

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: D.J. Jacobetti Home for Veterans

Location: 425 Fisher St., Marquette, MI 49855

Onsite / Virtual: Onsite

Dates of Survey: 4/14/26 – 4/17/26

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 126

Census on First Day of Survey: 102

Surveyed By: Deanna Kramer, MS, RN, LNHA; Sonya Crain, RN; Melissa Mrotek, Generalist; Louis Smith (LSC); Cicely Robinson, VACO.

VA Regulation Deficiency	Findings
	<p>Initial Comments:</p> <p>A VA Annual Survey was conducted from April 14, 2026, through April 17, 2026, at the D.J. Jacobetti Home for Veterans. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.</p>
<p>§ 51.140 (d) Food. Each resident receives and the facility provides—</p> <p>(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;</p> <p>(2) Food that is palatable, attractive, and at the proper temperature;</p> <p>(3) Food prepared in a form designed to meet individual needs; and</p> <p>(4) Substitutes offered of similar nutritive value to residents.</p> <p>Rating – Not Met Scope and Severity – E</p>	<p>Based on observations, resident and family interviews, staff interviews, record review, and facility policy review, the facility failed to ensure prepared food was palatable, attractive, and at the proper temperature, and that pureed food was smooth, cohesive, and lump-free.</p> <p>This failure had the potential to affect all residents who ate orally, including five (5) sampled residents (Resident #8, Resident #9, Resident #12, Resident #15, and Resident #18). At the time of survey entrance on 4/14/26, the census was 102 residents.</p> <p>The findings include:</p> <p>During an interview in the hallway on 1 South, beginning at 10:43 a.m., on 4/14/26, Resident #9 expressed a dislike for the</p>

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

<p>Residents Affected – Some</p>	<p>food being served at the facility, stating: “It’s got fancy names, but not fancy cooking – not even plain cooking.”</p> <p>During an interview in the resident’s room, beginning at 10:55 a.m., on 4/14/26, Resident #8 stated: “The food is pretty bad.” Resident #8’s roommate, Resident #9, entered the room and joined the conversation at 10:59 a.m., on 4/14/26. Resident #9 reported the vegetables were either “mush” (overcooked) or “raw” (undercooked), and the meat was sometimes “too hard, you couldn’t eat it.”</p> <p>At approximately 12:10 p.m., on 4/16/24, after a resident in the 1 South dining room remarked that he/she did not want to eat the “Mexican food” that was being served, Certified Nursing Assistant (CNA) D stated that the food served at the facility was “not what the men living in the U.P. [Upper Peninsula] eat ... They would eat meat and potatoes all the time...They don’t like Greek food [as was served for lunch on 4/14/26].”</p> <p>During an interview about food quality at 9:51 a.m., on 4/16/26, Resident #18 stated: “It has no taste to it...It’s not cooked enough...Some of the food is pretty good, but most of the time it sucks.” When asked if he/she had reported these concerns to the facility’s management, Resident #18 stated he/she reported it multiple times, including during the council meetings, “but it did no good.” When asked how long the food had been unsatisfactory, Resident #18 stated the problems began when the new food service company started in September of 2025. Resident #18 also reported he/she often requested alternate foods, because he/she often did not like what was served on the planned menus.</p> <p>A review of the undated facility policy titled, “Puréed Food Policy,” found: “Policy Statement [-] The facility will provide puréed foods that are safe, nutritionally adequate, visually acceptable, and consistent with physician orders, resident preferences, and recognized standards (e.g., IDDSI [International Dysphagia Diet Standardization Initiative] Level 4 – Puréed). All puréed foods will be prepared and served to maintain dignity, promote intake, and reduce risk of choking or aspiration.</p> <p>Definition [-] Puréed foods are foods that are smooth, cohesive, and lump-free; require no chewing; hold their shape on a spoon; and are easily swallowed with minimal effort.</p> <p>Expected Outcomes Consistency & Texture Compliance [-] Food is uniformly smooth, with no lumps, skins, seeds, or chunks. Food meets</p>
---	---

