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: Michigan Veterans Homes at Chesterfield Township

Location: 47901 Sugarbush Road, Chesterfield Township, MI 48047

Onsite / Virtual: Onsite

Dates of Survey: 7/18/23 – 7/21/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 128

Census on First Day of Survey: 103

Surveyed By: Susan Dannels, RN LNC; Jacquelyn Muir, RD; Gwendolyn DuBose, MPA; Allen Beebe (LSC); Louis Smith (LSC); Cicely Robinson, VACO

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from 7/18/23 through 7/21/23 at the Michigan Veterans Homes at Chesterfield Township. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.120 (d) Pressure sores. Based on the comprehensive assessment of a resident, the facility management must ensure that— (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. **Rating** – Not Met	Based on observation, interview, and record review, the facility failed to complete the pressure ulcer (PU) treatment as ordered and failed to use appropriate infection control technique for one (1) of five (5) residents reviewed for PUs (Resident #9). The findings include: Review of Resident #9's clinical record listed the admission date of 10/25/22, and the diagnoses included: Alzheimer's Disease, Thrombocytopenia, Acute Kidney Failure, Encephalopathy, and Muscle Wasting and Atrophy. Review of Resident #9's Quarterly Minimum Data Set (MDS) Assessment, dated 5/1/23, documented the Brief Interview for Mental Status (BIMS) score of one (1), which indicated severe cognitive impairment. Resident #9 required extensive assistance of two (2) people with bed mobility, transfers,

Scope and Severity - D **Residents Affected** – Few	dressing, toileting, and personal hygiene, did not ambulate and required extensive assistance of one (1) person with locomotion. The MDS documented the resident had one (1) unstageable PU present on admission. Review of Resident #9's PU Care Plan, dated 5/19/23, included the intervention to provide the treatment as ordered and monitor for effectiveness. Review of the "Wound Evaluation," dated 7/18/23, identified the sacral PU as unstageable and that it measured 0.72 centimeters (cm) by 0.38 cm with a depth of 0.5 cm. Review of the Physician Order, dated 6/15/23, documented to clean sacral wound with normal saline, use cotton tip applicator if needed to pack wound with cut to fit Calcium Alginate. Apply Calazime paste to skin surrounding the wound and cover with a pink Optifoam gentle dressing daily and as needed. Observation, on 7/9/23, at 11:44 a.m., revealed Licensed Practical Nurse (LPN) E and Certified Nurse Aide (CNA) G donned gowns and gloves and provided the PU treatment for Resident #9. Observation revealed LPN E placed the PU treatment supplies on the resident's bed and then LPN E and CNA G unhooked the resident's brief and noted the resident was incontinent of feces. LPN E then helped the resident onto their left side while CNA G provided fecal incontinence care. LPN E reached over the resident and removed the dressing from the sacral PU, and CNA G continued to wipe between the buttocks and then up and over the PU. CNA G and LPN E then changed sides of the bed. LPN E sprayed Prophase Wound Cleaner into the wound, placed a piece of Calcium Alginate over the wound (without packing into the wound), and then rubbed Calmoseptine over the Calcium Alginate and around the PU, and then applied a foam dressing. LPN E and CNA G applied an incontinence brief and with the assistance of CNA H and transferred the resident to his/her wheelchair. Observation revealed LPN E and CNA G did not change their gloves throughout the observation until after the resident was placed in the wheelchair. In an interview with Wound Care Registered Nurse (WC RN), on 7/20/23, at 1:40 p.m., he/she stated the nurse should have changed his/her gloves after each step of the wound care process. WC RN also stated LPN E should have used the physician ordered normal saline and gauze to clean the wound. Additionally, the nurse should have packed the PU with the Calcium Alginate, as ordered, and applied the Calazime paste around the wound and not on top of the wound. The WC RN stated the nurse should have waited until the incontinence care was completed prior to removing the wound dressing, and the

