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: Minnesota Veterans Home - Fergus Falls

Location: 1821 North Park Street, Fergus Falls, Minnesota 56537

Onsite / Virtual: Onsite

Dates of Survey: 08/22/23 – 08/25/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 106

Census on First Day of Survey: 85

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from August 22, 2023 through August 25, 2023 at the Minnesota Veterans Home – Fergus Falls. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** –Many	Based on observation, interview, documentation review, and review of facility policy, the facility failed to ensure food items were stored and/or prepared under sanitary conditions for 84 residents who received their meals from the facility's [LOCATION]. 1. Opened food items were stored without being labeled and/or dated in the [LOCATION'S] preparation (prep) area, in the dry food storage area, inside the reach-in cooler, inside the walk-in freezer and inside the reach-in freezer. 2. Food items inside the reach-in freezer were soaked in water as a result of the improper drainage from the freezer's defrost cycle. 3. Dietary Staff improperly used and/or did not use the facility's three (3)-compartment sink as required. The findings include:

	Review of the "Practice Standards for Food Storage" policy taken from the facility's Policy and Procedure Manual section 3-17 (a) (not dated) noted that "Foods that will be held under refrigeration/frozen, or stock in dry storage shall be clearly date-marked at the time of preparation or storage. **See Food Storage Guidelines." Review of the "Food Storage" policy taken from the facility's Policy and Procedure Manual section 3-17 (not dated) revealed "Policy: Sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. Food is stored in an area that is clean, dry and free from contaminants. Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination…4. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled and dated…8. c. Food should be dated as it is placed on the shelves…13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 3 days or discarded…14. Refrigerated Food Storage f. All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded…15. Frozen Foods: a. All freezer units are kept clean and in good working condition at all times…c. All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded." Review of the facility's Dietary Staff Cleaning Assignments "A," "B," and "C", revised 3/17/22 noted the following tasks were to be completed, respectively: Saturday – Check for outdated items in [LOCATION] and fridges and cupboards; Saturday - Check for outdated items in [LOCATION] and fridges and cupboards; and Tuesday – Clean lower refrigerator (#6) under the toaster and discard outdated items. 1. Observations conducted with Dietary Staff A and Dietary Staff B during the initial tour of the facility's [LOCATION] on 8/22/23 between 10:37 a.m. and 11:23 a.m. revealed the following: Prep Area On a shelf inside of a cupboard located in the prep area of the [LOCATION], the following spices were opened and stored without a date of opening, as follows: One (1) bottle of whole bay leaves;

	One (1) bottle of ground cayenne pepper; One (1) bottle of ground cumin; and One (1) bottle of parsley flakes. During an interview at 10:42 a.m., Dietary Staff B said that once opened all spices were to be dated, and Dietary Staff B acknowledged that the bottles of whole basil leaves, ground cayenne pepper, ground cumin, and parsley flakes were not dated upon opening. Continued observation in the prep area revealed that on a shelf above the prep table was a plastic container that had: One (1) opened and undated package of pork gravy mix; One (1) opened and undated package of cheese sauce; and One (1) opened and undated package of chicken gravy mix. Reach-in Cooler Inside of a reach-in cooler near the prep area was one (1) opened and undated package of whipped topping. Walk-in Freezer Inside the walk-in freezer the following opened and undated items were observed: One (1) bag of carrots; One (1) bag of peppers and onion mix; One (1) bag of French fries; One (1) bag of hash browns; and One (1) bag of peas & carrot mix The bags were not dated to indicate when they were opened, and an expiration date was not observed to be on the bags. Reach-in Freezer Observation of a reach-in freezer located near the dry food storage area revealed on the outside of the freezer was a sign posted that read: “All food items not in original sealed packaging must be covered labeled and dated.” {sic} Inside of the freezer on the right side were the following: 20 opened, unlabeled, and undated packages of oatmeal raisin bars (as identified by the CC); and One (1) bag of opened, unlabeled, and undated oatmeal cookies (as identified by the CC). Dry Storage Area In the dry storage area, the following was observed: One (1) opened and undated bag of dry cheesecake filling. During an interview on 8/22/23 at 10:58 a.m. with Dietary Staff A, the staff stated there was a “pattern” of the dietary staff not labeling and dating food items appropriately as required.