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

	<p>IDDSI Level 4 standards, holding shape on a spoon and sliding off easily. Food is not too thin or too thick/sticky.</p> <p>Food Presentation & Appearance [-] Foods are separated on the plate when appropriate. Colors are distinct and recognizable. Plates are neat and visually appealing.</p> <p>Temperature & Quality [-] Hot foods are served hot and cold foods are served cold. Food maintains appropriate moisture and is not dry or watery.”</p> <p>At 12:03 p.m., on 4/14/26, during lunch in the 1 South dining room, during an observation of the lunch tray prepared for Resident #12, in the presence of the resident’s family member, found only one (1) of the compartments of a beige-colored, three (3) section, divided plate contained any food, and the food item on the plate was of the same color as the plate itself. The only other pureed food item on the tray was served in a dark brown, 4 ounce (oz) bowl, with the food filling about half of the bowl. The two (2) pureed items were similar in color, and there was no way to distinguish one (1) from the other without tasting them. When interviewed, the family member agreed the pureed food served to Resident #12 for lunch, on 4/14/26, was all the same color (monochromatic). Examination of the tray ticket found only two (2) pureed items listed: a 4 oz serving of pureed rice pudding sprinkled with nutmeg and a 1/3 cup (equivalent to 2.67 oz) serving of pureed Greek pasta salad.</p> <p>At 12:08 p.m., on 4/14/26, an observation of the lunch tray prepared for Resident #15 found a tray ticket which contained the following instruction: “All Food in Bowls.” Per the tray ticket, Resident #15 was to be served the following pureed food items: 4 oz of rice pudding sprinkled with nutmeg, 1/3 cup (2.67 oz) of pureed Greek pasta salad, and “Gyro w/ [with] Feta, Lettuce, Tomato, & Onion,” with no serving size provided. An observation of the contents of the tray found only two (2) pureed food items: a light-brown pureed food item filling a 4 oz dark brown bowl, and another light-brown pureed food item filling an 8 oz dark brown bowl. The two (2) pureed items were similar in color, and there was no way to distinguish one (1) from the other without tasting them. There was not a third pureed food item on the tray.</p> <p>Review of an undated and untitled facility policy on Potentially Hazardous Foods, revealed: “All potentially hazardous foods...will be maintained at safe temperatures during holding and at the point of service...Hot foods will be maintained and served at $\geq 135^{\circ}\text{F}$ [greater than or equal to 135 degrees Fahrenheit]...at the point of service...To ensure temperatures remain compliant through service delivery: Hot foods will be</p>
--	---

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

	<p>maintained at 140°F - 165°F during holding and prior to service.”</p> <p>A review of the regular planned menu for lunch, on 4/17/26, found the following hot items were to be served: one (1) each mushroom and Swiss burger on a bun, 0.5 cup Delmonico potatoes, and a 4 oz three-bean salad. A review of the menu extension for the pureed diet of this same meal found the following hot items were to be served: one (1) each mushroom & Swiss hamburger on a bun, 0.5 cup Delmonico potatoes, and a 4 oz green and gold beans.</p> <p>An observation was made, at 11:58 a.m., on 4/17/26, as Resident #12’s lunch tray was being prepared on the tray line of the main kitchen. Diet Aide C scraped the last scoop of the pureed entrée out of a small pan on the steam table and put it in one (1) of the three (3) sections of a divided plate. The pureed entrée was dark brown in color and held its shape after being scooped. Diet Aide C identified that Resident #12 was to receive double portions of the entrée, and he/she called out asking staff in the kitchen to prepare more of the pureed entrée. Diet Aide C then continued plating Resident #12’s hot items, by adding a serving of mashed potatoes topped with gravy and a serving of pureed vegetables to the plate. Diet Aide C then placed a dome lid over the plate and set the resident’s meal tray aside on the counter.</p> <p>At 12:03 p.m., on 4/17/26, a small pan of a light-brown colored substance was brought to the serving line. The dome lid was removed from Resident #12’s plate, and a scoop of this light-colored substance was poured on top of the dark brown pureed entrée that was already on the plate. The dome lid was placed over the plate, and Cook B picked up the tray and carried it into the kitchen.</p> <p>At 12:04 p.m., on 4/17/26, the surveyor met Cook B at the tray cart inside the kitchen and was asked to examine the resident’s plate. The light-colored substance that had been poured over the dark brown pureed entrée was noticeably different in both color and texture; it was thinner and did not hold its shape, and it was not free of lumps. This was pointed out to the Assistant Dietary Manager at 12:05 p.m., on 4/17/26, who acknowledged the differences.</p> <p>Test trays were requested for both regular consistency and pureed consistency diets on 4/16/26. At 11:50 a.m., on 4/16/26, the two (2) test trays were placed on the food cart for delivery to the dining room on 1 South, which was the last unit to be served.</p>
--	---

