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: Illinois Veterans Home – Quincy

Location: 1707 North 12th St., Quincy, IL 62301

Onsite / Virtual: Onsite

Dates of Survey: 5/6/24 – 5/9/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 386

Census on First Day of Survey: 250

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from May 6, 2024, through May 9, 2024, at the Illinois Veterans Home – Quincy. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.41 (c) (2) Payments under State home care agreements. (2) The State home shall not charge any individual, insurer, or entity (other than VA) for the nursing home care paid for by VA under a State home care agreement. Also, as a condition of receiving payments under paragraph (c), the State home must agree not to accept drugs and medicines from VA provided under 38 U.S.C. 1712(d) on behalf of veterans covered by this section and corresponding VA regulations (payment under this paragraph (c) includes payment for drugs and medicines). **Level of Harm** – No Actual Harm, with potential for minimal harm	The facility was unable to demonstrate that no individual, insurer, or entity (other than VA) was charged for the nursing home care paid for by VA under a VA provider agreement. The findings include: Based on communications and record reviews, it was identified that the facility utilizes third-party providers for dental, mental health, radiology, and foot care services. Upon review of the written agreements between the facility and the third-party providers for each of the services, it was identified that the agreements did not specify that costs for services for Veterans for whom the facility receives the prevailing rate of VA Per Diem (Prevailing Rate Veterans) for nursing home care must be billed to the facility. Instead, each of the written agreements directed the third-party provider to invoice all residents' Medicare, Medicaid and/or private insurance for services provided. Further review identified that the facility does not currently have any responsibility towards payment of dental services for any residents. The written agreements for mental health, radiology,

Residents Affected – Many	and foot care stipulate that all residents' insurance is billed first, with the facility only paying if there is a copay or other remaining balance. The facility leadership could not provide evidence to demonstrate that the facility had paid the costs for Prevailing Rate Veterans in receipt of the services identified above.
§ 51.70 (c) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	Based on record review, interviews, and review of the facility policy, the facility management failed to ensure two (2) of five (5) residents trust fund accounts reviewed were conveyed within 90 calendar days of the resident's death (Resident #25 and Resident #26). The findings include: Review of the facility's undated policy titled, "Resident Trust Fund Policy Notification and Authorization," revealed: "Upon the death of a resident, the Home shall provide the executor or administrator of the resident's estate with a complete accounting of all of the funds in a resident's trust account. Within 30 days of a resident's death, the IVH must convey the resident's funds and a final accounting of those funds to, in order of precedence: the executor or administrator of the estate; the attorney for the estate; or in the absence of a will or trust, the IVH may accept a small estate affidavit and disburse the deceased resident's trust accounts funds to the small estate affiant." Review of Resident #25's Electronic Health Record (EHR) revealed the resident expired on [DATE]. Resident #25's Trust Fund Statement revealed an ending balance of $166.80. Review of Resident #26's EHR revealed the resident expired on [DATE]. Resident #26's Trust Fund Statement revealed an ending balance of $157.37. An interview was conducted with Administrative Staff A on 5/8/24, at 10:03am. They revealed that the resident's trust fund accounts were not conveyed within 90 calendar days because the facility management did not have a will or trust for either resident. Administrative Staff A revealed it was the facility's expectation to convey funds at least 30 days after a resident expires.
§ 51.80 (b) (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, facility management must provide to the resident and a family member or legal	Based on staff interview, record review, and facility policy review, the facility failed to ensure each resident and a family member or legal representative received a written notice of the facility's bed-hold policy at the time of hospitalization for three (3) of four (4) residents whose closed records were reviewed (Resident #24, Resident #28, and Resident #30).

representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	The findings include: The facility policy titled, "Bed Hold Policy Notification," not dated, stated: "It is the policy of the Illinois Department of Veterans' Affairs to hold a member's bed for them when the members leaves the facility for any of the following reasons: …2. An authorized medical leave of absence for any length of time…The member's belongings and bed will be maintained during their absence. The member is still responsible for all monthly maintenance charges, Aid and Attendance charges (if applicable), and cable TV charges." Review of Resident #24's medical record revealed the resident was readmitted to the facility on [DATE], and diagnoses included Congestive Heart Failure, Urinary Tract Infection, and Exacerbation of Chronic Obstructive Pulmonary Disease. Review of a Health Status Note, dated [DATE], at 4:15 p.m., revealed Resident #24 was transferred to the hospital via ambulance for Hypoxia. A subsequent Health Status Note, dated [DATE], at 6:10 p.m., stated Resident #24 was being released to return to the facility. There was nothing in the resident's electronic medical record to state the resident or their family member or legal representative was notified of the facility's Bed Hold Policy at the time of the resident's transfer to the hospital, or anytime thereafter. Review of Resident #28's medical record revealed the resident was admitted to the facility on [DATE], and diagnoses included Atrial Fibrillation, Gastrointestinal Hemorrhage, Atherosclerotic Heart Disease, and Benign Prostatic Hyperplasia. Review of a Health Status Note, dated [DATE], at 7:00 p.m., noted the resident was started on an antibiotic twice daily for seven (7) days for a Urinary Tract Infection. Review of a Physician's Progress Note, dated [DATE], at 10:43 a.m., revealed that Nursing voiced concern to the Provider that the resident was weaker, speech more difficult to understand, had worsening edema with weight gain, and little urinary output on the preceding night shift. The Provider contacted the resident's legal representative, and it was agreed that the resident would be transported to the Emergency Room via security and a stretcher for evaluation. There was nothing in the resident's electronic medical record to state the resident or their family member or legal representative was notified of the facility's Bed Hold Policy at the time of the resident's transfer to the hospital, or anytime thereafter. Review of Resident #30's medical record revealed the resident was readmitted to the facility on [DATE], and diagnoses include Unspecified Dementia and Personal History of Traumatic Brain Injury. According to a Progress Note, dated [DATE], at 6:45 p.m., Resident #30 fell while in the [LOCATION], hitting their

	head. The resident was found to be unresponsive with no respiration or palpable pulse. Cardiopulmonary resuscitation was initiated with success, and the resident was transported to the hospital via ambulance. There was nothing in the resident's electronic medical record to state the resident or their family member or legal representative was notified of the facility's Bed Hold Policy at the time of the resident's transfer to the hospital or anytime thereafter. When asked for documentation that residents were provided a written copy of the facility's Bed Hold Notice upon transfer to the hospital, at approximately 11:00 a.m., on 5/9/24, Administrative Staff A provided a copy of the "Home Resident Contract Between Resident and Facility," which was signed at the time of admission. Administrative Staff A reported that, because the facility always held a resident's bed when a resident transferred to the hospital, the facility did not provide a written notice of the bed hold policy. Administrative Staff A also reported that nursing staff provided verbal notification to the resident/legal representative at the time of transfer that the resident's bed would be held for them, and that this verbal notification was recorded in the resident's Progress Notes. As of the time of the survey exit, at 9:15 a.m., on 5/10/24, the facility was unable to provide evidence that the resident or a family member or legal representative was provided a written notice at the time of transfer, informing them that the bed would be held and/or that the resident would be responsible for any applicable charges during their absence.
§ 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 observation, interview, record review, and facility policy review, the facility failed to accurately code a resident's tobacco use on the Minimum Data Set (MDS) for one (1) of 22 sampled residents (Resident #8). The findings include: An observation during the initial tour, on 5/6/24, at 11:30 a.m., revealed Resident #8 wore weather appropriate clothing. The resident utilized a motorized wheelchair and had a contracture of the left hand. Continued observation revealed the resident had a pack of cigarettes located in their shirt pocket. An interview was conducted during the initial tour with Licensed Nurse A, on 5/6/24, at 11:40 a.m., and revealed Resident #8 was assessed to be a safe smoker; therefore, the resident was allowed to smoke freely without supervision. During an observation, on 5/7/24, at 1:10 p.m., Resident #8 was observed in the [LOCATION] with a lit cigarette and smoked without any safety concerns. After completion of smoking, the