	In an interview with Dietary Staff A and Dietary Staff B on 8/22/23 at 11:20 a.m. revealed all residents on the [LOCATIONS] ate their meals in the main [LOCATION]; and a food cart with residents' meals was delivered to the [LOCATION]. 2. Review of an invoice dated 11/25/22 revealed the following notation: "Freezer not working right. Found low gas. Found leak on hi [sic] side liquid line pumped down. Repaired leak, installed new filter and charged back up reinsulated suction line was bad." [sic] Review of the facility's "Work Request Details" dated 8/23/23 revealed a request was made on 8/23/23 at 1:10 p.m. for repair regarding "Freezer #11 is iced up on the coils." According to the document, on 8/23/23, maintenance staff spent 90 minutes making repair to the freezer. Observation of the reach-in freezer on 8/22/23 at 11:10 a.m. revealed inside of the freezer and on the left side were two (2) medium sized pans that contained frozen left-over spaghetti and one (1) plastic food storage bag of frozen left-over spaghetti, all dated 7/7/23. The pans and storage bag were soaked with water that was dripping from inside of the freezer and onto the pans/bag. According to Dietary Staff B at this time (11:10 a.m.), the freezer was going through a defrost cycle, and Dietary Staff B was "not sure" how often the defrost cycle happened. Per Dietary Staff B, the situation had happened before with the defrost cycle, which caused water to drip onto food products in the freezer. Dietary Staff B said the situation had happened approximately three (3) times within the past year, and the problem was verbally reported to maintenance staff. Dietary Staff B said that no food was exposed when this happened, and the outcome could be ice-build up on the containers. A follow-up tour conducted with Dietary Staff A on 8/23/23 at 9:40 a.m. revealed that the two (2) pans of left-over spaghetti dated 7/7/23 and the plastic bag of left-over spaghetti dated 7/7/23 remained in the freezer. The pans had icicles around the lids and the bag had a layer of ice on top of the bag that was approximately ¼ inch thick. At that time, Dietary Staff A stated that they did not feel comfortable with the food remaining in the freezer and removed the left-over spaghetti at that time. On the same shelf and towards the back of the freezer were two (2) small bins containing left-over beans dated "3/30". The bins were covered with plastic wrap and had a cover on top. There were icicles hanging from around bottom edge of the lid of the bins that contained the left-over beans. An interview on 8/23/23 at 9:33 a.m. with Dietary Staff B revealed they reported the defrost issue regarding the reach-in