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

	<p>Cook B transported the food cart containing the test trays to the dining room on 1 South, arriving at 11:53 a.m., on 4/16/26. After taking the temperatures of entrees on two (2) different residents' plates, Cook B left his/her thermometer with the two (2) surveyors, for use in measuring food temperatures on the test trays after the last resident was served.</p> <p>At 12:08 p.m., on 4/16/26, the last resident's meal tray was removed from the cart for service. At this time, the surveyors removed the test trays from the cart and placed them on the countertop. The dome lid covering the regular consistency test tray was removed from the plate, and the temperatures of the hot food items were measured with the following results:</p> <ul style="list-style-type: none">- Barbeque (BBQ) chicken = 131.2°F at 12:10 p.m.- Broccoli & cheese = 135.3°F at 12:10 p.m.- Corn = 132.4°F at 12:11 p.m. <p>Next, the dome lid covering the pureed consistency test tray was removed from the plate, and the temperatures of the hot food items were measured with the following results:</p> <ul style="list-style-type: none">- BBQ chicken (bone-in) = 137.5°F at 12:12 p.m.- Green vegetable = 138.9°F at 12:12 p.m.- Corn = 125.1°F at 12:12 p.m. <p>The pureed foods were then sampled by both surveyors for flavor, consistency, and texture. The pureed BBQ chicken contained lumps; the pureed corn contained pieces of the outer skin of the kernels; and the green vegetable lacked flavor and seasoning such that the surveyors could not agree whether the vegetable was broccoli or green peas.</p> <p>At approximately 12:13 p.m., on 4/16/26, the Dietary Manager (DM) and Assistant Dietary Manager (ADM) arrived at the 1 South Dining Room. The results of the temperature measurements were shared with them, and they both were unsure what the facility's policy was for plated hot foods, but they thought the target temperature might be 140°F at the point of service to the residents. (This was inconsistent with the policy, which had a target temperature of 135°F.) The DM also stated that all hot foods were well above 140°F immediately before being plated and placed in the tray cart, and any drop in food temperatures after a tray cart left the kitchen was due to a failure of the nursing staff to promptly deliver the meal trays to the residents once the food cart arrived on the floor.</p> <p>When asked what the texture and consistency of pureed foods should be, the DM stated the foods should be "liquidized." When asked if this meant that pureed foods should be free of lumps, the DM stated: "Yes."</p>
--	--