	CNA should not have wiped over the PU with the same wipe that cleaned between the buttocks.
§ 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. **Rating** – Not Met **Scope and Severity** - D **Residents Affected** – Few	Based on observations, interviews, record review, and review of facility policies, the facility failed to ensure that medications were administered correctly for two (2) of four (4) residents observed during the medication pass (Resident #14 and Resident #15). The findings include: Review of the facility policy titled, "Medication Administration," dated 4/14/21, documented: "Guidelines 14. Administer medication as ordered." Review of the facility policy titled, "Administering Medications through a Metered Dose Inhaler," dated 10/10, documented: "Steps in the Procedure…15. Allow at least one (1) minute between inhalations of the same medication and at least two (2) minutes between inhalations of different medications." Review of Resident #14's Physician Orders revealed an order for Flonase, one (1) spray to each nostril every day for allergic rhinitis with the ordered date of 8/10/22. Observation during the medication pass, on 7/19/23, at 8:55 a.m., revealed Licensed Practical Nurse (LPN) C administered medication to Resident #14. LPN C handed Resident #14 the bottle of Flonase Nasal Spray. Resident #14 administered four (4) sprays of the Flonase into the right nare and then administered seven (7) sprays of Flonase into the left nare. Observation revealed LPN C did not stop the resident from administering too many sprays of the Flonase or instruct Resident #14 on the number of sprays that were ordered. Review of Resident #15's Physician Order, dated 6/2/23, listed an order for Symbicort Inhalation, 160-4.5 micrograms (mcg), two (2) puffs orally every 12 hours for Chronic Obstructive Pulmonary Disease (COPD). Review of Resident #15's Physician Order, dated 6/3/23, listed an order for Spiriva Respimat Inhalation, 2.5 mcg, one (1) puff orally one (1) time per day for COPD. Observation during the medication pass, on 7/19/23, at 9:40 a.m., revealed LPN D administered medication to Resident #15. Observation revealed LPN D administered Symbicort inhaler, one (1) puff, and, after thirty seconds, administered the second puff. One (1) minute later LPN D administered one (1) puff of Spiriva inhaler to Resident #15.

	During an interview with Registered Nurse Unit Coordinators (RNUCs) A and B, on 7/20/23, at 12:30 p.m., they stated the nurse should have followed the policy for how long they should wait between administering the same inhaler puffs between different inhalers. RNUCs A and B also stated the nurse could allow the resident to administer their own nasal spray, but should stop the resident if they were not doing it correctly or were administering the incorrect dose. During an interview with LPN I, on 7/21/23, at 9:42 a.m., he/she stated the nurse should wait five (5) minutes between the administration of different inhalers. LPN I also stated if he/she did not know how to administer a medication, he/she would ask the House Supervisor and they would get the policy for him/her.
§ 51.200 (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. **Rating** – Not Met **Scope and Severity** - F **Residents Affected** – Many	**Smoke Barriers and Sprinklers** 1. Based on records review and interview, the facility failed to inspect the Fire Alarm in accordance with the code. The deficient practice affected two (2) of two (2) smoke compartments in the Main Building, two (2) of two (2) smoke compartments in the Heritage Building, two (2) of two (2) smoke compartments in the Sunrise Building, two (2) of two (2) smoke compartments in the Crossing Building, two (2) of two (2) smoke compartments in the Freshwater Building, staff, and all residents. The facility had a capacity for 128 beds with a census of 103 on the first day of the survey. The findings include: Records review of the fire alarm inspection reports for the 12-month period prior to the survey revealed there was no documentation of a semi-annual visual inspection of the smoke detectors, as required by table 14.3.1 of NFPA 72, National Fire Alarm and Signaling Code. The last inspections of the smoke detectors were during the annual testing of the fire alarm on 4/11/23, and in 4/22. An interview with the with Maintenance Director, on 7/19/23, at 10:21 a.m., revealed the facility was not aware of the requirements for semi-annual visual inspections for the smoke detectors, and that only annual inspections were taking place at the facility. The census of 103 was verified by the Administrator on 7/19/23, at 8:45 a.m. The findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 7/20/23, at 4:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)**