	freezer to maintenance on 8/22/23. Dietary Staff B said they were not sure if maintenance had followed-up with the issue. An interview with Maintenance Staff A on 8/23/23 at 2:50 p.m. revealed that they reviewed the work orders for the reach-in freezer and found where it had been repaired in November of 2022. They said there were no other work orders in the system regarding the reach-in freezer; however, the maintenance department did receive a call on 8/22/23 and 8/23/23 regarding the freezer's defrost cycle. Maintenance Staff A provided a document titled "Work Request Details" dated 8/23/23, that indicated the reach-in freezer had been repaired on the afternoon of 8/23/23. Maintenance Staff A was not aware of any other reports throughout the year of the reach-in freezer having problems with its defrost cycle. 3. Review of the "Cleaning Dishes – Manual Dishwashing" policy taken from the facility's Policy and Procedure Manual section 4-16 (not dated) noted: "Policy: Dishes and cookware will be washed after each meal to assure that all dishes are clean and sanitary. Procedure:…3. Prepare the sinks according to the chart below. All sinks should be cleaned and sanitized prior to beginning. 4. Place a few dishes at a time into the sink. Wash thoroughly with a clean cloth or sponge. Scrub items as needed using a scouring pad. Rinse in sink 2, and sanitize in sink 3 following the directions below… Sink 1: Wash – Wash dishes in detergent and warm water to remove all soil: 1. Prepare the clean sink by measuring the appropriate amount of water into the sink and marking the sink with a water line. 2. Determine the appropriate amount of detergent to be used, and follow the manufacturer's directions for use. 3. Water should be about (120 to 125° [degrees] F [Fahrenheit]. 4. Change water frequently to assure effective cleaning of dishes. Sink 2: Rinse – Rinse dishes in clean warm water: 1. Prepare the clean sink with hot water (120 to 140° F). 2. Rinse the dishes thoroughly before placing in the sanitizing sink. Sink 3: Sanitize – Sanitize dishes: 1. Measure the appropriate amount of sanitizing chemical into the appropriate amount of water (following the manufacture's guidelines). 2. Test the sanitizing solution in the sink using the manufacturer's suggested test strips to assure appropriate level. 3. Place the dishes in the sanitizing sink. Allow to stand according to the manufacturer's guidelines for sanitizer…4. Allow dishes to air dry. Invert dishes in a single layer to air dry. Check all dishes to be sure they are clean and dry prior to storing. Note: If hot water is used as the sanitizing methos, water must be at least 171° F

	and dishes must be immersed [in the water] for at least 30 seconds…" In an interview on 8/23/23 at 9:55 a.m., Dietary Staff C said they had been working in the [LOCATION] for approximately four (4) months and their primary responsibility was to load the dish machine with dirty dishes and run them through the machine. When asked to confirm the dishwashing machine was reaching an appropriate rinse cycle temperature of 180 degrees F, Dietary Staff C stated that they did not know how to complete that task and said that they had not been trained regarding that. Continued interview with Dietary Staff C revealed they had not been trained on using the three (3)-compartment sink for dishes that could not fit into the dish machine. Dietary Staff C said that when a dish item came through that was too large to place into the dish machine, they filled the middle sink (of the three (3)-compartment sink) with warm water and dish soap and washed the item. Dietary Staff C said to rinse the item, to place it under warm running water and no sanitizer was used. An interview on 8/23/23 at 9:57 a.m. with Dietary Staff D revealed they had been working in the facility's [LOCATION] for nine (9) years. They stated that the facility no longer used the three (3)-compartment sink due to "restrictions put in place during COVID." Dietary Staff D said the facility had not used the sink within the last three (3) to four (4) years. In addition, Dietary Staff D said that all dish items in the [LOCATION] fit into the dish machine so there was not a need to use the three (3)-compartment sink. In a follow-up interview with Dietary Staff A on 8/23/23 at 9:58 a.m., they said they were not aware of any restrictions regarding the use of the three (3)-compartment sink. Dietary Staff A said the three (3)-compartment sink should be used according to protocol when dishes, pots, or pans did not fit into the dish machine. Dietary Staff A further stated that the former Dietary Staff E (the facility had been without a Dietary Staff E for approximately a month and a half) did not provide adequate training for the [LOCATION] staff to implement. A follow-up interview with Dietary Staff B on 8/23/23 at 10:10 a.m. revealed there were at least one (1) large pot and one (1) large mixing bowl that did not fit into the facility's dish machine and the three (3)-compartment sink was used to wash and sanitize those items.
§ 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.	**<u>Means of Egress Requirements</u>** 1. Based on observations and interview, the facility failed to install required exit and directional signage. The deficient practice affected one (1) of 11 smoke compartments, staff,