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

	<p>The surveyors invited the DM and ADM to sample the pureed food items. Both agreed the pureed chicken was not uniformly smooth; the pureed green vegetable would not have contained any salt or seasoning unless the recipe called for it; and the pureed corn had husk or skin in it.</p> <p>A subsequent review of the menu extension for lunch, served on 4/16/26, found the pureed green vegetable, which lacked both flavor and seasoning when tasted, was neither broccoli nor peas – it was green beans.</p>
<p>§ 51.140 (e) Therapeutic diets. Therapeutic diets must be prescribed by the primary care physician.</p> <p>Rating – Not Met Scope and Severity – D Residents Affected – Few</p>	<p>Based on observation, interview, and record review, the facility failed to provide therapeutic diets as prescribed for two (2) residents of random opportunity of six (6) residents receiving a pureed diet during lunch on 4/14/26 (Resident #12 and Resident #15).</p> <p>The findings include:</p> <p>A review of Resident #12’s clinical record found the following diet order, dated 10/3/24: “Large Portions diet [-] Puree texture, thin liquids consistency, regular oatmeal OK” [sic].</p> <p>Further review of Resident #12’s clinical record found a Nutrition Note, dated 2/25/26, which identified the resident as being “a high nutrition & dehydration risk” due, in part, to being dependent on others for all food and fluid intake, being on comfort care with no routine weights being done, and not eating breakfast. Per a family member’s request, Resident #12 was to receive large portions at lunch and supper since the resident only ate two (2) meals per day.</p> <p>At 12:03 p.m., on 4/14/26, an observation of Resident #12’s lunch tray, in the presence of the resident’s family member, found only one (1) of the compartments of a beige-colored, three (3) section, divided plate contained any food, and the food item on the plate was of the same color as the plate itself. The only other pureed food item on the tray was served in a dark brown, 4 ounce (oz) bowl, with the food only filling about half of the bowl. The two (2) pureed items were similar in color, and there was no way to distinguish one (1) from the other without tasting them.</p> <p>When interviewed, the family member agreed the pureed food served to Resident #12 for lunch, on 4/14/26, was all the same color (monochromatic).</p> <p>Examination of the tray ticket found only two (2) pureed items listed: a 4 oz serving of pureed rice pudding sprinkled with nutmeg and a 1/3 cup (equivalent to 2.67 oz) serving of pureed</p>

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

	<p>Greek pasta salad. The planned entrée for this meal, which was a gyro with feta, lettuce, tomato, and onion, was not listed on Resident #12's tray ticket. No alternate entrée was listed on the tray ticket. The tray ticket also included the following special instruction: "Large Portions."</p> <p>The family member, who was preparing to assist Resident #12 with eating lunch, stated: "[Resident #12 is] supposed to get double portions....This is where the kitchen falls apart."</p> <p>A review of Resident #15's clinical record found the following diet order, dated 5/8/25: "General diet [-] Puree texture, Mildly thick/Nectar Thick consistency [liquids], w/ [with] fortified hot cereal w/ breakfast, NO STRAWS, small-portioned lunch & supper per guardian, foods served in individual bowls." [sic].</p> <p>Further review of Resident #15's clinical record found the following intervention in the resident's comprehensive Care Plan addressing nutrition risk, which was dated 5/15/25, and revised on 2/25/26: "DIET: general, pureed food textures, thin liquids + fortified hot cereal w/breakfast (kitchen process) NECTAR thick liquids. Per Guardian, small-portioned lunch & supper. Small sized spoons to prevent [Resident #15] from overfilling [his/her] mouth. Needs cues to slow pace & not overfill. Foods sent in separate bowls to prevent frustration trying to get every bit of food out of the divided plate."</p> <p>At 12:08 p.m., on 4/14/26, an observation of Resident #15's lunch tray found a tray ticket which contained the following special instructions: "SMALL PORTIONS AT LUNCH & DINNER (-) SMALL SPOONS ONLY (-) SUPERVISION – CUE TO SLOW PACE" [sic]; and: "All Food in Bowls." Per the tray ticket, Resident #15 was to receive the following pureed food items: 4 oz of rice pudding sprinkled with nutmeg, 1/3 cup (2.67 oz) of pureed Greek pasta salad, and "Gyro w/ [with] Feta, Lettuce, Tomato, & Onion" with no serving size provided.</p> <p>An observation of the contents of the tray found only two (2) pureed food items: a light-brown pureed food item filling a 4 oz dark brown bowl, and another slightly different shade of light-brown pureed food item filling an 8 oz dark brown bowl. The two (2) pureed items were similar in color, and there was no way to distinguish one (1) from the other without tasting them. There was not a third pureed food item on the tray.</p> <p>A subsequent review of the menu extension, for the lunch meal, served on 4/16/26, found the portion size for the pureed gyro with feta cheese, lettuce, tomato, and onion was 4 oz.</p>
--	---