	resident extinguished the cigarette butt into the designated receptacle. Review of the facility's "Resident Assessment Instrument/Minimum Data Set" policy, reviewed/revised 9/2020, revealed: "The Resident Assessment Instrument (RAI) assists staff to consistently and accurately gather information regarding resident needs/strengths, preferences, and assess change in condition utilizing a standardized assessment tool (MDS 3.0) which provides the foundations for an individualized plan of care for each resident." Review of the Resident #8's clinical record revealed, on [DATE], the facility admitted the resident with diagnoses of Cerebral Infarction, Hemiplegia left non-dominant side, and Multiple Contractures. Review Resident #8's Annual MDS, with an Assessment Reference Date (ARD) of [DATE], revealed the facility assessed the resident to be cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. Continued review of the MDS revealed the facility assessed the resident to not use tobacco. Review of Annual MDS, with an ARD date of [DATE], revealed the facility assessed the resident to have intact cognition. Further review of the MDS found it assessed Resident #8 to not use tobacco. An interview, on 5/8/24, at 10:45 a.m., with Licensed Nurse B revealed they were aware of Resident #8's tobacco use. They revealed the purpose of having an accurate MDS assessment was to ensure the resident's care needs were individualized. Licensed Nurse B revealed the failure to capture Resident #8's tobacco use on the MDS was an oversight. The lack of capturing Resident #8's smoking on the MDS lead the facility to not develop a Care Plan for smoking.
§ 51.110 (e) (1) Comprehensive care plans. (1) The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following— (i) The services that are to be furnished to attain or maintain the resident's	Based on observation, interview, and review of facility policies, the facility failed to develop a comprehensive, person-centered Care Plan to include measurable objectives and timeframes to meet the resident's care needs for tobacco use for one (1) of 22 sampled residents whose Care Plans were reviewed (Resident #8). The findings include: Review of the facility's "Care Plan (Baseline/Comprehensive) – Care Plan Meeting" Policy No 3.5-C, with a revised/reviewed date of 9/2023, revealed the facility will utilize the Resident Assessment Instrument (RAI) to develop a Comprehensive

highest practicable physical, mental, and psychosocial well-being as required under §51.120; and (ii) Any services that would otherwise be required under §51.120 of this part but are not provided due to the resident's exercise of rights under §51.70, including the right to refuse treatment under §51.70(b)(4) of this part. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Care Plan. The facility used various sources to obtain needed information for the RAI sources which included, but were not limited to: 1. Identified resident's problems. 2. Identified resident's unique characteristics, strengths, weaknesses, needs and preferences. It further stated: "Readmissions and unit to unit transfers will require updating of the Comprehensive Care Plan in the EHR [Electronic Health Record] as indicated to guide appropriate resident centered care." Observation during the initial tour, on 5/6/24, at 11:30 a.m., revealed Resident #8 wore weather appropriate clothing. The resident utilized a motorized wheelchair and had a contracture to their left hand. Continued observation revealed the resident had a pack of cigarettes located in their shirt pocket. An observation, on 5/7/24, at 1:10 p.m., revealed Resident #8 in a [LOCATION], with a lit cigarette, and they smoked without any safety concerns. After completion of smoking, the resident extinguished the cigarette butt into the designated receptacle. Review of Resident #8's clinical record revealed, on [DATE], the facility admitted the resident with diagnosis of Cerebral Infarction, Hemiplegia left non-dominant side, and Multiple Contractures. Review of Resident #8's comprehensive Care Plan, with a review date of [DATE], revealed no Care Plan for tobacco use was developed. An interview, on 5/8/24, at 10:45 a.m., with Licensed Nurse B revealed they were aware of Resident #8's tobacco use. They were revealed the purpose of developing a Care Plan was to guide a resident's care needs. Licensed Nurse B stated the lack of capturing Resident #8's smoking on the MDS lead the facility to not develop a person-centered Care Plan for smoking.
§ 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, interview, and policy review, the facility failed to remove from use and discard medications and treatment supplies kept past their expiration dates. There were expired items in four (4) of eight (8) medication carts and in two (2) of three (3) [LOCATIONS] reviewed. The findings include: The facility policy titled, "PHARMACY POLICY AND PROCEDURES STORAGE OF MEDICATIONS AT THE NURSING UNITS," revised August, 2003, found: "PROCEDURE…6. Expired or discontinued medications shall be returned to the Pharmacy Department in a timely manner in accordance with policies and procedures in effect. The

