/3/23, at 11:10 a.m., Administrative Staff A stated there were residents in the facility who received mental health and dental services outside of the facility, and currently there was no sharing agreement for the provision for mental services, and no written agreement for dental services in place.

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	