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

Location: 1300 N. Kniss Avenue Luverne, MN 56156

Onsite / Virtual: Onsite

Dates of Survey: 8/16/2022-8/19/2022

NH / DOM / ADHC: Nursing Home

Survey Class: Annual

Total Available Beds: 85

Census on First Day of Survey: 61

VA Regulation Deficiency	Findings
	Initial comments: A VA Annual Survey was conducted from August 16, 2022, through August 19, 2022, at the Minnesota Veterans Home in Luverne, Minnesota. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.110 (e) (2) Comprehensive care plans. A comprehensive care plan must be— (i) Developed within 7 calendar days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.	Based on interviews and record reviews, the facility failed to revise the Care Plan to include accurate interventions for a toileting program for one (1) resident (Resident #1) from a total of 16 sampled residents. The findings include: The facility's policy for Care Plans titled, "Care Plan Processes," was reviewed. The policy included a revision date of 9/11/19. The policy directed the facility's Interdisciplinary Team (IDT) to maintain a comprehensive Care Plan for each resident and revise each Care Plan as changes in the resident's status dictated. Review of Resident #1's medical record revealed an admission date of 2021. Their primary medical diagnosis was Fracture of the Left Femur. Secondary medical diagnoses included Repeated Falls, Dementia, and Macular Degeneration. Review of a Significant Change Minimum Data Set (MDS) assessment,

Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of three (3), indicating severely impaired cognition. Resident #1 required extensive assistance with activities of daily living (ADLs), including toileting and transfers. Resident #1 was incontinent of bowel and bladder. A post fall assessment, dated [DATE], at 6:45 p.m., indicated Resident #1 sustained a fall after attempting to self-transfer. The assessment also indicated Resident #1 was reviewed by the IDT and Resident #1 was to be offered toileting after supper to "prevent further attempts at self-transfer." Review of Resident #1's Comprehensive Care Plan revealed a focus area for elimination. An intervention, dated [DATE], read, "TOILETING PLAN -- Assist to toilet when requests. Assist of 1 staff to toilet and with cleansing after bowel movement." The Care Plan had not been revised to include the intervention to assist Resident #1 with toileting after supper. A bowel and bladder assessment, dated [DATE], read, "Resident currently has at least daily incontinence of bowels and bladder. [They are] aware at times of need for toileting. Wears a brief at all times, managed by staff. Toileting plan: Toilet resident upon arising in a.m., before and after meals and PRN [as needed] as resident requests." The Care Plan had not been revised to include the intervention to assist Resident #1 according to the toileting schedule developed on [DATE]. During an interview with Administrative Nurse A, on 8/19/22, at 10:16 a.m., Resident #1's fall history was reviewed. Administrative Nurse A reviewed Resident #1's Care Plan and acknowledged that it had not been revised to include new toileting interventions developed on [DATE] and [DATE].
§ 51.120 (i) Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	Based on observations, interviews, and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents by failing to 1) Identify underlying causative factors of falls and develop an appropriate toileting plan for one (1) (Resident #1) of three (3) residents reviewed for falls, and 2) Ensure safe transportation of residents to ancillary appointments. This failure resulted in actual harm for one resident (Resident #7) who fell while unattended, sustaining multiple fractures, a subarachnoid hemorrhage and hospital admission. The findings include:

Level of Harm – Actual Harm that is not immediate jeopardy Residents Affected – Few	1. Review of Resident #1's medical record revealed an admission date of 2021. Their primary medical diagnosis was Fracture of the Left Femur. Secondary medical diagnoses included Repeated Falls, Dementia, and Macular Degeneration. Review of a Significant Change Minimum Data Set (MDS) assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of three (3), indicating severely impaired cognition. Resident #1 required extensive assistance with activities of daily living (ADLs), including toileting and transfers. Resident #1 was incontinent of bowel and bladder. On 8/17/22, at 1:50 p.m., an interview was attempted with Resident #1. They were sitting in their wheelchair in the living area of the secured unit. Their eyes were closed. They responded to verbal stimuli by opening their eyes, but they were not able to answer any questions. On 8/17/22, at 2:00 p.m., an interview was conducted with Licensed Nurse A. They confirmed that they were familiar with Resident #1 and confirmed that they were caring for Resident #1 at the time of the interview. They identified Resident #1 as having repeated falls. They stated, "[They] did fall and break [their] hip about a month ago." Licensed Nurse A was not sure of the circumstances of the fall that lead to Resident #1's hip fracture. Licensed Nurse A explained that Resident #1 did require staff assistance for ADLs, to include toileting, and stated that they were not generally able to carry on a conversation due to cognitive impairment. On 8/17/22, at 2:08 p.m., an interview was conducted with Certified Nurse Aide A. They confirmed that they were familiar with Resident #1 and were caring for them on the day of the interview. They identified Resident #1 as having a history of falls and recalled that they had been moved to the secured unit due to cognitive decline. Certified Nurse Aide A explained that Resident #1 required assistance to the restroom due to weakness and explained that staff assisted them to the restroom "every two or so hours." They added that Resident #1 was not usually able to request assistance to the restroom. Review of Resident #1's Comprehensive Care Plan revealed a focus area for elimination. An intervention, dated [DATE], read, "TOILETING PLAN-- Assist to toilet when requests. Assist of 1 staff to toilet and with cleansing after bowel movement." The facility produced a list of Resident #1's falls since [DATE] which indicated Resident #1 suffered falls on [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE].

	Review of a post fall assessment, dated [DATE], at 2:20 p.m., indicated Resident #1 was found lying on the floor in their bathroom. Resident #1 was wearing shoes but was not wearing socks and the Velcro straps on their shoes were not fastened. Resident #1 stated that they were returning from the restroom and fell. The assessment identified Resident #1 as independent with toileting. Education was provided to the resident regarding safe and appropriate footwear. The assessment indicated Resident #1 was reviewed by the interdisciplinary team and no additional recommendations were made. Review of a post fall assessment, dated [DATE], at 2:30 a.m., indicated Resident #1 was found on the floor. Resident #1 stated that they were trying to find the restroom. The assessment indicated Resident #1's toileting plan was effective at the time of the assessment. A silent bed alarm and silent chair alarm were placed, and "frequent visual checks" were scheduled. The assessment indicated Resident #1 was reviewed by the interdisciplinary team. The team attributed Resident #1's fall to abnormal labs and failed to identify the need for a revised toileting plan. A quarterly MDS assessment, dated [DATE], indicated a BIMS of five (5) and that Resident #1 required extensive assistance with toileting, but that Resident #1 was not on a toileting program. A significant change MDS assessment, dated [DATE], indicated a BIMS of six (6) and that Resident #1 required extensive assistance with toileting, but that Resident #1 was not on a toileting program. A post fall assessment, dated [DATE], at 6:45 p.m., indicated Resident #1 sustained a fall after attempting to self-transfer. The assessment indicated the toileting plan at the time of the assessment was effective. No bowel and bladder evaluation was documented. The assessment also indicated Resident #1 was reviewed by the Interdisciplinary Team and Resident #1 was to be offered toileting after supper to prevent further attempts at self-transfer. A post fall assessment, dated [DATE], 9:10 a.m., indicated Resident #1 was found on the floor. The assessment indicated staff were to assist Resident #1 to the toilet when they requested, and indicated Resident #1 stated that they needed to go to the restroom at the time of the fall. The assessment read, “Current toileting plan effective.” A narrative note in the assessment read, “Staff noted silent bed alarm alerting and entered room to find resident on the floor. Walker was next to