	Emergency Medication Box and stock medications shall also be monitored in a similar manner on a routine basis." During a tour of the [LOCATION] on the [LOCATION], at 9:25 a.m., on 5/6/24, observation found 19 Male End IV (Intravenous) Caps, which were kept past their expiration date of 4/1/24, and were available for patient use. These findings were verified with Administrative Nurse A at 9:40 a.m., on 5/6/24. During a tour of the [LOCATION], at 7:30 a.m., on 5/9/24, observation found one (1) opened, almost full, 100-count box of 30-gauge x 1/3-inch Novofine disposable safety needles that had expired on 9/23/23, and were available for patient use. These findings were verified with Administrative Nurse B at 7:40 a.m., on 5/9/24. During an observation of medication carts on the [LOCATION], on 5/9/24, the following items were found expired and available for use: • At 7:32 a.m., on 5/9/24, an observation of Medication Cart B #2 found five (5) vials of sterile 0.9% saline with expiry dates of "FEB 24." This observation was verified by Administrative Nurse B at 7:38 a.m., on 5/9/24. • At 7:50 a.m., on 5/9/24, an observation of Medication Cart A #2 found 19 individually packaged Bisacodyl rectal suppositories with expiry dates of "05/22," and one (1) 30-ounce bottle of Nutricia Pro-Stat Concentrated Liquid Protein Medical Food with an expiry date of "21/MAR/2024." This observation was verified by Administrative Nurse B at 7:56 a.m., on 5/9/24. • At 7:58 a.m., on 5/9/24, an observation of Medication Cart D #2 found the following: three (3) packages of Transparent Film Dressing with expiry dates of "2022-11-30;" two (2) packages of Xeroform Occlusive Gauze with expiry dates of "2023-04-30;" and one (1) VanishPoint 3 milliliter syringe with an expiry date of "2024-01." These observations were verified by Administrative Nurse B at 8:10 a.m., on 5/9/24. • At 8:12 a.m., on 5/9/24, an observation of Medication Cart D #1 found the following: one (1) bottle of CoaguChek test strips with an expiry date of "2023-07-31;" and eight (8) vials of sterile 0.9% saline with expiry dates of "23-07." These observations were verified by Administrative Nurse B at 8:22 a.m., on 5/9/24. When interviewed at 3:12 p.m., on 5/9/24, Administrative Nurse C stated their expectations were that [LOCATIONS] and carts

	were to be checked weekly on night shift for expired items; expired medications were to be placed in a box and returned to the pharmacy; and expired supplies were to be discarded.
§ 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 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	Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff performed hand hygiene and glove changes in a manner to prevent the spread of infection, and failed to ensure bandage scissors were sanitized before and after use for one (1) of three (3) residents observed who received treatments (Resident #3). The findings include: Review of the facility policy titled, "Hand Hygiene," with a revision date of 3/19/24, stated: "PROCEDURE: I. Who, what, when, where how – Staff members should perform hand hygiene for the clinical indications list below…A. When to perform hand hygiene: 1. Immediately before touching a patient; 2. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; 3. Before moving from work on a soiled body site to a clean body site on the same patient; 4. After touching a patient or the patient's immediate environment; 5. After contact with blood, body fluids, or contaminated surfaces; 6. Immediately after glove removal; 7. Before eating and after using toilet." Record review revealed Resident #3 was admitted to the facility on [DATE], and diagnoses included Peripheral Vascular Disease and Lymphedema. Resident #3's Quarterly Minimum Data Set (MDS) Assessment, dated [DATE], contained a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS also identified Resident #3 had a total of three (3) venous/arterial ulcers present. Resident #3's Provider Orders contained the following treatment orders: "RIGHT LATERAL AND MEDIAL LEG VENOUS WOUNDS: Cleanse with save-cleanse do not scrub, blot dry, Calmoseptine to peri wound areas, do not wipe old off, cut Aquacel cal alg [calcium alginate] to fit wound bed, [three] 3 non adhesive aquacell 4x4 to laterial wound, [three] 3 ABD pad around leg, and Kerlix. Double layer of tubagrip. every day shift for venous wound" [sic] (dated [DATE]).

	"LEFT HEEL: Cleanse with save-cleanse do not scrub, blot dry, Calmoseptine to peri wound areas, do not wipe old off, cut Aquacel cal alg to fit wound bed, Aquacel heel dressing with Double layer of tubagrip. one time a day for venous wound" [sic] (dated [DATE]). During an observation of wound care for Resident #3 that began at 10:28 a.m., on 5/7/24, Licensed Nurse C entered the room carrying a clipboard with a storage compartment and two (2) cloth underpads ("chux"). Resident #3 was seated in a recliner at bedside with both legs elevated on the recliner's footrest. Licensed Nurse C placed one (1) chux on the top of Resident #3's bed, to create a clean field, and one (1) chux on the footrest under the resident's legs. Licensed Nurse C obtained wound care supplies from the resident's wardrobe cabinet, as well as several gloves from the glove dispenser by the door, and placed the items on the clean field. Licensed Nurse C also removed dressing supplies from the clipboard's storage compartment and placed those items on the clean field. After setting up the supplies on the clean field, and without first performing any hand hygiene, at 10:30 a.m., Licensed Nurse C donned a pair of gloves, opened a package of 4x4 gauze, removed the gauze from the package, and used the dry gauze to wipe dried drainage from the lateral wound on the resident's right lower extremity. After wiping the wound, and without changing gloves, Licensed Nurse C discarded the used gauze, opened a second package of 4x4 gauze, and held it open in one (1) gloved hand. Licensed Nurse C then obtained a spray can of Sterile Saline Wound Cleanser from the clean field with the other gloved hand, sprayed saline into the open package of gauze, and returned the spray can of saline to the clean field. Licensed Nurse C removed the moistened 4x4 gauze from the open package wearing a contaminated glove, cleansed the lateral wound on the resident's right lower extremity, and discarded the used gauze. Without changing gloves, Licensed Nurse C obtained another 4x4 gauze and patted the wound dry. Licensed Nurse C used the ruler printed on the edge of the gauze package to measure the dimensions of the lateral wound. Licensed Nurse C then removed gloves, retrieved a small bottle of hand sanitizer from their pocket, sanitized their hands, and placed the bottle of sanitizer on the clean field. Licensed Nurse C donned a new pair of gloves, examined the medial wound on the resident's right lower extremity, and used the ruler on the package from another 4x4 gauze to measure

	the dimensions of the medial wound. Licensed Nurse C then removed and discarded the gloves and donned another pair of gloves without performing hand hygiene. Licensed Nurse C retrieved a pair of bandage scissors from a pocket on their uniform top, picked up a length of Suprasorb dressing material from the clean field, trimmed the Suprasorb to a size to cover the lateral wound, and returned the cut piece of Suprasorb to the clean field. Licensed Nurse C opened additional supplies in preparation for dressing both wounds on the right lower extremity and placed them and the used bandage scissors on the clean field. Licensed Nurse C applied the trimmed piece of Suprasorb to the wound bed of the lateral wound, placed the foam cover dressings over both the lateral and medial wounds, applied ABD [Army Battle Dressing] pads over the foam dressings, and wrapped the right lower extremity with a roll of Kerlix. Licensed Nurse C cut the Kerlix, discarded the unused portion of the roll, and applied tape to secure the Kerlix. Licensed Nurse C then applied Tubigrip over the Kerlix on the right lower extremity. At 10:40 a.m., on 5/7/24, Licensed Nurse C removed and discarded their gloves, used hand sanitizer, and applied a new pair of gloves. Licensed Nurse C opened another package of 4x4 gauze, picked up the spray can of normal saline that had been handled while wearing contaminated gloves, sprayed the normal saline into the open package to moisten the gauze, and returned the spray can of normal saline to the clean field. Without changing gloves after handling the spray can, Licensed Nurse C removed the moistened gauze from the open package and cleansed the wound on the left heel. Licensed Nurse C discarded the used gauze, opened another package of 4x4 gauze, patted the wound dry, and used the package to measure the dimensions of the left heel wound. Licensed Nurse C discarded the package, removed and discarded their gloves, sanitized hands, and donned new gloves. Licensed Nurse C retrieved the previously used scissors from the clean field and, without sanitizing the scissors, trimmed another piece of Suprasorb for use on the left heel wound. Licensed Nurse C opened the package to a cover dressing for the heel, applied the Suprasorb to the wound, and applied the cover dressing to the heel. Licensed Nurse C applied Tubigrip to the left lower leg and doffed their gloves. Licensed Nurse C then discarded trash, placed the used scissors in their uniform pocket, collected supplies and both chux in their ungloved hands, and placed the unused supplies

