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: Southwestern Veterans' Center

Location: 7060 Highland Dr. Pittsburgh, Pennsylvania 15206

Onsite / Virtual: Onsite

Dates of Survey: 8/2/22-8/5/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 236

Census on First Day of Survey: 140

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from 8/2/22-8/5/22, at the Southwestern Veterans' Center. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.70 (c) (6) Assurance of financial security. The facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Many	Based on record review and staff interview, the facility failed to provide evidence that a surety bond, or other assurance satisfactory to the Under Secretary for Health, was secured for the security of all personal funds of residents deposited with the facility. This affected all residents whose funds were managed by the facility. The findings include: In an interview on 8/2/22, at 3:00 p.m., with Administrative Staff A and Administrative Staff B, they confirmed that, as per state law, the facility did not have a surety bond and had not been granted approval by the Under Secretary of Health for the Veterans Administration to maintain an alternate form of protection for the residents' personal fund accounts.
§ 51.100 (i) (3) Environment. Clean bed and bath linens that are in good condition.	Based on observation and staff interview, the facility failed to ensure residents received linens that were in good repair for one (1) of 27 sampled residents (Resident #3) and one (1) resident of random opportunity (Resident #35).

Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected - Few	The findings include: A tour of [LOCATION] was conducted beginning at 11:50 a.m., on 8/2/22, in the company of Administrative Nurse A. At 12:22 p.m., on 8/2/22, observation found Resident #3 in bed with their feet uncovered, allowing the fitted sheet on their bariatric bed to be visualized. The sheet, which was noted to be made of a stretchy fabric, was observed to have a hole in it about the size of a quarter. At 12:41 p.m., on 8/2/22, observation found Resident #35's unoccupied bariatric bed was covered with a stretchy, fitted sheet. This sheet had three (3) holes in it, with runs in the fabric running vertically above and below the holes. The largest of the holes was also about the size of a quarter. The surveyor called Administrative Nurse A's attention to the holes in this sheet, the presence of which Administrative Nurse A then acknowledged. On the midmorning of 8/4/22, an interview with Administrative Nurse B revealed that the facility's linen was laundered offsite by [LOCATION]. Administrative Nurse B noted there was no internal facility policy for identifying and removing from use any linens that were damaged or stained, as these actions were tasked to the [LOCATION] as part of the contract between the facility and the [LOCATION].
§ 51.110 (c) Accuracy of assessments. (1) Coordination— (i) Each assessment must be conducted or coordinated with the appropriate participation of health professionals. (ii) Each assessment must be conducted or coordinated by a registered nurse that signs and certifies the completion of the assessment. (2) Certification. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on clinical record review and staff interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for one (1) of 27 sampled residents (Resident #2) who received hemodialysis during their stay in the facility. The findings include: Review of the clinical record for Resident #2 found a quarterly MDS Assessment with an assessment reference date (ARD) of [DATE]. Item O01002J was left blank, indicating the resident had not received any hemodialysis outside of the facility in the preceding 14 days. Review of Resident #2's Physician Order revealed they received hemodialysis on an outpatient basis three (3) times per week In an interview on 8/5/22, at 10:58 a.m., Administrative Nurse C was asked to review Section O of Resident #2's MDS with the ARD of [DATE]. Upon viewing Section O of this MDS, Administrative Nurse C immediately identified that Item O01002J was not marked to indicate Resident #2 had received dialysis during the assessment reference period. Administrative Nurse C verified this was an error and stated they would submit a Correction MDS.

§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care. 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 Physician Orders were correct and/or complete for two (2) of eight (8) residents observed during medication administration (Resident #32 and Resident #33). The findings include: 1. Observation on 8/4/22, beginning at 7:38 a.m., found that Licensed Nurse A gave Resident #32 their Flutter Valve (a handheld device used as a type of breathing therapy to clear the lungs of mucus) before administering any of their medications. Licensed Nurse A encouraged them to complete 10 repetitions of their breathing exercise. After completion of these repetitions, Licensed Nurse A administered their Combivent Respimat handheld inhaler and then administered their other scheduled medications. Review of Resident #32's clinical record found a Physician Order, dated [DATE], stating: "Flutter valve, 10 reps [repetitions] via inhaler QID [four (4) times a day] following each combivent [*sic*] TX {treatment]." An interview with Administrative Nurse A and Administrative Nurse B, at 9:22 a.m., on 8/4/22, found the order for the Flutter Valve that displayed on the electronic Medication Administration Record (e-MAR) did not contain any special instruction to direct the nurse to give the Flutter Valve to Resident #32 after each Combivent Treatment. They confirmed the order required this to be done in a specific sequence. 2. Observation on 8/4/22, beginning at 7:38 a.m., found Licensed Nurse A applied Erythromycin ointment (an antibiotic) to an area on Resident #33's face below their left eye. Review of Resident #33's clinical record found a Physician Order, dated [DATE], which identified the route of administration for the Erythromycin as "ophthalmic" (to be applied to the external surface of the eyeball), not "topical" (to be applied to the skin). At 9:38 a.m., on 8/4/22, Administrative Nurse A reviewed the resident's paper record at the nursing station on [LOCATION] and identified the Erythromycin was to treat a facial lesion. Administrative Nurse A verified the facility did use the services of temporary agency nurses and that an agency nurse may not know to apply the ointment to the skin when the order identified the route as ophthalmic. Administrative Nurse A stated that they would contact the provider to obtain a clarification order for the route of administration for the Erythromycin. On 8/5/22, at approximately 8:35 a.m., Administrative Nurse B provided evidence that the order for Resident #33's Erythromycin