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	and no residents. The facility has a capacity for 106 beds with a census of 85 on the day of the survey. The findings include: Observation during the building inspection tour on 8/22/23 at 10:06 a.m. of the door leading out from the [LOCATION] the surveyors were in, had a "Not an Exit" sign to an [LOCATION] which is not the compliance signage, as required by section 7.10.8.3 of NFPA 101, Life Safety Code. Interview on 8/22/23 at 10:06 a.m. with Maintenance Staff A revealed the facility was not aware the sign was missing as all other doors to the [LOCATIONS] had the required signage. The census of 85 was verified by Administrative Staff A on 8/22/23 at 9:00 a.m. The finding was acknowledged by Administrative Staff A and verified by other facility staff during the Life Safety Code (LSC) exit interview on 8/23/23 at 4:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.2.10 Marking of Means of Egress.** **19.2.10.**1 Means of egress shall have signs in accordance with Section 7.10, unless otherwise permitted by 19.2.10.2, 19.2.10.3, or 19.2.10.4. **7.10.8.3* No Exit.** **7.10.8.3.1** Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: **NO** **EXIT** **7.10.8.3.2** The NO EXIT sign shall have the word NO in letters 2 in. (51 mm) high, with a stroke width of 3⁄8 in. (9.5 mm), and the word EXIT in letters 1 in. (25 mm) high, with the word EXIT below the word NO, unless such sign is an approved existing sign. **<u>Smoke Barriers and Sprinklers</u>** 2. Based on records review and interview, the facility failed to test and inspect the fire alarm system in accordance with code. The deficient practice affected 11 of 11 smoke compartments, staff, and all residents. The facility has a capacity for 106 beds with a census of 85 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 a facility semiannual report dated 7/11/22 and 7/10/23 which had Fire Alarm "semi-annual" written on typing paper. Each report had a facility staff person indicated as having completed the inspection. Additional record review revealed there was no documentation of facility staff training/certification on the inspection, testing or maintenance of fire alarm systems or components, as required by section 10.4.3of NFPA 72, National Fire Alarm and Signaling Code. An interview with Maintenance Staff A, on 8/22/23, at 9:42 a.m., revealed the facility was unaware of the training/certification requirement to inspect fire alarm systems or components. The staff person who completed the semi-annual fire alarm inspection reports dated 7/11/22 and 7/10/23 was not trained/certified to inspect fire alarm systems. The census of 85 was verified by Administrative Staff A on 8/22/23 at 9:00 a.m. The findings were acknowledged by Administrative Staff A and verified by other facility staff during the exit interview on 8/23/23 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. **Actual NFPA Standard: NFPA 72, National Fire Alarm and Signaling Code (2010)** **10.4.3 Inspection, Testing, and Maintenance Personnel. (SIGTMS)** **10.4.3.1*** Service personnel shall be qualified and experienced

	in the inspection, testing, and maintenance of systems addressed within the scope of this Code. Qualified personnel shall include, but not be limited to, one or more of the following: **(1)*** Personnel who are factory trained and certified for the specific type and brand of system being serviced **(2)*** Personnel who are certified by a nationally recognized certification organization acceptable to the authority having jurisdiction **(3)*** Personnel who are registered, licensed, or certified by a state or local authority to perform service on systems addressed within the scope of this Code **(4)** Personnel who are employed and qualified by an organization listed by a nationally recognized testing laboratory for the servicing of systems within the scope of this Code **10.4.3.2** Evidence of qualifications shall be provided to the authority having jurisdiction upon request. 3. 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 11 smoke compartments, staff, and no residents. The facility has a capacity for 106 beds with a census of 85 on the day of the survey. The findings include: Observation during the building inspection tour on 8/23/23 at 12:36 p.m. revealed the four (4) wheeled, six (6) burner gas fired cooking surface with gas fired griddle Vulcan stove located on the cooking line in the [LOCATION] was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning, as required by sections 12.1.2.3 and 12.1.2.3.1 of NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Interview on 8/23/23 at 12:36 p.m. with Maintenance Staff A revealed the facility was not aware of the requirement for 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. The census of 85 was verified by Administrative Staff A on 8/22/23 at 9:00 a.m. The finding was acknowledged by Administrative Staff A and verified by other facility staff during the exit interview on 8/23/23 at 4:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012) 19.3.2.5 Cooking Facilities.**

19.3.2.5.1 Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4.
19.3.2.5.2* Where residential cooking equipment is used for food warming or limited cooking, the equipment shall not be required to be protected in accordance with 9.2.3, and the presence of the equipment shall not require the area to be protected as a hazardous area.
9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service.