	19.3.4.1 General. Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. **9.6 Fire Detection, Alarm, and Communications Systems.** **9.6.1* General.** **9.6.1.1** The provisions of Section 9.6 shall apply only where specifically required by another section of this Code. **9.6.1.2** Fire detection, alarm, and communications systems installed to make use of an alternative permitted by this Code shall be considered required systems and shall meet the provisions of this Code applicable to required systems. **9.6.1.3** A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. **9.6.1.4** All systems and components shall be approved for the purpose for which they are installed. **9.6.1.5*** To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. **4.6.12 Maintenance, Inspection, and Testing.** **4.6.12.1** Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. **4.6.12.2** No existing life safety feature shall be removed or reduced where such feature is a requirement for new construction. **4.6.12.3*** Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. **4.6.12.4** Any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. **10.2 Purpose.** The purpose of fire alarm and signaling systems shall be primarily to provide notification of alarm, supervisory, and trouble conditions; to alert the occupants; to summon aid; and to control emergency control functions. **10.3 Equipment.**

10.3.1 Equipment constructed and installed in conformity with this Code shall be listed for the purpose for which it is used.

Actual NFPA Standard: NFPA 72, National Fire Alarm and Signaling Code (2010)
14.3 Inspection.
14.3.1* Unless otherwise permitted by 14.3.2 visual inspections shall be performed in accordance with the schedules in Table 14.3.1 or more often if required by the authority having jurisdiction.
14.4.5* Testing Frequency. Unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction.

Table 14.3.1 Visual Inspection Frequencies

Fire Safety and Operations

2. Based on records review and interview, the facility failed to conduct all required fire drills. The deficient practice affected two (2) of two (2) smoke compartments in the Main Building, two (2) of two (2) smoke compartments in the Heritage Building , two (2) of two (2) smoke compartments in the Sunrise Building, two (2) of two (2) smoke compartments in the Crossing Building, two (2) of two (2) smoke compartments in the Freshwater Building, staff, and all residents. The facility had a capacity for 128 beds with a census of 103 on the first day of the survey.

The findings include:

a. Records review of the fire drill reports from the 12 months preceding the survey revealed the facility had conducted the 7/27/22 fire drill without sounding the facility fire alarm, as required by section 19.7.1.4 of NFPA 101, Life Safety Code. Additional record review revealed that the fire drill was conducted at 6:30 a.m., and no other fire drills were conducted during that shift in that quarter.

An interview with the Maintenance Director, on 7/19/23, at 9:45 a.m., revealed the facility was not aware that the fire drills after 6:00 a.m. required the use of the fire alarm or audible alarms.

b. Records review of the fire drill reports from the 12 months preceding the survey revealed the facility had not conducted a fire drill on the second shift during the first quarter of 2023, as required by

section 19.7.1.6 of NFPA 101, Life Safety Code. Additional record review revealed no other fire drills were conducted during that shift in that quarter.

An interview with the Maintenance Director, on 7/19/23, at 9:44 a.m., revealed the facility did conduct an additional third shift drill that was closer to the start of the first shift and that the facility was not aware that the second shift drill was not conducted.

The census of 103 was verified by the Administrator on 7/19/23, at 8:45 a.m. The findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 7/20/23, at 4:00 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.

Electrical Systems

3. Based on records review, observation, and interview, the facility failed to maintain documentation of inspections on the Patient-Care Related Electrical Equipment (PCREE). The deficient practice affected two (2) of two (2) smoke compartments in the Main Building, two (2) of two (2) smoke compartments in the Heritage Building , two (2) of two (2) smoke compartments in the Sunrise Building, two (2) of two (2) smoke compartments in the Crossing Building, two (2) of two (2) smoke compartments in the Freshwater Building, staff, and all residents. The facility had a capacity for 128 beds with a census of 103 on the first day of the survey.

The findings include:

Records review revealed there was no documentation of testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. An