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

	<p>There was no pureed item on the menu extension that exceeded a 4 oz serving size as a regular portion.</p> <p>During an interview with the Assistant Dietary Manager (ADM), at approximately 11:30 a.m., on 4/17/26, he/she acknowledged having been the individual who prepared the pureed foods served at lunch on 4/14/26, including the pureed gyro. When asked why Resident #12's tray ticket did not list pureed gyro as a menu item for that meal, the ADM stated he/she did not know. The ADM further stated that, if a menu item were not listed on a resident's tray ticket, the dietary staff would not put that item on the resident's tray.</p> <p>During an interview with the Administrator and the Dietitian, at approximately 12:30 p.m., on 4/17/26, the surveyor asked what "large portions" and "small portions" meant with respect to the diet orders for Resident #12 and Resident #15, respectively. According to the Dietitian, "large portions" meant Resident #12 was to receive double the regular portion of the entrée at lunch and dinner. Also according to the Dietitian, "small portions" meant Resident #15 was to only receive half of the regular portion size of the entrée at lunch and dinner.</p> <p>The Dietitian was informed that, for lunch on 4/16/26, Resident #12 received only two (2) pureed food items on his/her tray (Greek pasta salad and rice pudding), and that the entrée (gyro with feta cheese, lettuce, tomato, and onion) was not listed on the tray ticket. The Dietitian stated there was no reason Resident #12 should not have received an entrée at lunch 4/16/26; even if the resident had a known dislike for the planned entrée, the tray card system was so sophisticated that it would have automatically added an acceptable alternate entrée to the resident's tray ticket. The Dietitian also confirmed that Resident #12 was to receive two (2) portions of the planned entrée, or an alternate, at every lunch and dinner.</p> <p>The Dietitian was informed that, for lunch on 4/16/26, Resident #15 also received only two (2) pureed food items on his/her tray, even though the tray ticket listed three (3) pureed items were to be served. When informed that one (1) of the items served to Resident #15 filled an 8 oz bowl, the Dietitian confirmed that, because he/she was supposed to receive small portions for lunch and dinner, none of the pureed items served to Resident #15, at lunch on 4/14/26, should have measured 8 oz.</p>
<p>§ 51.140 (h) Sanitary conditions. The facility must:</p>	<p>Based on observations, interviews, record review, and policy review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions for 102 of 102 residents.</p>

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

<p>(1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities;</p> <p>(2) Store, prepare, distribute, and serve food under sanitary conditions; and</p> <p>(3) Dispose of garbage and refuse properly.</p> <p>Rating – Not Met</p> <p>Scope and Severity – F</p> <p>Residents Affected – Many</p>	<p>The findings include:</p> <p>Review of the facility policy titled, “Food Safety Requirements v3,” revised on 5/25/23, found: “Policy...Food will also be stored, prepared, distributed, and served in accordance with professional standards for food service safety...Guidelines...1. Food safety practices shall be followed throughout the Home’s entire food handling process...Elements of the process include the following: ...b. Storage of food in a manner that helps prevent deterioration or contamination of the food...e. Equipment used in the handling of food, including dishes, utensils, mixers, grinders, and other equipment that comes in contact with food...f. Employee hygienic practices...</p> <p>3. Home staff shall inspect all food...and ensure timely and proper storage...c. Refrigerated storage...Practices to maintain safe refrigerated storage include: ...i. monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operation...v. Keeping foods covered or in tight containers...</p> <p>6. All equipment used in the handling of food shall be cleaned and sanitized...and handled in a manner to prevent contamination. a. All utensils, counter, shelves, and equipment are kept clean, maintained in good repair and are free from breaks, corruptions, open seams, cracks and chipped areas that may affect their use or proper cleaning...h. Food thermometers used to check food temperatures are clean, sanitized, and calibrated for accuracy...</p> <p>8. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects.”</p> <p>Review of the policy titled, “Refrigerators and Freezers,” dated 9/8/25, found stated: “2. Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures...4. Food service supervisors or designated employees check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening.”</p> <p>Review of the policy titled, “Bare Hand Contact with Food and Use of Plastic Gloves,” dated 2023, found stated: “3. Gloved hands are considered a food contact surface that can become contaminated or soiled. If used, single use gloves shall be used for only one task such as working with ready-to-eat (RTE) food...used for no other purpose and discarded when damaged or soiled, or when interruptions occur in the operation.”</p>
---	---