	bed, overbed table pushed up against closet door. Resident found on L [left] side on floor. States that [they were] using 'my little walker' indicating overbed wheeled table, to get to the bathroom." A post fall assessment, dated [DATE], at 5:15 p.m., indicated Resident #1 was found on the floor by staff. A narrative note in the assessment read, "Per interview with LPN [Licensed Practical Nurse] [they] had been in res. [resident's] room just prior to fall and noted res. [resident] walker was within reach of resident in recliner. Was asked to lie down on floor, guidance was attempted by staff. Resident assisted to lie on R [right] side and full body sling placed underneath [them]. Note that resident was incontinent of stool at time of fall, was likely responding to urge to toilet." Resident #1 was transferred to a clinic appointment and was diagnosed with a fracture of the left femoral neck. They were subsequently transferred to the hospital where they underwent surgical repair. A bowel and bladder assessment, dated [DATE], read, "Resident currently ha[d] at least daily incontinence of bowels and bladder. [They are] aware at times of need for toileting. Wears a brief at all times, managed by staff. Toileting plan: Toilet resident upon arising in a.m., before and after meals and PRN [as needed] as resident requests." On 8/19/22, at 10:16 a.m., an interview was conducted with Administrative Nurse A. Resident #1's fall history was reviewed with Administrative Nurse A. They acknowledged that Resident #1 was not always able to ask for assistance to the restroom and stated, "I agree with you. There should have been a better toileting program starting in [DATE]." 2. Review of the undated policy titled, "Resident Appointment Transportation Standard of Work," revealed: "General Resident Appointment Information and Guidelines: • We attempt to have our transportation drivers only transport one resident at a time, however there are times that two residents have appointment in the same area at approximately the same time. • In the case of two residents having appointments at the same time, we will have each resident transported separately with a staff member or family member. When that is not possible and both residents need to ride together in our facility vehicle, we will ensure our driver is accompanied by an additional staff member, volunteer, or family member. • It is our goal to have each resident accompanied by a staff member, volunteer, or family member during transportation and during handoff of residents to the medical provider.

- This may mean having to park the facility vehicle a reasonable distance from the appointment location and pushing the resident in a wheelchair to ensure our staff is with the resident until handoff to the medical provider.

  Appointment Cancellation:
  Appointments may be cancelled by facility staff for reasons, including, but not limited to: Inclement weather, Outside temperature, Road conditions, and Vehicle Mechanical concerns."

Further review of the "Transportation Policy," revealed that photographs were included to show where to park at the most used facilities.

Observation on 8/16/22, at 11:25 a.m., of Resident #7, revealed the resident in the [LOCATION] dining room with a pureed diet with thickened liquids. The resident fed themself with the right hand and ate 75% of the meal.

Review of the medical record revealed Resident #7 had the following diagnoses, including: Hemiplegia/Hemiparesis, Hemiplegia/Hemiparesis, Cerebral Vascular Accident Cerebral Vascular Accident (CVA), Traumatic Subarachnoid Hemorrhage, Traumatic Subarachnoid Hemorrhage, Le Fort Fracture (fracture of the midface), Fracture Metacarpal, Aphasia.

Review of the resident's Annual Minimum Data Set (MDS) assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) assessment of three (3), indicating severe cognitive impairment. The resident was coded for extensive assistance by two (2) persons for transfers and bed mobility, limited assistance for locomotion by one (1) person, and was assessed for wandering daily. The resident used a wheelchair for locomotion.

Review of the Quarterly MDS assessment, dated [DATE], revealed a BIMS assessment of five (5), indicating severe cognitive impairment, and extensive assistance by one (1) or two (2) persons for bed mobility and transfers. The resident used a wheelchair for locomotion. The resident was assessed for wandering daily in the wheelchair.

Review of the Care Plan, dated [DATE], revealed a Plan of Care that indicated: "at risk for injury secondary to falls or wandering related to (r/t) cognitive impairment/poor insight into my need for assistance. Wheelchair used for locomotion, wheels self around to dining room and at times requires assistance. I scoot around the unit and nearer destinations within the facility."