	interview with the Maintenance Director, on 7/19/23, at 11:00 a.m., revealed the facility was not aware if any testing had been completed on any PCREE. The facility received respiratory equipment from a vendor and was not sure if the vendor completed any electrical safety testing before it was delivered to the facility. Observation during the building inspection tour, on 7/19/23, from 12:30 p.m., to 2:30 p.m., and on 7/20/23, from 9:30 a.m., to 12:00 p.m., revealed that the facility provided electric beds for all residents and that PCREE, such as vital sign monitors, nebulizers, oxygen concentrators, portable suction units, concentrators, air pumps for air mattresses, and other medical equipment was present at the facility. An interview, on 7/20/23, at 11:48 a.m., with the Regional Life Safety Manager during the building inspection tour revealed the facility was aware of the electrical safety testing for PCREE and currently was creating a program to address the PCREE requirements. The census of 103 was verified by the Administrator on 7/19/23, at 8:45 a.m. The findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 7/20/23 at 4:00 p.m. **Actual NFPA Standard: NFPA 99, Health Care Facilities Code (2012)** **3.3.137 Patient-Care-Related Electrical Equipment.** Electrical equipment appliance that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care vicinity. **10.3 Testing Requirements — Fixed and Portable.** **10.3.1* Physical Integrity.** The physical integrity of the power cord assembly composed of the power cord, attachment plug, and cord-strain relief shall be confirmed by visual inspection. **10.3.2* Resistance.** **10.3.2.1** For appliances that are used in the patient care vicinity, the resistance between the appliance chassis, or any exposed conductive surface of the appliance, and the ground pin of the attachment plug shall be less than 0.50 ohm under the following conditions: **(1)** The cord shall be flexed at its connection to the attachment plug or connector. **(2)** The cord shall be flexed at its connection to the strain relief on the chassis. **10.3.2.2** The requirement of 10.3.2.1 shall not apply to accessible metal parts that achieve separation from main parts by double insulation or metallic screening or that are unlikely to

	become energized (e.g., escutcheons or nameplates, small screws). **10.3.3* Leakage Current Tests.** **10.3.3.1 General.** **10.3.3.1.1** The requirements in 10.3.3.2 through 10.3.3.4 shall apply to all tests. **10.3.3.1.2** Tests shall be performed with the power switch ON and OFF. **10.3.3.2 Resistance Test**. The resistance tests of 10.3.3.3 shall be conducted before undertaking any leakage current measurements. **10.3.3.3*** Techniques of Measurement. The test shall not be made on the load side of an isolated power system or separable isolation transformer. **10.3.3.4* Leakage Current Limits.** The leakage current limits in 10.3.4 and 10.3.5 shall be followed. **10.3.4 Leakage Current — Fixed Equipment.** **10.3.4.1** Permanently wired appliances in the patient care vicinity shall be tested prior to installation while the equipment is temporarily insulated from ground. **10.3.4.2** The leakage current flowing through the ground conductor of the power supply connection to ground of permanently wired appliances installed in general or critical care areas shall not exceed 10.0 mA (ac or dc) with all grounds lifted. **10.3.5 Touch Current — Portable Equipment.** **10.3.5.1* Touch Current Limits.** The touch current for cord connected equipment shall not exceed 100 µA with the ground wire intact (if a ground wire is provided) with normal polarity and shall not exceed 500 µA with the ground wire disconnected. **10.3.5.2** If multiple devices are connected together and one power cord supplies power, the leakage current shall be measured as an assembly. **10.3.5.3** When multiple devices are connected together and more than one power cord supplies power, the devices shall be separated into groups according to their power supply cord, and the leakage current shall be measured independently for each group as an assembly. **10.3.5.4** Touch Leakage Test Procedure. Measurements shall be made using the circuit, as illustrated in Figure 10.3.5.4, with the appliance ground broken in two modes of appliance operation as follows: **(1)** Power plug connected normally with the appliance on **(2)** Power plug connected normally with the appliance off (if equipped with an on/off switch) **10.3.5.4.1** If the appliance has fixed redundant grounding (e.g., permanently fastened to the grounding system), the touch leakage current test shall be conducted with the redundant