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

	<p>Review of the undated policy titled, "Taking Accurate Temperatures using Metal Stem Thermometers," revealed: "1. To take temperatures, a clean, rinsed sanitized and air-dried thermometer that is the metal stem type...is needed. Should this thermometer have a tube type cover, it must also be sanitized as indicated for the thermometer...2. To take hot food temperatures, insert the thermometer...wait for the thermometer to rise to the maximum temperature, read and record the temperature and then remove the thermometer from the food item and immediately clean and sanitize. Repeat these guidelines until all hot food temperatures have been taken."</p> <p>Observation of the walk-in refrigerator, on 4/14/26, at 9:14 a.m., revealed one (1) box containing bacon with the plastic wrapping not sealed, allowing the bacon to be exposed to the air.</p> <p>Observation of the kitchen, on 4/14/26, at 9:14 a.m., revealed incomplete refrigerator and freezer temperature logs, with multiple missing entries for the month of April 2026 for the walk-in freezer and the pre-line juice reach-in refrigerator.</p> <p>Observation of the floor stand mixer, on 4/14/26, at 9:35 a.m.; 4/16/26, at 4:54 p.m.; and 4/17/26, at 11:35 a.m., revealed dried debris on the planetary surface (the underside of the mixer where the mixing attachment was inserted).</p> <p>Observation, on 4/14/26, at 9:35 a.m., revealed an opaque container, containing metal lids used for covering food, sitting on a shelf next to the stove. Debris was observed both on the container and on the metal lids inside.</p> <p>Observation, on 4/16/26, at 11:45 a.m., revealed multiple pitchers and hot beverage carafes, some uncovered, and some turned upside down, sitting on a metal shelf that had grease buildup and debris. Additional observation, on 4/16/26, at 4:56 p.m., revealed food debris on the handles of the oven and refrigerators. A seal on the door of the food warmer was broken, creating an incomplete seal. Dried food debris was also observed on multiple kitchen appliances including a food warming cabinet, the ice machine cover, shelving in the main kitchen, and on the racks of the reach-in refrigerator.</p> <p>Observation, on 4/16/26, at 11:53 a.m., after delivering a food cart to the dining room in 1 South, revealed Cook B removed a metal stemmed food thermometer from a sheath in the front pocket of his/her shirt and, without additional sanitizing of the thermometer, checked the temperature of a piece of baked, bone-in chicken on the plate of a resident's meal tray. Cook B</p>
--	--