	back in the resident's wardrobe cabinet. Licensed Nurse C carried the two (2) chux out of the resident's room, down hall, and placed them in a linen hamper in another room. When interviewed at 10:55 a.m., on 5/7/24, Licensed Nurse C reported having performed hand hygiene prior to entering the resident's room, but not immediately after touching surfaces in the environment (e.g., storage clipboard, items in wardrobe, etc.), and before donning gloves to cleanse the lateral wound on the right lower extremity. Licensed Nurse C acknowledged it was not their practice to wipe down the outside of the spray can of normal saline before storing it in the wardrobe for the next dressing change. Therefore, the spray can was not clean before it was placed on the clean field, and the exterior of the can was further contaminated when handled by contaminated gloves. Licensed Nurse C acknowledged they did not perform hand hygiene after each glove change during the dressing changes. Licensed Nurse C acknowledged they did not clean the bandage scissors before or after each use. During an interview at approximately 2:00 p.m., on 5/7/24, Administrative Nurse C agreed that the bandage scissors should have been sanitized before and after each use; hand hygiene should have been performed prior to donning gloves and after removing gloves; and Licensed Nurse C should not have handled the spray can of saline with contaminated gloves, or handled the gauze after it was moistened with the saline with the same gloves that handled the spray can.
§ 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** – Few	**<u>Smoke Barriers and Sprinklers</u>** 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 nine (9) smoke compartments in [LOCATION], staff, and no residents. The facility had a capacity for 386 beds with a census of 250 on the day of the survey. The findings include: Observation during the building inspection tour, on 5/9/24, at 5:51 p.m., revealed the wheeled, gas-fired four (4) burner range, the griddle, and the deep fat fryer located on the cooking line in the [LOCATION] 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, on 5/9/24, at 5:51 p.m., with Maintenance Staff A

	revealed that the facility was not aware an approved method should be provided to ensure that the appliances were returned to an approved design location after maintenance or cleaning. The census of 250 was verified by Administrative Staff B on 5/9/23, at 8:40 a.m. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff A during the exit interview on 5/10/23, at 9:14 a.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 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.
§ 51.200 (b) Emergency power. (1) An emergency electrical power system must be provided to supply power adequate for illumination of all	Based on observation and interview, the facility failed to maintain the emergency battery powered lighting in the [LOCATION]. The deficient practice affected one (1) of three (3)

exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination. (2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. (3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Health Care Facilities Code. (4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	smoke compartments in [LOCATION], staff, and 43 residents. The facility had a capacity for 386 beds with a census of 250 on the day of the survey. The findings include: Observation during the building inspection tour, on 5/9/24, at 4:05 p.m., revealed the battery powered emergency lighting unit located in the [LOCATION] for the [LOCATION] was not functional when the test button was pushed to simulate a power disruption to the unit. The facility failed to maintain the battery powered emergency lighting unit required to be installed in the [LOCATION] in accordance with section 7.3.1 of NFPA 110, Standard for Emergency and Standby Power Systems. An interview, on 5/9/24, at 4:05 p.m., with Maintenance Staff A revealed the facility was not aware the battery powered emergency lighting unit was not functional, and the preventative maintenance procedures were in place to have the battery powered emergency lighting unit tested on a monthly basis for 30-seconds and on an annual basis for 90-minutes. The census of 250 was verified by Administrative Staff B on 5/9/23, at 8:40 a.m. The findings were acknowledged by Administrative Staff B and verified by Maintenance Staff A during the exit interview on 5/10/23, at 9:14 a.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.5 Building Services.** **19.5.1 Utilities.** **19.5.1.1** Utilities shall comply with the provisions of Section 9.1. **9.1.3 Emergency Generators and Standby Power Systems.** Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. **9.1.3.1** Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. **Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems (2010)** **7.3 Lighting.** **7.3.1** The Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. **7.3.2** The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.

	7.3.3 * The intensity of illumination in the separate building or room housing the EPS equipment for Level 1 shall be 32.3 lux (3.0 ft-candles), unless otherwise specified by a requirement recognized by the authority having jurisdiction.
§ 51.210 (h) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section. (2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. (3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed services and will notify the veteran or the authorized representative of the veteran. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on interview and record review, the facility's management failed to obtain a provider for routine and emergency dental services to meet the needs of all residents. The findings include: During review of the facility's professional contracts, it was determined the facility did not have a contractual agreement with a dental provider. Further review revealed the facility staff provided a list of dental providers in the area for residents to choose from. On 5/8/24 at 11:30 a.m., Administrative Staff A confirmed the facility did not have a dental provider agreement. However, the facility did provide the residents with transportation to several local dentist providers in the area. Administrative Staff A further revealed that to their knowledge, the facility had always done it that way and did not have a contract or written agreement with any dentist.