	grounding intact. **10.3.5.4.2** Test shall be made with Switch A in Figure 10.3.5.4 closed. **10.3.6* Lead Leakage Current Tests and Limits — Portable Equipment.** **10.3.6.1** The leakage current between all patient leads connected together and ground shall be measured with the power plug connected normally and the device on. **10.3.6.2** An acceptable test configuration shall be as illustrated in Figure 10.3.5.4. **10.3.6.3** The leakage current shall not exceed 100 µA for ground wire closed and 500 µA ac for ground wire open. **10.5.2.1 Testing Intervals.** **10.5.2.1.1** The facility shall establish policies and protocols for the type of test and intervals of testing for patient care–related electrical equipment. **10.5.2.1.2** All patient care–related electrical equipment used in patient care rooms shall be tested in accordance with 10.3.5.4 or 10.3.6 before being put into service for the first time and after any repair or modification that might have compromised electrical safety. **10.5.2.5* System Demonstration.** Any system consisting of several electric appliances shall be demonstrated to comply with this code as a complete system. **10.5.3 Servicing and Maintenance of Equipment.** **10.5.3.1** The manufacturer of the appliance shall furnish documents containing at least a technical description, instructions for use, and a means of contacting the manufacturer. **10.5.3.1.1** The documents specified in 10.5.3.1 shall include the following, where applicable: **(1)** Illustrations that show the location of controls **(2)** Explanation of the function of each control **(3)** Illustrations of proper connection to the patient or other equipment, or both **(4)** Step-by-step procedures for testing and proper use of the appliance **(5)** Safety considerations in use and servicing of the appliance **(6)** Precautions to be taken if the appliance is used on a patient simultaneously with other electric appliances **(7)** Schematics, wiring diagrams, mechanical layouts, parts lists, and other pertinent data for the appliance **(8)** Instructions for cleaning, disinfection, or sterilization **(9)** Utility supply requirements (electrical, gas, ventilation, heating, cooling, and so forth) **(10)** Explanation of figures, symbols, and abbreviations on the appliance

	(11) Technical performance specifications **(12)** Instructions for unpacking, inspection, installation, adjustment, and alignment **(13)** Preventive and corrective maintenance and repair procedures **10.5.3.1.2** Service manuals, instructions, and procedures provided by the manufacturer shall be considered in the development of a program for maintenance of equipment. **10.5.6 Record Keeping — Patient Care Appliances.** **10.5.6.1 Instruction Manuals.** **10.5.6.1.1** A permanent file of instruction and maintenance manuals shall be maintained and be accessible. **10.5.6.1.2** The file of manuals shall be in the custody of the engineering group responsible for the maintenance of the appliance. **10.5.6.1.3** Duplicate instruction and maintenance manuals shall be available to the user. **10.5.6.1.4** Any safety labels and condensed operating instructions on an appliance shall be maintained in legible condition. **10.5.6.2* Documentation.** **10.5.6.2.1** A record shall be maintained of the tests required by this chapter and associated repairs or modifications. **10.5.6.2.2** At a minimum, the record shall contain all of the following: **(1)** Date **(2)** Unique identification of the equipment tested **(3)** Indication of which items have met or have failed to meet the performance requirements of 10.5.6.2 **10.5.6.3 Test Logs.** A log of test results and repairs shall be maintained and kept for a period of time in accordance with a health care facility's record retention policy. **10.5.8 Qualification and Training of Personnel.** **10.5.8.1*** Personnel concerned for the application or maintenance of electric appliances shall be trained on the risks associated with their use. **10.5.8.1.1** The health care facilities shall provide programs of continuing education for its personnel. **10.5.8.1.2** Continuing education programs shall include periodic review of manufacturers' safety guidelines and usage requirements for electrosurgical units and similar appliances. **10.5.8.2** Personnel involved in the use of energy-delivering devices including, but not limited to, electrosurgical, surgical laser, and fiberoptic devices shall receive periodic training in fire suppression. **10.5.8.3** Equipment shall be serviced by qualified personnel only.