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

	<p>then removed the thermometer from the first piece of chicken and inserted it into a piece of chicken on a second resident's meal tray without sanitizing the probe between the pieces of chicken.</p> <p>Observation, on 4/16/26, at 4:56 p.m., revealed one (1) bucket containing boiled eggs which was not covered, dated 3/26/26, with no use by date, and containing a green/yellow colored liquid.</p> <p>Observation, on 4/17/26, during lunch service in the main kitchen, at 11:42 a.m., revealed Diet Aide C wearing disposable gloves while preparing and plating hamburgers. Diet Aide C was observed repeatedly, between preparing sandwiches, leaning on the serving line with both hands grasping the bars where the trays sat, and then using the same gloved hands to directly touch hamburger buns, lettuce, tomato, and onions. Diet Aide C was also observed opening the door of a reach-in refrigerator with the same gloved hands, reaching into the refrigerator, and removing shredded lettuce from a container and then placing the shredded lettuce on a hamburger.</p> <p>Review of the facility's undated "Daily Cleaning Checklists," from the month of April 2026, revealed incomplete tasks as evidenced by the lack of initials indicating task completion. Daily cleaning tasks included cleaning and sanitizing refrigerator handles, refrigerator shelves, and all food preparation surfaces. Review of nine (9) days of the undated "Daily Cleaning Checklist," from the month of April 2026, found that the task: "Clean and sanitize refrigerators (handles, shelves)," was not documented as completed on six (6) of nine (9) days; and the task: "Wipe down all high-touch areas," was not documented as completed on five (5) of nine (9) days.</p> <p>In an interview with the Dietary Manager, on 4/14/26, at 9:17 a.m., the Dietary Manager stated that he/she had: "just been in the refrigerator and covered the bacon," and didn't know why it was uncovered and open to air at the time of the observation. At approximately 10:30 a.m., on 4/14/26, the Dietary Manager stated that the facility had recently had a mock survey, and had identified areas of concern and were working on several things.</p> <p>During a follow-up interview, on 4/17/26, at 3:55 p.m., the Dietary Manager revealed several staff in the kitchen had not received formal food safety training, but they were working on getting staff educated.</p> <p>In an interview with the Administrator and the Director of Nursing, on 4/17/26, at 11:14 a.m., they confirmed that a mock</p>
--	--

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

	<p>survey had recently been completed on 3/24/26, and problems in the dietary department had been identified. The Administrator stated it was their expectation that greater improvement in the identified areas would be achieved by this time. The Administrator also stated that the dietary concerns were incorporated into the QAPI (Quality Assurance and Program Improvement) program, with ongoing monitoring that included the Dietitian as well as the Dietary Manager.</p>
<p>§ 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.</p> <p>Rating – Not Met Scope and Severity – E Residents Affected – Some</p>	<p><u>General Requirements</u></p> <ol style="list-style-type: none"> 1. Based on record review, observation, and interview, the facility failed to provide a building with a conforming construction type limited in height in accordance with the code. The deficient practice affected one (1) of 10 smoke compartments in the Original Building, and zero (0) of two (2) smoke compartments of the Part F Building, staff, and 17 residents. The facility had a capacity for 126 beds with a census of 102 on the first day of the survey. <p>The findings include:</p> <p>Observation during a tour of the building, on 4/15/26, at 10:25 a.m., revealed missing fireproofing on structural steel in a mechanical penthouse above #2 South. The missing fireproofing would reduce the construction type down to type II (000). Without fireproofing, the facility failed to provide a conforming construction type with height limitations in accordance with table 19.1.6.1 of NFPA 101, Life Safety Code.</p> <p>An interview with the Maintenance Technician, on 4/15/26, at 10:25 a.m., revealed the Maintenance Technician thought the missing fireproofing in the mechanical penthouse needed to be fixed.</p> <p>Record review, on 4/15/26, at 11:00 a.m., revealed in building description documentation provided to the surveyor a construction type of II (222) for the south wing, and that all structural elements were intended to have a two (2) hour fire rating.</p> <p>The census of 102 was verified by the Administrator on 4/14/26, at 9:07 a.m. The findings were acknowledged by the Administrator and verified by the Facilities Director and Maintenance Technician during the exit conference on 4/17/26, at 3:56 p.m.</p> <p>Actual NFPA Standard: NFPA 101 (2012) Life Safety Code</p>

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

19.1.6 Minimum Construction Requirements.

19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)

Table 19.1.6.1 Construction Type Limitations

II (222) Any number of stories non-sprinklered or sprinklered
II (000) Maximum 2 stories sprinklered

The total number of stories of the building is to be determined as follows:

(1) The total number of stories is to be counted starting with the level of exit discharge and ending with the highest occupiable story of the building.

(2) Stories below the level of exit discharge are not counted as stories.

(3) Interstitial spaces used solely for building or process systems directly related to the level above or below are not considered a separate story.

(4) A mezzanine in accordance with 8.6.9 is not counted as a story.

+Sprinklered throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. (See 19.3.5.)

++Basements are not counted as stories.

Building Services (Elevators, Escalators, Laundry Chutes, etc.)