	had been clarified with the prescribing provider to indicate the medicated ointment was to be applied topically to the facial lesion and not to the external surface of the resident's left eye.
§ 51.120 (l) Special needs. The facility management must ensure that residents receive proper treatment and care for the following special services: (1) Injections; (2) Parenteral and enteral fluids; (3) Colostomy, ureterostomy, or ileostomy care; (4) Tracheostomy care; (5) Tracheal suctioning; (6) Respiratory care; (7) Foot care; and (8) Prostheses. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on observation, staff interview, and review of the facility's policies, the facility failed to ensure oxygen supplies were changed out weekly for one (1) of eight (8) residents observed during medication administration (Resident #36). The findings include: The facility policy titled, "OXYGEN THERAPY," revised 3/31/22, stated: "All humidifier bottles must be dated and changed as needed. … Used cannulas, masks, and tubing shall be stored in a plastic bag, labeled with the Resident's name, when not in use. … Oxygen masks and tubing are to be changed and dated by night shift licensed Staff on Sunday evening. Tubing and mask can be changed more frequently upon infection control need." Beginning at 1:53 p.m., on 8/3/22, as Licensed Nurse B was setting up Resident #36's nebulizer treatment, observation found the plastic bag used to store the tubing, mask, and nebulizer cup (when not in use) was dated [DATE]. Per the facility's policy, these items should have been changed out weekly on every Sunday by the night shift staff, with the most recent change to have occurred on [DATE]. In an interview on 8/5/22, at 8:25 a.m., Administrative Nurse B confirmed that the tubing, mask, and nebulizer cup – as well as the storage bag – should have been changed the previous Sunday ([DATE]) by the night shift staff.
§ 51.180 (d) Labeling of drugs and biologicals. Drugs and biologicals used in the facility management must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Some	Based on observation, staff interview, and review of the facility's policies, the facility failed to ensure expired medications were removed from use in two (2) of three (3) sampled medication rooms and two (2) of five (5) sampled medication carts. The findings include: The facility's policy titled, "DRUG DISTRIBUTION SYSTEM," reviewed 4/20/22, stated: "OUTDATED MEDICATION: Licenses [*sic*] staff checks expiration dates on the units daily. Pharmacy Techs check expiration dates on the Medication Carts on a monthly basis. When a particular product is outdated and removed, a replacement supply is ordered." Observations made in the company of Administrative Nurse A found the following: • At 1:42 p.m., on 8/3/22, in the [LOCATION] – a tube of Glucose 15 Gel (EXP 5/22)