§51.200 (b) Emergency power. (1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination. (2) The system must be the appropriate type essential electrical system in 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. **Rating** – Not Met **Scope and Severity** - F **Residents Affected** – Many	Based on records review and interview, the facility failed to inspect and test the emergency generator in accordance with the code. The deficient practice affected two (2) of two (2) smoke compartments in the Main Building, two (2) of two (2) smoke compartments in the Heritage Building , two (2) of two (2) smoke compartments in the Sunrise Building, two (2) of two (2) smoke compartments in the Crossing Building, two (2) of two (2) smoke compartments in the Freshwater Building, staff, and all residents. The facility had a capacity for 128 beds with a census of 103 on the first day of the survey. The findings include: Records review of the generator inspection, testing, and maintenance records for the prior year revealed during the monthly load test the load handled by the generators did not list or document the percent of the nameplate kW rating and it was unknown if the generators reached the 30 percent threshold, as required by section 8.4.2 of NFPA 110, Standard for Emergency and Standby Power Systems. Additional records review revealed there was no annual load bank test in 12-months prior to the survey as required by section 8.4.2.3 of NFPA 110, Standard for Emergency and Standby Power Systems. Additional records review revealed the last load bank test of the two (2) facility generators was completed on 5/10/22. An interview with the Maintenance Director, on 7/19/23, at 10:01 a.m., revealed the facility was aware that this information was required to be obtained. The interview went on to reveal that the connected load could not reach the 30 percent threshold in any month, and that a new vendor had been contracted to perform load bank testing. The next annual load bank test was scheduled for September, 2023. The census of 103 was verified by the Administrator on 7/19/23, at 8:45 a.m. The findings were acknowledged by the Administrator and verified by the Maintenance Director during the exit interview on 7/20/23, at 4:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.5 Building Services.** **19.5.1 Utilities.** **19.5.1.1** Utilities shall comply with the provisions of Section 9.1. **9.1.3 Emergency Generators and Standby Power Systems.** Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. **9.1.3.1** Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems.

	Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems (2010) **8.3.7.1** Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. **8.4.2*** Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: **(1)** Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer **(2)** Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating **8.4.2.3** Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours.
§ 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	Based on interview and record review, the facility's management failed to obtain a sharing agreement that governed mental health services provided to one (1) of the 103 residents by the Veterans Administration Medical Center (VAMC). The findings include: Review of administrative documents provided by the facility did not identify a sharing agreement with the VAMC to cover residents who received mental health services there. During the entrance conference, on 7/18/23, at 9:30 a.m., the Administrator reported that one (1) resident who lived in the facility received mental health services from the VAMC. The Administrator provided a copy of an email, dated 6/22/23, that requested assistance in obtaining a sharing agreement to cover mental health services received by one (1) resident who resided in the facility. Review of the clinical record for Resident #16, who was admitted to the facility on 8/3/21, revealed he/she began receiving mental health services from the VAMC 9/15/22.

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. **Rating** – Not Met **Scope and Severity** – D **Residents Affected** – Few	
§ 51.210 (j) Credentialing and Privileging. Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care practitioner, which may include physicians, podiatrists, dentists, psychologists, physician assistants, nurse practitioners, licensed nurses to provide patient care services in or for a health care organization. Privileging is the process whereby a specific scope and content of patient care services are authorized for a health care practitioner by the facility management, based on evaluation of the individual's credentials and performance. (1) The facility management must uniformly apply credentialing criteria to licensed practitioners applying to provide resident care or treatment under the facility's care. (2) The facility management must verify and uniformly apply the following core criteria: current licensure; current certification, if applicable, relevant education, training, and experience; current competence; and a statement that the individual is able to perform the services he or she is applying to provide. (3) The facility management must decide whether to authorize the independent practitioner to provide resident care or treatment, and each credentials file must indicate that these criteria are uniformly and individually applied.	Based on interview and record review, the facility failed to maintain current and complete credentialing and privileging records for eight (8) of eight (8) Licensed Practitioners who provided care to the residents. The findings include: Review of facility files for the purpose of documenting verification of credentials and granting of privilege to practice within the facility, revealed the facility had not maintained Credentialing and Privileging Records for any of its Licensed Independent Practitioners. In an interview, on 7/18/23, at 2:00 p.m., the Administrator confirmed that the Credentialing and Privileging files contained verification that both he/she and the Medical Director had reviewed and approved all licensed independent practitioners who provided care to the veterans in the facility. However, the files weren't signed prior to the survey and were signed and dated on 7/19/23 for verification of the credentialing process. The Credentialing and Privileging files the facility provided did not contain all needed documentation to support verification.

(4) The facility management must maintain documentation of current credentials for each licensed independent practitioner practicing within the facility. (5) When reappointing a licensed independent practitioner, the facility management must review the individual's record of experience. (6) The facility management systematically must assess whether individuals with clinical privileges act within the scope of privileges granted. **Rating** – Not Met **Scope and Severity** - F **Residents Affected** – Many	