2. Based on observation and interview, the facility failed to properly install gas equipment and appliances. The deficient practice affected one (1) of 10 smoke compartments in the Original Building, and zero (0) of two (2) smoke compartments of the Part F Building, staff, and no residents. The facility had a capacity for 126 beds with a census of 102 on the first day of the survey.

The findings include:

Observation during the building inspection tour, on 4/16/26, at 1:08 p.m., revealed two (2) double ovens on casters which were located on the cooking line in the kitchen were not provided with a restraint system to limit the movement of the appliance to prevent strain on the connections, as required by sections 9.6.1.2 and 10.12.6 of NFPA 54, National Fuel Gas Code.

An interview, on 4/16/26, at 1:08 p.m., with the Maintenance Technician revealed the facility was not aware of the

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

	<p>requirement for a restraint system to limit the movement of the appliances to prevent strain on the connections.</p> <p>The census of 102 was verified by the Administrator on 4/14/26, at 9:07 a.m. The findings were acknowledged by the Administrator and verified by the Facilities Director and Maintenance Technician during the exit conference on 4/17/26, at 3:56 p.m.</p> <p>Actual NFPA Standard: NFPA 101 (2012), Life Safety Code 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.</p> <p>Actual NFPA Standard: NFPA 54 (2012), National Fuel Gas Code 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. 10.12.6 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.</p> <p><u>Fire Safety and Operations</u></p> <p>3. Based on record review, observations, and interviews, the facility failed to prohibit the use of portable space heaters that did not meet the requirements of the code. The deficient practice affected one (1) of 10 smoke compartments in the Original Building, and zero (0) of two (2) smoke compartments of the Part F Building, staff, and no residents. The facility had a capacity for</p>
--	--

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

126 beds with a census of 102 on the first day of the survey.

The findings include:

- A. Observation during the building inspection tour, on 4/15/26, at 8:55 a.m., revealed two (2) portable space heaters were in the Clinical Coordinator's office located in #1 West.
- B. Observation during the building inspection tour, on 4/15/26, at 9:50 a.m., revealed a portable space heater was plugged in and in use in the Infection Control office located in #1 West.
- C. Observation during the building inspection tour, on 4/15/26, at 10:49 a.m., revealed a portable space heater was in the Health Information Specialist office located in #2 West.

An interview, on 4/15/26, at 10:49 a.m., with the Maintenance Technician revealed the portable heaters found during the tour of the facility had not gone through maintenance, and the facility did not have documentation showing they did not exceed 212°F (100°C), as required by section 19.7.8 of NFPA 101, Life Safety Code. The interview went on to reveal that staff members brought the heaters into the facility from home.

Record review, on 4/16/26, at 2:23 p.m., revealed a facility policy entitled, "Electrical Appliances v4," with an effective date of 4/15/21. The policy, in the section "Policy Interpretation and Implementation," subsection seven (7), stated:

"Portable space heating devices are prohibited in all Home areas, unless:

- a. Approved by the Administrator or Director of General Services (Physical Plant Supervisor) and inspected annually,
- b. The devices are used ONLY in nonsleeping, staff area,
- c. The heating elements of the devices do not exceed 212 degrees Fahrenheit (100 degrees Celsius, AND
- d. The devices are equipped with a tip-over safety mechanism."

The census of 102 was verified by the Administrator on 4/14/26, at 9:07 a.m. The findings were acknowledged by the

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88

Department of Veterans Affairs State Veterans Home Survey Report

	<p>Administrator and verified by the Facilities Director and Maintenance Technician during the exit conference on 4/17/26, at 3:56 p.m.</p> <p>Actual NFPA Standard: NFPA 101 Life Safety Code (2012) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies, unless both of the following criteria are met:</p> <ul style="list-style-type: none">(1) Such devices are used only in nonsleeping staff and employee areas.(2) The heating elements of such devices do not exceed 212°F (100°C).
--	---

All documents containing protected or sensitive information have been appropriately destroyed or disposed of in accordance with VA Directive 6371, VA Handbook 6500.1 and NIST 800-88