	• At 2:01 p.m., on 8/3/22, in the [LOCATION] Medication Cart – a bottle of Antacid (EXP 6/22) • At 2:15 p.m., on 8/3/22, in the [LOCATION] Medication Cart – a tube of Glucose 15 Gel (EXP 5/22) • At 2:32 p.m., on 8/3/22, in the [LOCATION] – a carton of Acetaminophen 650mg rectal suppositories 50-count (EXP 4/22) Administrative Nurse A, when interviewed at 1:42 p.m., on 8/3/22, stated the nurses were responsible for checking the medication rooms for expired medications and the pharmacy staff was responsible for checking the medication carts for expired medications when the medication carts were exchanged, which occurred every 15 days.
§ 51.180 (e) (1) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on observation, staff interview, and review of the facility's policies, the facility failed to ensure a medication cart was locked when unattended for one (1) of three (3) nurses observed during medication administration. The findings include: The facility's policy titled, "MEDICATION ADMINISTRATION BEFORE AND AFTER MEDICATION PASS," reviewed 6/14/21, stated, "During the medication pass: 15. Always keep the medication cart in your sight or locked. Bring the cart to the room of the resident who is receiving medication. The cart should be left in the resident's doorway and not brought into the room." Observation during medication administration at 7:38 a.m., on 8/4/22, found that Licensed Nurse A pulled their medication cart into the doorway of Resident #34's room, but left it unlocked and out of their line of sight when they went to check Resident #34's blood glucose via a fingerstick. Upon their return to the cart, Licensed Nurse A acknowledged that they had left it unsecured during their absence.
§ 51.190 (b) Preventing spread of infection. (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident. (2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease. (3) The facility management must require staff to wash their hands after each	Based on observation, staff interview, and review of the facility's policies, the facility failed to ensure staff practiced hand hygiene in accordance with accepted professional practice for two (2) of two (2) wound care observations (Resident #3 and Resident #19). The findings include: 1. The facility policy titled, "HAND HYGIENE," revised 4/5/22, directed, "Perform hand hygiene in the following situations: After (immediately after) removing personal protective equipment (PPE) – gloves, gowns, facemask, face shield, etc. … Notes: Unless hands are visibly soiled, or suspected contact is with spores, an alcohol-based hand rub is preferred over soap

direct resident contact for which hand washing is indicated by accepted professional practice. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	and water in most clinical situations due to evidence of better compliance compared to soap and water." According to the procedure outlined in this policy, after hand washing was performed, staff were to "Turn off water taps with paper towel and discard." Observation of a treatment to Resident #3's right heel was observed beginning at 8:29 a.m., on 8/3/22. The treatment was performed by Licensed Nurse C with the assistance of Licensed Nurse D. Over the course of the treatment, Licensed Nurse C washed their hands with soap and water between glove changes on four (4) separate occasions. After each of these occasions, Licensed Nurse C dried their hands with a paper towel, discarded the paper towel, and used their bare hand to turn off the water taps. At 8:55 a.m., on 8/3/22, after the treatment was completed, the above observations were shared with Licensed Nurse C and Administrative Nurse A, and Administrative Nurse A was asked to provide a copy of the facility's policy and procedure on hand washing. 2. Review of the facility policy for "Simple Dressing Changes," dated 9/23/11, and revised 3/3/22, revealed the "Procedure" included to: "6. Wash hands, apply gloves… 11. Remove soiled dressing, place it in small biohazard bag. 12. Remove gloves, wash hands, apply new gloves… 14. Clean wound with normal saline or prescribed cleanser. Follow procedure for wound cleansing/irrigating… 16. Remove gloves, wash hands, apply new gloves… 21. Apply wound dressing." Resident #19 was admitted into the facility in [DATE] and readmitted in [DATE]. The resident's diagnoses included infection of right ankle and foot in infectious and parasitic diseases classified elsewhere, Staphylococcal arthritis, multiple sclerosis, and quadriplegia. Review of the Physician Order dated [DATE] for Resident #19's deep tissue injury (DTI) to their right lateral foot deep tissue injury revealed special instructions: "Liquid barrier to right lateral foot every shift and cover with ABD pad." Observation of right lateral foot/heel DTI care on 8/3/22, at 7:30 a.m., for Resident #19 by Licensed Nurse C revealed the nurse failed to wash their hands after removing the old dressing and cleansing the DTI with saline, and before applying clean gloves

	and applying the skin protectant and ABD pad and wrapping with gauze. An interview with Administrative Nurse B on 8/3/22, at 8:10 a.m., revealed that Licensed Nurse C should have washed their hands after removing the old dressing, the old gloves, and before donning a new pair of gloves and the clean dressing. Administrative Nurse B provided the facility policies for "Simple Dressing Changes," and "Wound Care." An interview with Licensed Nurse C and Administrative Nurse A on 8/4/22, at 9:00 a.m., revealed that Licensed Nurse C recalled that they did not wash or sanitize their hands between removing the old dressing and cleansing the wound and applying the clean dressing to Resident #19.
51.200(a) Physical environment The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Some	**Means of Egress** Based on observation and interview, the facility failed to maintain the path of egress in accordance with the code. The deficient practice affected eight (8) of 26 smoke compartments, staff, and 64 residents. The facility had a capacity for 236 beds with a census of 140 on the day of the survey. The findings include: 1. Observation during the building inspection tour on 8/3/22, at 1:02 p.m., revealed the path of egress leading out from the stairwell from [LOCATION] had a split in the sidewalk and lead in two (2) directions; one (1) lead to another stairwell and one (1) lead to the public way. There was no sign directing occupants to the public way, as required by section 7.10.2.1 of NFPA 101, Life Safety Code. An interview at that time with Maintenance Staff A and Maintenance Staff B revealed that the facility was not aware of the requirement for directional signs where the path of egress was not obvious. 2. Observation during the building inspection tour on 8/3/22, at 1:03 p.m., of the path of egress leading around the back side of the building had projections (tree limbs) coming down from overhead reducing the headroom to less than 6 feet 8 inches, as prohibited by section 7.1.5 of NFPA 101, Life Safety Code. An interview at that time with Maintenance Staff B revealed that the facility was not aware the limbs from the trees had grown down so much as to reduce the headroom in the path of egress. The census of 140 was verified by Administrative Staff C on 8/2/22. The findings were acknowledged by Administrative Staff C and verified by Maintenance Staff A and Maintenance Staff B during the exit interview on 8/3/22.

	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. 19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4. 19.2.10.2 Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons. 19.2.10.3 Where the path of egress travel is obvious, signs shall not be required at gates in outside secured areas. 19.2.10.4 Access to exits within rooms or sleeping suites shall not be required to be marked where staff is responsible for relocating or evacuating occupants. 7.1.5* Headroom. 7.1.5.1 Means of egress shall be designed and maintained to provide headroom in accordance with other sections of this Code, and such headroom shall be not less than 7 ft 6 in. (2285 mm), with projections from the ceiling not less than 6 ft 8 in. (2030 mm) with a tolerance of −3⁄4 in. (−19 mm), above the finished floor, unless otherwise specified by any of the following: (1) In existing buildings, the ceiling height shall be not less than 7 ft (2135 mm) from the floor, with projections from the ceiling not less than 6 ft 8 in. (2030 mm) nominal above the floor. (2) Headroom in industrial equipment access areas as provided in 40.2.5.2 shall be permitted. 7.10.2 Directional Signs. 7.10.2.1* A sign complying with 7.10.3, with a directional indicator showing the direction of travel, shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. 7.10.2.2 Directional exit signs shall be provided within horizontal components of the egress path within exit enclosures as required by 7.10.1.2.2. **Smoke Barriers and Sprinklers** Based on observation and interview, the facility failed to properly install and maintain equipment protected by the kitchen hood extinguishing system. The deficient practice affected one (1) of 26 smoke compartments, staff, and zero (0) residents. The facility had the capacity for 236 beds with a census of 140 on the day of survey. The findings include:

	Observation during the building inspection tour on 8/3/22, at 12:31 p.m., revealed the wheeled, gas-fired, stove and the wheeled, gas-fired, deep fryer located on the cooking line in the kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning, as required by section 12.1.2.3 and 12.1.2.3.1 of NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. An interview at that time with Maintenance Staff B revealed that blue wheel chucks were in place at one point for the express purpose of returning the appliances to their designed location. but Maintenance Staff B was not sure why they had been removed. The census of 140 was verified by Administrative Staff C on 8/2/22. The finding was acknowledged by Administrative Staff C and verified by Maintenance Staff A and Maintenance Staff B during the exit interview on 8/3/22. **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 Protection of Commercial Cooking Operations (2011) 12.1.2 Installation. 12.1.2.1 All listed appliances shall be installed in accordance with the terms of their listings and the manufacturer's instructions. 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing

	agent, unless otherwise allowed by the design of the fire extinguishing system. 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. **Building Services (Elevators, Escalators, Laundry Chutes, etc.)** 1. Based on observation and interview, the facility failed to properly install and maintain gas equipment and appliances. The deficient practice affected one (1) of 26 smoke compartments, staff, and zero (0) residents. The facility had the capacity for 236 beds with a census of 140 on the day of survey. The findings include: Observation during the building inspection tour on 8/3/22, at 12:32 p.m., revealed that the gas-fired stove and deep-fat fryer with caster-style wheels located on the cooking line in the kitchen were provided with a restraint system to limit the movement of the appliances to prevent strain on the connection, but the restraints were not connected, as required by sections 9.6.1.2 and 10.12.6 of NFPA 54, National Fuel Gas Code. An interview with the with Maintenance Staff B at that time revealed that the facility was not aware the restraints were not being used. The census of 140 was verified by Administrative Staff C on 8/2/22. The finding was acknowledged by Administrative Staff C and verified by Maintenance Staff A and Maintenance Staff B during the exit interview on 8/3/22. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012) 19.5.1 Utilities.** 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1 Utilities. 9.1.1 Gas. Equipment using gas and related gas piping shall be in accordance with NFPA 54, National Fuel Gas Code, or NFPA 58, Liquefied Petroleum Gas Code, unless such installations are approved existing installations, which shall be permitted to be continued in service.