	Review of the Care Plan, dated [DATE], revealed a Care Plan for mobility, "impaired mobility r/t hospital fall on [DATE], with Le Fort fracture, right 4th metacarpal, left thumb fracture, and history Cerebral Vascular Accident (CVA) left sided weakness. Interventions: I use a wheelchair. Had a subarachnoid hemorrhage on [DATE] assist me to my destination." The Safety Care Plan interventions were: "Resident not to be left at appointments unattended due to poor spatial awareness and depth perception issues due to CVA." A family interview for Resident #7, on 8/16/22, at 1:00 p.m., revealed the resident had a fall at a hospital, for an appointment, which resulted in a decline for the resident. An interview with Licensed Nurse B, on 8/16/22, at 1:11 p.m., revealed that Resident #7 had a fall after the facility transported the resident for an appointment at the hospital. Licensed Nurse B stated that the facility driver was transporting two (2) residents, in wheelchairs, to their VA appointments. They then left the residents in the lobby, with hospital staff, and went to park the van. During that time, Resident #7, scooted the wheelchair to the stairs and fell three (3) to four (4) stairs, sustaining injuries requiring hospitalization. Licensed Nurse B revealed that Resident #7 was known to wander about the facility in the wheelchair, although they did not attempt to leave the building. A second interview with the family member of Resident #7, on 8/16/22, at 1:30 p.m., revealed that the fall occurred at the hospital during an appointment. The family member understood the accident occurred while waiting for the appointment due to the facility driver leaving the resident in the hospital lobby to park the van. The resident moved the wheelchair, with their feet to the stairs, then fell down the stairs resulting in a facial fracture, hand fracture, and a "brain bleed." The resident had not been able to wear their dentures since the fall. An interview with Administrative Staff A, on 8/16/22, at 4:20 p.m., revealed that the facility did not have a transportation policy prior to Resident #7's accident. An interview with Certified Nurse Aide B, on 8/17/22, at 9:28 a.m., revealed that they had worked at the facility for 28 years and was familiar with Resident #7, and that they wandered throughout the facility when in the wheelchair. Certified Nurse Aide B revealed that they had been the driver for about two (2) weeks prior to the accident with Resident #7. Certified Nurse Aide B had worked alongside the previous driver for about six (6) trips prior to taking over the position, and since they were

	along on the trips, the residents were not left alone. Their training was related to van safety, such as checking mirrors. Continued interview with Certified Nurse Aide B revealed that on 5/18/22, they left both residents, who were in wheelchairs, in the lobby of the hospital. They stated two receptionists asked if they could check in the residents, but Certified Nurse Aide B asked them to wait until they returned from parking the van. One resident was cognitively intact, but Resident #7 was confused. The cognitively intact resident was no longer a resident at the facility. Certified Nurse Aide B stated they did not specifically ask the registration staff to watch the residents while they parked the van, and felt uncomfortable leaving them to park the van but had no other choice. Certified Nurse Aide B recalled that, returning to the lobby about five (5) to seven (7) minutes later, they could not see the residents or the two (2) registration staff. Certified Nurse Aide B then went up a handicap ramp from the lobby to the reception desk, although no one was in that area. They then noticed a wheelchair near this area and went directly to the wheelchair and noted three stairs with Resident #7 lying at the bottom of the stairs. The resident was surrounded by hospital staff that would not allow them access to the resident who did not appear to be conscious. They then notified Administrative Nurse A of the accident. Certified Nurse Aide B remained at the hospital to return the second resident back to the facility. Certified Nurse Aide B further revealed that since the accident the facility had put a new transportation policy into place, and they were educated on the procedure. Certified Nurse Aide B revealed that a copy of the policy was kept in the facility van for staff to review. Review of the written education for Certified Nurse Aide B and two other drivers, dated 5/19/22, included responsibilities related to the new facility. Observation and interview with Certified Nurse Aide B, on 8/17/22, at 10:15 a.m., of the facility transportation van, revealed a laminated copy of the transportation policy in a pocket, behind the passenger's seat. An interview with Administrative Nurse A, on 8/17/22, at 10:34 a.m., revealed that they were responsible for scheduling outside appointments and arranging transportation for the residents. This had been their responsibility for several years. They now followed a new policy for transportation for residents to appointments. Administrative Nurse A stated that if more than one (1) resident was being transported at one (1) time, then a second staff member was assigned to travel with the van driver. Administrative Nurse A revealed that prior to Resident #7's accident, the facility did not have a transportation policy, although they made decisions on a case-by-case basis. The