Actual NFPA Standard: NFPA 96, Standard for Ventilation Control and Fire 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.

<u>Building Services (Elevators, Escalators, Laundry Chutes, etc.)</u>

4. Based on observation and interview, the facility failed to properly install gas equipment and appliances. The deficient practice affected one (1) of 11 smoke compartments, staff, and no residents. The facility has a capacity for 106 beds with a census of 85 on the first day of the survey.

The findings include:

Observation during the building inspection tour on 8/23/23 at 9:47 a.m. revealed the wheeled Vulcan gas fired flat-top grill

	with six (6) burners with griddle located on the cooking line in the [LOCATION] was 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. Interview on 8/23/23 at 9:47 a.m. with Maintenance Staff A revealed the facility was not aware of the restraint requirement. The census of 85 was verified by Administrative Staff A on 8/22/23 at 9:00 a.m. The finding was acknowledged by Administrative Staff A and verified by other facility staff during the exit interview on 8/23/23 at 4:00 p.m. **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. **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. **<u>Fire Safety and Operations</u>** 5. Based on observation and interview, the facility failed to provide the designated [LOCATIONS] with the required equipment. The deficient practice affected one (1) of 11

	smoke compartments, staff, and four (4) residents. The facility has a capacity for 106 beds with a census of 85 on the day of the survey. The findings include: Observation during the building inspection tour on 8/22/23 at 11:40 a.m. of the resident's designated [LOCATION] located inside the facility at [LOCATION] near the [LOCATION] revealed the facility did not have any metal containers with self-closing lid/cover devices into which ashtrays can be emptied, as required by section 19.7.4 (6) of NFPA 101, Life Safety Code. Interview with Maintenance Staff A on 8/22/23 at 11:40 a.m. revealed the facility was not aware there were requirements for a metal container with self-closing lid/cover device in which to place the butts from the designated [LOCATIONS] ashtrays into. The census of 85 was verified by Administrative Staff A on 8/22/23 at 9:00 a.m. The finding was acknowledged by Administrative Staff A and verified by other facility staff during the exit interview on 8/23/23 at 4:00 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.7.4* Smoking.** Smoking regulations shall be adopted and shall include not less than the following provisions: **(1)** Smoking shall be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. **(2)** In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. **(3)** Smoking by patients classified as not responsible shall be prohibited. **(4)** The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision. **(5)** Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. **(6)** Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. **<u>Electrical Systems</u>** 6. 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 11 of 11 smoke compartments, staff, and all residents. The facility has a capacity for 106 beds with a census of 85 on the first day of the survey. The findings include: Records review revealed there was no documentation of testing of the electric, resident beds in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Interview on 8/23/23 at 10:55 a.m. with Maintenance Staff A revealed the facility inspects the electric, resident beds visually when they conduct room audits. They do not conduct any electrical safety testing like the other medical equipment. The interview went on to reveal that the electric, resident beds do not have any unique identification and there was no electrical safety testing documentation for any of the electric, resident beds in the facility. Observation during the building inspection on 8/23/22 from 9:30 a.m. to 11:30 a.m. revealed, none of the electric, resident beds in the facility were provided with any markings that indicated electrical safety testing had been performed on them, as required by section 10.3 of NFPA 99, Health Care Facilities Code. Interview on 8/23/23 at 3:19 p.m. with Maintenance Staff A revealed the facility was aware that the electric resident beds should be tested and had received a vendor quote on getting the electric beds electrically tested to meet code. An additional interview revealed the facility has not secured a vendor and the in facility electric beds have not been tested to code. The census of 85 was verified by Administrative Staff A on 8/22/23 at 9:00 a.m. The finding was acknowledged by Administrative Staff A and verified by other facility staff during the exit interview on 8/23/23 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.