	Actual NFPA Standard: NFPA 54, National Fuel Gas Code (2012) 9.6 Appliance and Equipment Connections to Building Piping. 9.6.1.1 Commercial Cooking Appliances. Commercial cooking appliances that are moved for cleaning and sanitation purposes shall be connected in accordance with the connector manufacturer's installation instructions using a listed appliance connector complying with ANSI Z21.69/CSA 6.16, Connectors for Movable Gas Appliances. The commercial cooking appliance connector installation shall be configured in accordance with the manufacturer's installation instructions. 9.6.1.2 Restraint. Movement of appliances with casters shall be limited by a restraining device installed in accordance with the connector and appliance manufacturer's installation instructions. 10.12 Food Service Appliance, Floor-Mounted. 10.12.6 Use with Casters. Floor-mounted appliances with casters shall be listed for such construction and shall be installed in accordance with the manufacturer's installation instructions for limiting the movement of the appliance to prevent strain on the connection. 2. Based on records review and interview, the facility failed to properly maintain the elevators. The deficient practice affected five (5) of 26 smoke compartments, staff, and zero (0) residents. The facility had the capacity for 236 beds with a census of 140 on the day of survey. The findings include: Records review on 8/3/22, at 2:37 p.m., revealed the last recorded test of the fire fighters' emergency operations for elevators was on 12/8/21. An interview with the with Maintenance Staff B at that time revealed that the facility was not aware the elevators' fire fighters' emergency operations were to be tested monthly, as required by sections 9.4.3.2 and 9.4.6.2 of NFPA 101, Life Safety Code. The census of 140 was verified by Administrative Staff C on 8/2/22. The finding was acknowledged by Administrative Staff C and verified by Maintenance Staff A and Maintenance Staff B during the exit interview on 8/3/22. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** 19.5.3 Elevators, Escalators, and Conveyors. Elevators, escalators, and conveyors shall comply with the provisions of Section 9.4. 9.4.3 Fire Fighters' Emergency Operations.

	9.4.3.1 All new elevators shall conform to the fire fighters' emergency operations requirements of ASMEA17.1/CSA B44, Safety Code for Elevators and Escalators. 9.4.3.2 All existing elevators having a travel distance of 25 ft (7620 mm) or more above or below the level that best serves the needs of emergency personnel for fire-fighting or rescue purposes shall conform to the fire fighters' emergency operations requirements of ASMEA17.3, Safety Code for Existing Elevators and Escalators. 9.4.6 Elevator Testing. 9.4.6.1 Elevators shall be subject to periodic inspections and tests as specified in ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. 9.4.6.2 All elevators equipped with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASMEA17.1/CSA B44, Safety Code for Elevators and Escalators. 9.4.6.3 The elevator inspections and tests required by 9.4.6.1 shall be performed at frequencies complying with one of the following: (1) Inspection and test frequencies specified in Appendix N of ASME A17.1/CSA B44, Safety Code for Elevators and Escalators (2) Inspection and test frequencies specified by the authority having jurisdiction **Electrical Systems** Based on observation and interview, the facility failed to post the required signs at oxygen transfilling rooms. The deficient practice affected one (1) of 26 smoke compartments, staff, and seven (7) residents. The facility had a capacity for 236 beds with a census of 140 on the day of the survey. The findings include: Observation during the building inspection tour on 8/3/22, at 11:00 a.m., of the oxygen storage and transfilling room on the third (3rd) floor revealed there was no sign outside the room indicating transfilling was occurring within, as required by section 11.5.2.3.1 (3) of NFPA 99, Health Care Facilities Code. An interview at that time with Maintenance Staff A and Maintenance Staff B revealed that the facility was not aware the sign was missing, as it was posted at the transfilling rooms on the second (2nd) and fourth (4th) floors. The census of 140 was verified by Administrative Staff C on 8/2/22. The finding was acknowledged by Administrative Staff C and verified by Maintenance Staff A and Maintenance Staff B during the exit interview on 8/3/22.

	Actual NFPA Standard: NFPA 99 Health Care Facilities Code (2012) 11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable. 11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures.
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.	Based on record review and interview, the facility's management failed to obtain a written sharing agreement that governed mental health services provided to 19 residents by the Veterans Administration Medical Center (VAMC). The findings include: Review of documents provided by the facility revealed there was no written sharing agreement with the Veterans Administration to provide mental health services for the residents. In an interview on 8/4/22, at 11:05 a.m., Administrative Staff C confirmed that the facility had not completed the approval process for a sharing agreement with the VAMC to cover the residents who received mental health services.

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