	facility had no previous incidents with residents transported for appointments. Administrative Nurse A stated that they were aware the resident was mobile in the wheelchair, but in thirty years with no accidents, "It just wasn't on my radar." They revealed that the transportation driver was new to the position. Review of the incident report, supplied by Administrative Nurse A via email, dated 5/18/22, at 4:45 p.m., confirmed the incident occurred on [DATE] when the resident was transported to an appointment at the hospital. The resident's fall resulted in a Le Fort fracture of the face, fracture of the hand, and fracture of the wrist. Review of a Progress Note for Resident #7, dated [DATE] by Administrative Nurse B, titled, "[Administrative Nurse B] Follow up post incident," noted: "Incident and cause: On [DATE] resident sustained injuries from a fall that occurred in the (name of facility) medical center lobby near the registration desk. Facility driver to the entrance and safely unloaded this resident and second resident who had appointments at the medical facility. Driver asked the screening staff to watch the two residents while [they] parked the facility vehicle. They said yes. Driver parked facility vehicle and returned to the entrance within 5-6 minutes of leaving the residents. Driver reported neither resident, nor the two (2) screening staff [they] left the residents with, were where [they] had left them. Driver was concerned as [they] could not see the residents. [They] began searching for the residents and screening staff. Driver noted this resident [*sic*] wheelchair without the resident in it. As [they] approached, [they] noted this resident on the floor with multiple hospital medical staff surrounding [them]. It appeared someone had pushed this resident up the handicap ramp to the registration area along with the other resident. The registration staff had registered the other resident and took [them] back to [their] procedure area, leaving this resident unsupervised near the registration area. Driver reported the resident fell down 2-3 stairs. Resident was transferred to the Emergency Department (ED) for further evaluation. Driver verified other resident was safe and in procedure area, then accompanied this resident to the ED. Driver notified [Administrative Nurse A] of incident and provided ED staff with resident information packet. [Administrative Nurse A] then called ED and spoke with staff caring for the resident for updates and provided answers to questions the ED staff had regarding resident. [Administrative Nurse A] then notified the resident's family member and informed [them] the resident would be kept for evaluation and not be returning to the facility [DATE]. On [DATE] at 0845, [Administrative Nurse A] received an update from the hospital staff who reported the resident had facial injuries/fracture, bilateral hand injures and a small subarachnoid hemorrhage.

	Resident admitted to the medical center's Neuro acute floor on [DATE] and discharge plan is pending. "Intervention to prevent reoccurrence: Discussion with hospital risk management who will work together to prevent further incidents. Administrative Nurse B was informed the hospital will not provide patient care advocates to sit with facility residents while staff parks the vehicle. The facility will send a second staff member to assist if there are more than one resident."[sic] Review of the Oral Surgeon's Progress Notes, dated [DATE], revealed the following: "the resident was seen today, for a follow-up. The resident (Resident #7) was initially seen at the hospital for a maxillary fracture. Nothing has changed, everything is stable, and post-op Computerized Tomography (CT) scan shows that there is no shift of the fragments and should heal without further intervention." Review of the Dentist Progress Notes, dated [DATE], at 6:40 a.m., revealed that an impression was made for upper and lower dentures. A second visit and Progress Notes, dated [DATE], revealed the dentures were fitted and adjusted then sent for processing. An interview with Administrative Nurse B, Administrative Nurse A, and Consultant Staff A, on 8/17/22, at 2:27 p.m., revealed that Resident #7's appointment on [DATE], was for a video speech therapy screen to determine if a diet downgrade was needed, due to resident difficulty with eating and drinking. The staff noted that they had been told the resident's dentures should be ready by the next week and had made all arrangements for dental appointments. Consultant Staff A was not certain that the resident's dentures would change the needed food form, and that the resident was tolerating and eating well on a pureed diet with thickened liquids. Consultant Staff A further revealed that the resident was currently at their baseline weight.
§ 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. Level of Harm – No Actual Harm, with potential for more than minimal harm	Based on interviews and record review, the facility failed to prevent medication errors for one (1) resident (Resident #1) from a total of 16 sampled residents. The findings include: Review of Resident #1's medical record revealed an admission date of 2021. Their primary medical diagnosis was Fracture of the Left Femur. Secondary medical diagnoses included Repeated Falls, Dementia, and Macular Degeneration. Review of a Significant Change Minimum Data Set (MDS) assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of three (3), indicating severely impaired cognition.

Residents Affected – Few	Review of a physician's Progress Note, dated [DATE], revealed an additional medical diagnosis of Nonalcoholic Liver Disease with Possible Cirrhosis. Further review of the physician's Progress Note revealed a directive by the physician to limit Resident #1 to two (2) grams of Tylenol per day "given [their] underlying liver disease." Review of Resident #1's Medication Administration Records (MAR) for [DATE] revealed an order, dated [DATE], which read, "Acetaminophen Tablet Give 1000 mg [milligrams] by mouth three times a day for pain." The MAR also indicated the medication had been administered 49 times since [DATE]. Continued review of Resident #1's MAR revealed a second order, dated [DATE], which read, "Acetaminophen Tablet Give 650 mg by mouth every 4 hours as needed for mild to moderate pain or fever." The MAR indicated the medication was administered on [DATE], and [DATE]. On 8/17/22, at approximately 4:00 p.m., Administrative Nurse B was notified of the potential medication error. They explained that they would review Resident #1's medical record and clarify it, if needed. On 8/18/22, at approximately 3:30 p.m., an interview was conducted with Administrative Nurse B and Administrative Nurse A regarding Resident #1's Tylenol orders. Administrative Nurse A explained that the physician had reviewed Resident #1's Tylenol restrictions and had discontinued the scheduled Tylenol order and agreed with the two (2) gram Tylenol restriction given Resident #1's underlying liver disease. A physician's Visit Note, dated [DATE], read, "Note Text: Chart reviewed on medical director rounds, Tylenol dosage restrictions clarified. New orders received to d/c [discontinue] scheduled Tylenol and specific parameters of no greater than 2G [grams] of Tylenol qd [every day] added."
§ 51.200 (a) Life safety from fire. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	**<u>Smoke Barriers and Sprinklers</u>** Based on observation and interview, the facility failed to ensure fire extinguishers were properly installed. The deficient practice affected one (1) of seven (7) smoke compartments, staff, and no residents. The facility had a capacity for 85 beds with a census of 61 on the day of the survey. The findings include: Observation during the building inspection tour, on 8/17/22, at 10:22 a.m., in the kitchen revealed an ABC Fire extinguisher

	installed over five (5) feet from the floor. Maintenance Staff A retrieved a tape measure and measured the fire extinguisher to be 5'7" from the floor as prohibited by section 6.1.3.8.1 of NFPA 10, Standard for Portable Fire Extinguishers. An interview, on 8/17/22, at 10:22 p.m., with Maintenance Staff A revealed that the facility was not aware of the requirement for fire extinguishers to be installed under five (5) feet. The census of 61 was verified by Maintenance Staff A on 8/17/22. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 8/17/22. **Actual NFPA Standard:** **NFPA 101, Life Safety Code (2012)** **Chapter 19 Existing Health Care Occupancies** **19.3.5.12** Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. **9.7.4 Manual Extinguishing Equipment.** **9.7.4.1*** Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. **Actual NFPA Standard:** **NFPA 10, Standard for Portable Fire Extinguishers 2010** **6.1.3.8 Installation Height.** **6.1.3.8.1** Fire extinguishers having a gross weight not exceeding 40 lb. (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor.