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 – Minneapolis

Location: 5101 Minnehaha Ave., South Minneapolis, MN 55417

Onsite / Virtual: Onsite

Dates of Survey: 1/22/24 – 1/25/24

NH / DOM / ADHC: NH

Survey Class: 2023 Annual

Total Available Beds: 341

Census on First Day of Survey: 260

VA Regulation Deficiency	Findings
	A VA Annual Survey was conducted from January 22, 2024, through January 25, 2024, at the Minnesota Veterans Home – Minneapolis. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.43(e) Drugs and medicines for certain veterans As a condition for receiving drugs or medicine under this section or under §17.96 of this chapter, the State must submit to the VA medical center of jurisdiction a completed VA Form 10-0460 with the corresponding prescription(s) for each eligible veteran. **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Few	The facility was unable to demonstrate submission of VA Form 10-0460 for Veterans who are be eligible to have medications provided by the VA of jurisdiction. Based on interviews and record reviews, the facility obtained reimbursement for medications from the Veterans Affairs (VA) of jurisdiction for Veterans who meet eligibility under 38 CFR §51.43. During interviews and record reviews, it was identified the facility failed to complete and submit VA Form 10-0460 as required for each eligible Veteran. The SVH did not have on file VA Form 10-0460 for one (1) of four (4) sampled Veterans.
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and	Based on observations, interviews, and record review, the facility failed to implement interventions to prevent dialysis complications in accordance with each resident's Plan of Care for one (1) of one (1) resident reviewed for dialysis. The findings include:

(ii) Be provided by qualified persons in accordance with each resident's written plan of care. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Resident #6 had a diagnosis of End Stage Renal Disease and received hemodialysis. A quarterly Minimum Data Set (MDS), dated [DATE], identified the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of a total of 15 possible points with no short or long – term memory problems. The resident was independent with activities of daily living (ADLs). In addition, the assessment identified the resident received hemodialysis. A review of Resident #6's dialysis comprehensive Care Plan, dated [DATE], identified the resident received hemodialysis related to End Stage Renal Failure on Monday, Wednesday, and Friday. An intervention, dated [DATE], instructed staff not to draw blood or take the blood pressure on the affected arm with the graft; however, the Care Plan did not identify which arm had the graft. During observation and interview, on 1/22/24, at 1:25 p.m., Resident #6 was in their room seated in a chair and stated they had just returned from dialysis and had no problems. When interviewed, on 1/24/24, at 2:02 p.m., Resident #6 stated they had had no problems with their access site (the resident pointed to their left forearm). They stated they had dialysis that morning and it went well. When interviewed, on 1/23/24, at 3:12 p.m., Administrative Nurse A acknowledged Resident #6's Plan of Care did not identify the location of the dialysis access site, and stated they would find out the location of the access site. When interviewed at 4:00 p.m., Administrative Nurse A stated they set their own professional standards and did not provide any further information on the location of the resident's access site. When interviewed, on 1/24/24, at 9:07 a.m., Administrative Nurse B stated Resident #6's Care Plan was revised on 1/24/24, to include the resident's access site, left forearm shunt.
§ 51.120 (a) (3) Reporting of Sentinel Events The facility management must report sentinel events to the director of VA medical center of jurisdiction within 24 hours of identification. The VA medical center of jurisdiction must report sentinel events by calling VA Network Director (10N 1-22) and Office of Geriatrics and Extended Care in VA Central Office within 24 hours of notification.	Based on interview and record review, the facility failed to report sentinel events to the Veterans Administration (VA) Medical Center of Jurisdiction within 24 hours for one (1) of one (1) sampled residents (Resident #28) who had a sentinel event. The findings include: Review of the facility's "Sentinel Events" policy, revised 6/15/23, and effective 6/22/23, found that the policy purpose was: "To provide policies and procedures that ensure all sentinel events are responded to, reported, and investigated according to regulations and best practice recommendations." The policy identified a sentinel event as an adverse event: "unexpected

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	occurrences involving death, serious physical or psychological injury, or risk thereof. Serious injury specifically includes loss of limb or permanent loss function." It further stated: "Section B – Reporting, 1. Designated Minnesota Veterans Home (MVH) personnel will notify the VA Medical Center (VAMC) of Jurisdiction by phone or email within 24 hours of the sentinel event. A message may be left on voicemail indicating the facility, the resident's name, the date and time the event occurred, and the contact person and phone number. This also applies to evenings, weekends, and holidays." Resident #28's record review identified that, on [DATE], Resident #28 was found on the hallway floor by staff. The resident was alert, confused, denied hitting their head, and stated they fell and landed on their side. An assessment indicated no injury was noted, vital signs and neurological assessments were at baseline, and Resident #28 ambulated at baseline following the fall. A review of the facility's Root Cause Analysis (RCA) Form indicated, on [DATE], during a physical therapy evaluation, Resident #28 complained of pain and appeared to have external rotation on their left side and an inability to bear weight. The assessment was reported to the nurse, who contacted the on-call provider, and an order was received for an x-ray. On [DATE], the x-ray was completed and confirmed a left hip fracture. The decision was made at the hospital with the resident and the resident's family not to treat the fracture. The resident returned to the facility with comfort and pain medication. Resident #28 was put on Hospice Care on [DATE], and passed away on [DATE]. A review of the facility's sentinel event information revealed that the facility did not report the resident's death as a sentinel event within 24 hours. The sentinel event was reported via email on [DATE], three (3) days after the resident's death. During interview, on 1/24/24, at 2:20 p.m., Administrative Nurse A stated the sentinel event was the death of the resident. In addition, Administrative Nurse A agreed that the VA Medical Center of Jurisdiction was not notified by phone or email within 24 hours of the sentinel event.
§ 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</u>** 1. Based on observations and interview, the facility failed to ensure doors to hazardous areas were not held open with devices that did not have an automatic release device. The deficient practice affected zero (0) of seven (7) smoke compartments in [LOCATION], one (1) of 10

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	smoke compartments in [LOCATION], zero (0) of 11 smoke compartments in [LOCATION], staff, and no residents. The facility had a capacity for 341 beds with a census of 260 on the first day of the survey. The findings include: Observation during the building inspection tour, on 1/24/24, at 1:26 p.m., of the [LOCATION] off the [LOCATION] in the [LOCATION] revealed the room was over 50 square feet and filled with storage of cardboard boxes, plastic bags filled with food items, and other paper goods. Additional observation revealed that both of the doors leading into the room were provided with self-closing devices. The fixed leaf was held open by a brown, plastic, floor wedge that would not automatically release the door, as prohibited by section 19.2.2.2.7 of NFPA 101, Life Safety Code. The operable leaf was provided with a magnetic hold open device that was interconnected with the building fire alarm. There was no interconnection of the fixed leaf with the building fire alarm. An interview, on 1/24/24, at 1:30 p.m., with Administrative Staff A revealed that the [LOCATION] had just received a delivery earlier in the day, and it was customary for staff to wedge the door open. The census of 260 was verified by Administrative Staff A on 1/24/24, at 9:22 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 1/25/24, at 12:00 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.2.2.2.7*** Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2, shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. **7.2.1.8 Self-Closing Devices.** **7.2.1.8.1*** A door leaf normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2, unless otherwise permitted by 7.2.1.8.3. **7.2.1.8.2** In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, door leaves shall be permitted to be automatic-closing, provided that all of the following criteria are met:

	(1) Upon release of the hold-open mechanism, the leaf becomes self-closing. **(2)** The release device is designed so that the leaf instantly releases manually and, upon release, becomes self closing, or the leaf can be readily closed. **(3)** The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door leaf release service in NFPA 72, National Fire Alarm and Signaling Code. **(4)** Upon loss of power to the hold-open device, the hold open mechanism is released and the door leaf becomes self-closing. **19.3.2 Protection from Hazards.** **19.3.2.1 Hazardous Areas.** Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. **19.3.2.1.1** An automatic extinguishing system, where used in hazardous areas, shall be permitted to be in accordance with 19.3.5.9. **19.3.2.1.2*** Where the sprinkler option of 19.3.2.1 is used, the areas shall be separated from other spaces by smoke partitions in accordance with Section 8.4. **19.3.2.1.3** The doors shall be self-closing or automatic-closing. **19.3.2.1.4** Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (1220 mm) above the bottom of the door. **19.3.2.1.5** Hazardous areas shall include, but shall not be restricted to, the following: **(1)** Boiler and fuel-fired heater rooms **(2)** Central/bulk laundries larger than 100 ft2 (9.3 m2) **(3)** Paint shops **(4)** Repair shops **(5)** Rooms with soiled linen in volume exceeding 64 gal (242 L) **(6)** Rooms with collected trash in volume exceeding 64 gal (242 L) **(7)** Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction **(8)** Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard **<u>Smoke Barriers and Sprinklers</u>** 2. Based on records reviews, observation, and interviews, the facility failed to properly maintain the sprinkler system. The deficient practice affected seven (7) of

	seven (7) smoke compartments in [LOCATION], 10 of 10 smoke compartments in [LOCATION], 11 of 11 smoke compartments in [LOCATION], staff, and all residents. The facility had a capacity for 341 beds with a census of 260 on the first day of the survey. The findings include: 1. Records review of the facility's sprinkler reports for the five (5) year period prior to the survey, on 1/24/24, at 10:46 a.m., revealed the facility failed to test by comparison with a calibrated gauge or replace the gauges on the sprinkler riser, as required by sections 5.3.2.1 and 5.3.2.2 of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. An interview, on 1/24/24, at 10:46 a.m., with Maintenance Staff A revealed the facility was not aware the sprinkler gauges were not replaced or tested. Observation during the building inspection tour, on 1/24/24, at 1:22 p.m., of the sprinkler riser located in the [LOCATION] in the [LOCATION] revealed the air and water pressure gauges on the dry pipe valve were dated 2015, and there was no indication that they had been replaced or calibrated. An interview, on 1/24/24, at 1:22 p.m., with Administrative Staff A revealed the facility was aware the sprinkler gauges were required to be replaced or tested. 2. Records review, on 1/24/24, at 10:47 a.m., of the fire sprinkler inspection reports for the three (3) years prior to the survey did not document when the last full trip test of the three (3) dry pipe sprinkler valves were conducted as required by section 13.4.4.2.2.2 of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. An interview with Maintenance Staff B, on 1/24/24, at 10:47 a.m., revealed that the facility was not certain that this had been conducted, and the facility was having difficulty with getting reports from the sprinkler testing contractor. 3. Records review, on 1/24/24, at 10:48 a.m., of the inspection, testing, and maintenance records for the facility's sprinkler system revealed there was no record of the five (5) year internal inspection of the system, as

	required by section 14.2 of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. An interview, on 1/24/24, at 10:48 a.m., with Maintenance Staff A revealed the facility was not aware of the five (5) year internal inspection of piping requirement, and there was no documentation to indicate it had ever been conducted. The census of 260 was verified by Administrative Staff A on 1/24/24, at 9:22 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 1/25/24, at 12:00 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.3.5 Extinguishment Requirements.** **19.3.5.1** Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, unless otherwise permitted by 19.3.5.5. **9.7.5 Maintenance and Testing**. All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. **9.7.6 Sprinkler System Impairments.** Sprinkler impairment procedures shall comply with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. **9.7.7 Documentation.** All required documentation regarding the design of the fire protection system and the procedures for maintenance, inspection, and testing of the fire protection system shall be maintained at an approved, secured location for the life of the fire protection system. **9.7.8 Record Keeping.** Testing and maintenance records required by NFPA25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, shall be maintained at an approved, secured location. **4.5.8 Maintenance.** Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained, unless the Code exempts such maintenance. **Actual NFPA Standard: NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011)**

	5.1.1.1 This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. **5.1.1.2** Table 5.1.1.2 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. **5.3 Testing.** **5.3.2* Gauges.** **5.3.2.1** Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. **5.3.2.2** Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. **13.4.4.2 Testing.** **13.4.4.2.2.2*** Every 3 years and whenever the system is altered, the dry pipe valve shall be trip tested with the control valve fully open and the quick-opening device, if provided, in service. **14.1*** General. This chapter shall provide the minimum requirements for conducting investigations of fire protection system piping for possible sources of materials that could cause pipe blockage. **14.2 Internal Inspection of Piping.** **14.2.1** Except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. **14.2.1.1** Alternative nondestructive examination methods shall be permitted. **14.2.1.2** Tubercules or slime, if found, shall be tested for indications of microbiologically influenced corrosion (MIC). **14.2.1.3*** If the presence of sufficient foreign organic or inorganic material is found to obstruct pipe or sprinklers, an obstruction investigation shall be conducted as described in Section 14.3. **14.2.1.4** Non-metallic pipe shall not be required to be inspected internally. **14.2.1.5** In dry pipe systems and pre-action systems, the sprinkler removed for inspection shall be from the most remote branch line from the source of water that is not equipped with the inspector's test valve. **<u>Building Services (Elevators, Escalators, Laundry Chutes, etc.)</u>** 3. Based on record review and interview, the facility failed to inspect and test the fire dampers installed throughout the facility. The deficient practice affected seven (7) of seven (7) smoke compartments in [LOCATION], 10 of 10 smoke compartments in [LOCATION], 11 of 11 smoke compartments in [LOCATION], staff, and all residents.

	The facility had a capacity for 341 beds with a census of 260 on the first day of the survey. The findings include: Records review of the facility's fire damper testing records for the four (4) year period prior to the survey, on 1/24/24, at 10:50 a.m., revealed that no documentation existed that demonstrated that the fire and smoke dampers located in [LOCATION] had testing and inspection performed within the last four (4) years, as required by section 19.4.1.1 of NFPA 80, Standard for Fire Doors and Other Opening Protectives. Additional records review, on 1/24/24, at 10:50 a.m., revealed that the smoke and fire dampers in [LOCATION] were last tested and inspected in 2017. No other documentation was maintained or made available for review. An interview with Maintenance Staff A on, 1/24/24, at 10:50 a.m., revealed that the facility was not aware if any additional fire and smoke damper testing and inspection had been completed for [LOCATION]. The census of 260 was verified by Administrative Staff A on 1/24/24, at 9:22 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 1/25/24, at 12:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.5.2.1** Heating, ventilating, and air-conditioning shall comply with the provisions of Section 9.2 and shall be installed in accordance with the manufacturer's specifications, unless otherwise modified by 19.5.2.2. **9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and Related Equipment.** Air-conditioning, heating, ventilating ductwork, and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, or NFPA 90B, Standard for the Installation of Warm Air Heating and Air-Conditioning Systems, as applicable, unless such installations are approved existing installations, which shall be permitted to be continued in service. **Actual NFPA Standard: NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems (2012)** **5.4.8 Maintenance.** **5.4.8.1** Fire dampers and ceiling dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. **Actual NFPA Standard: NFPA 80 Standard for Fire Doors and Other Opening Protectives (2010)**

	19.4* Periodic Inspection and Testing. **19.4.1** Each damper shall be tested and inspected 1 year after installation. **19.4.1.1** The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years. **19.4.2** All tests shall be completed in a safe manner by personnel wearing personal protective equipment. **19.4.3** Full unobstructed access to the fire or combination fire/smoke damper shall be verified and corrected as required. **19.4.4** If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in place if so equipped. **19.4.5** The operational test of the damper shall verify that there is no damper interference due to rusted, bent, misaligned, or damaged frame or blades, or defective hinges or other moving parts. **19.4.6** The damper frame shall not be penetrated by any foreign objects that would affect fire damper operations. **19.4.7** The damper shall not be blocked from closure in any way. **19.4.8** The fusible link shall be reinstalled after testing is complete. **19.4.8.1** If the link is damaged or painted, it shall be replaced with a link of the same size, temperature, and load rating. **19.4.9** All inspections and testing shall be documented, indicating the location of the fire damper or combination fire/smoke damper, date of inspection, name of inspector, and deficiencies discovered. **19.4.9.1** The documentation shall have a space to indicate when and how the deficiencies were corrected. **19.4.10** All documentation shall be maintained and made available for review by the AHJ. **Actual NFPA Standard: NFPA 105 Standard for Smoke Door Assemblies and Other Opening Protectives (2010)** **6.5 Periodic Inspection and Testing.** **6.5.1** Smoke dampers for dedicated and non-dedicated smoke control systems shall be inspected and tested in accordance with NFPA 92A, Standard for Smoke-Control Systems Utilizing Barriers and Pressure Differences. **6.5.2*** Each damper shall be tested and inspected one year after installation. The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years. **6.5.3** Care shall be exercised that all tests are completed in a safe manner wearing the appropriate personal protective equipment. **6.5.4** Full unobstructed access to the damper shall be verified and corrected as required.

	6.5.5 Where a fusible link is installed on a combination fire/smoke damper, the fusible link shall be removed for testing the damper for full closure simulating a fire condition per the requirements and frequencies of 19.5.4 of NFPA 80, Standard for Fire Doors and Other Opening Protectives. **6.5.6** The test shall be conducted with normal HVAC airflow. **6.5.7** The operation of the damper shall verify that there is no damper interference due to rust or bent, misaligned, or damaged frame or blades, or defective hinges or other moving parts. **6.5.8** The damper frame shall not be penetrated by any foreign objects that would affect proper fire damper operations. **6.5.9** The damper shall be verified to not be blocked from closure in any way. **6.5.10** The fusible link shall be reinstalled after testing is complete. If the link is damaged or painted, it shall be replaced with a link of the same size, temperature rating, and load rating. **6.5.11** All inspections and testing shall be documented indicating the location of the damper, date of inspection, name of inspector, and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. **6.5.12** All documentation shall be maintained by the property owner and available for review by the authority having jurisdiction. **Electrical Systems** 4. 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 seven (7) of seven (7) smoke compartments in [LOCATION], 10 of 10 smoke compartments in [LOCATION], 11 of 11 smoke compartments in [LOCATION], staff, and all residents. The facility had a capacity for 341 beds with a census of 260 on the first day of the survey. The findings include: Records review, on 1/24/24, at 11:43 a.m., revealed there was no documentation of testing of all PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. An interview with Maintenance Staff A, on 1/24/24, at 11:43 a.m., revealed the facility was not aware that the resident lift systems and the portable suction units were tested by a contractor. The facility was not aware if testing was done on any of the other PCREE in use at the facility.

	Observation during the building inspection tour, on 1/24/24, from 1:20 p.m., to 3:06 p.m., and on 1/25/24, from 9:06 a.m., to 10:30 a.m., revealed that the facility provided electric beds for all residents and that PCREE such as vital sign monitors, nebulizers, oxygen concentrators, portable suction units, concentrators, air pumps for air mattresses, and other medical equipment was present at the facility. An interview, on 1/24/24, at 3:00 p.m., with Administrative Staff A revealed they had been in the healthcare industry for 40 years and never heard of the PCREE requirements. The census of 260 was verified by Administrative Staff A on 1/24/24, at 9:22 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 1/25/24, at 12:00 p.m. **Actual NFPA Standard: NFPA 99, Health Care Facilities Code (2012)** **3.3.137 Patient-Care-Related Electrical Equipment.** Electrical equipment appliance that is intended to be used for diagnostic, therapeutic, or monitoring purposes in a patient care vicinity. **10.3 Testing Requirements — Fixed and Portable.** **10.3.1* Physical Integrity.** The physical integrity of the power cord assembly composed of the power cord, attachment plug, and cord-strain relief shall be confirmed by visual inspection. **10.3.2* Resistance.** **10.3.2.1** For appliances that are used in the patient care vicinity, the resistance between the appliance chassis, or any exposed conductive surface of the appliance, and the ground pin of the attachment plug shall be less than 0.50 ohm under the following conditions: **(1)** The cord shall be flexed at its connection to the attachment plug or connector. **(2)** The cord shall be flexed at its connection to the strain relief on the chassis. **10.3.2.2** The requirement of 10.3.2.1 shall not apply to accessible metal parts that achieve separation from main parts by double insulation or metallic screening or that are unlikely to become energized (e.g., escutcheons or nameplates, small screws). **10.3.3* Leakage Current Tests.** **10.3.3.1 General.** **10.3.3.1.1** The requirements in 10.3.3.2 through 10.3.3.4 shall apply to all tests.

	10.3.3.1.2 Tests shall be performed with the power switch ON and OFF. **10.3.3.2 Resistance Test**. The resistance tests of 10.3.3.3 shall be conducted before undertaking any leakage current measurements. **10.3.3.3*** Techniques of Measurement. The test shall not be made on the load side of an isolated power system or separable isolation transformer. **10.3.3.4* Leakage Current Limits.** The leakage current limits in 10.3.4 and 10.3.5 shall be followed. **10.3.4 Leakage Current — Fixed Equipment.** **10.3.4.1** Permanently wired appliances in the patient care vicinity shall be tested prior to installation while the equipment is temporarily insulated from ground. **10.3.4.2** The leakage current flowing through the ground conductor of the power supply connection to ground of permanently wired appliances installed in general or critical care areas shall not exceed 10.0 mA (ac or dc) with all grounds lifted. **10.3.5 Touch Current — Portable Equipment.** **10.3.5.1* Touch Current Limits.** The touch current for cord connected equipment shall not exceed 100 µA with the ground wire intact (if a ground wire is provided) with normal polarity and shall not exceed 500 µA with the ground wire disconnected. **10.3.5.2** If multiple devices are connected together and one power cord supplies power, the leakage current shall be measured as an assembly. **10.3.5.3** When multiple devices are connected together and more than one power cord supplies power, the devices shall be separated into groups according to their power supply cord, and the leakage current shall be measured independently for each group as an assembly. **10.3.5.4** Touch Leakage Test Procedure. Measurements shall be made using the circuit, as illustrated in Figure 10.3.5.4, with the appliance ground broken in two modes of appliance operation as follows: **(1)** Power plug connected normally with the appliance on **(2)** Power plug connected normally with the appliance off (if equipped with an on/off switch) **10.3.5.4.1** If the appliance has fixed redundant grounding (e.g., permanently fastened to the grounding system), the touch leakage current test shall be conducted with the redundant grounding intact. **10.3.5.4.2** Test shall be made with Switch A in Figure 10.3.5.4 closed. **10.3.6* Lead Leakage Current Tests and Limits — Portable Equipment.**

	10.3.6.1 The leakage current between all patient leads connected together and ground shall be measured with the power plug connected normally and the device on. **10.3.6.2** An acceptable test configuration shall be as illustrated in Figure 10.3.5.4. **10.3.6.3** The leakage current shall not exceed 100 µA for ground wire closed and 500 µA ac for ground wire open. **10.5.2.1 Testing Intervals.** **10.5.2.1.1** The facility shall establish policies and protocols for the type of test and intervals of testing for patient care–related electrical equipment. **10.5.2.1.2** All patient care–related electrical equipment used in patient care rooms shall be tested in accordance with 10.3.5.4 or 10.3.6 before being put into service for the first time and after any repair or modification that might have compromised electrical safety. **10.5.2.5* System Demonstration.** Any system consisting of several electric appliances shall be demonstrated to comply with this code as a complete system. **10.5.3 Servicing and Maintenance of Equipment.** **10.5.3.1** The manufacturer of the appliance shall furnish documents containing at least a technical description, instructions for use, and a means of contacting the manufacturer. **10.5.3.1.1** The documents specified in 10.5.3.1 shall include the following, where applicable: **(1)** Illustrations that show the location of controls **(2)** Explanation of the function of each control **(3)** Illustrations of proper connection to the patient or other equipment, or both **(4)** Step-by-step procedures for testing and proper use of the appliance **(5)** Safety considerations in use and servicing of the appliance **(6)** Precautions to be taken if the appliance is used on a patient simultaneously with other electric appliances **(7)** Schematics, wiring diagrams, mechanical layouts, parts lists, and other pertinent data for the appliance **(8)** Instructions for cleaning, disinfection, or sterilization **(9)** Utility supply requirements (electrical, gas, ventilation, heating, cooling, and so forth) **(10)** Explanation of figures, symbols, and abbreviations on the appliance **(11)** Technical performance specifications **(12)** Instructions for unpacking, inspection, installation, adjustment, and alignment **(13)** Preventive and corrective maintenance and repair procedures

	10.5.3.1.2 Service manuals, instructions, and procedures provided by the manufacturer shall be considered in the development of a program for maintenance of equipment. **10.5.6 Record Keeping — Patient Care Appliances.** **10.5.6.1 Instruction Manuals.** **10.5.6.1.1** A permanent file of instruction and maintenance manuals shall be maintained and be accessible. **10.5.6.1.2** The file of manuals shall be in the custody of the engineering group responsible for the maintenance of the appliance. **10.5.6.1.3** Duplicate instruction and maintenance manuals shall be available to the user. **10.5.6.1.4** Any safety labels and condensed operating instructions on an appliance shall be maintained in legible condition. **10.5.6.2* Documentation.** **10.5.6.2.1** A record shall be maintained of the tests required by this chapter and associated repairs or modifications. **10.5.6.2.2** At a minimum, the record shall contain all of the following: **(1)** Date **(2)** Unique identification of the equipment tested **(3)** Indication of which items have met or have failed to meet the performance requirements of 10.5.6.2 **10.5.6.3 Test Logs.** A log of test results and repairs shall be maintained and kept for a period of time in accordance with a health care facility's record retention policy. **10.5.8 Qualification and Training of Personnel.** **10.5.8.1*** Personnel concerned for the application or maintenance of electric appliances shall be trained on the risks associated with their use. **10.5.8.1.1** The health care facilities shall provide programs of continuing education for its personnel. **10.5.8.1.2** Continuing education programs shall include periodic review of manufacturers' safety guidelines and usage requirements for electrosurgical units and similar appliances. **10.5.8.2** Personnel involved in the use of energy-delivering devices including, but not limited to, electrosurgical, surgical laser, and fiberoptic devices shall receive periodic training in fire suppression. **10.5.8.3** Equipment shall be serviced by qualified personnel only.
§51.200 (b) Emergency power. (1) An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of	Based on records review and interview, the facility failed to properly inspect and test all components of the emergency generator. The deficient practice affected seven (7) of seven (7) smoke compartments in [LOCATION], 10 of 10 smoke compartments in [LOCATION], 11 of 11 smoke compartments in

egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination. (2) The system must be the appropriate type essential electrical system in accordance with the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. (3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Health Care Facilities Code. (4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	[LOCATION], staff, and all residents. The facility had a capacity for 341 beds with a census of 260 on the first day of the survey. The findings include: 1. Records review, on 1/24/24, at 11:55 a.m., of the monthly emergency generator inspection and testing records dating back 12 months prior to the survey revealed there was no documentation of monthly specific gravity testing or conductance testing for the lead-acid batteries, as required by section 8.3.7.1 of NFPA 110, Standard for Emergency and Standby Power Systems. An interview, on 1/24/24, at 11:55 a.m., with Maintenance Staff A confirmed the batteries on the generator were lead-acid and revealed the facility was aware of the monthly generator battery testing requirements for generator batteries. The facility had just purchased the equipment to complete the monthly testing. 2. Records review, on 1/24/24, at 1:10 p.m., of the inspection and testing documentation for the emergency generator dating back 12 months prior to the survey indicated there was no documentation that the facility generator had been tested on load every month, as required by sections 8.3.4, 8.4.2, and 8.4.2.3 of NFPA 110, Standard for Emergency 1/24/24 at 1:10 p.m. indicated monthly load testing was not documented or available for review for February, 2023. An interview, on 1/24/24, at 1:10 p.m., with Maintenance Staff A revealed the facility was aware that the generators were not tested on load in February, 2023. The census of 260 was verified by Administrative Staff A on 1/24/24, at 9:22 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 1/25/24, at 12:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.5 Building Services.** **19.5.1 Utilities.** **19.5.1.1** Utilities shall comply with the provisions of Section 9.1. **9.1.3 Emergency Generators and Standby Power Systems.** Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2.

	9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. **Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems (2010)** **8.3.7.1** Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. **8.3.4** A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. **8.3.4.1** The permanent record shall include the following: **(1)** The date of the maintenance report **(2)** Identification of the servicing personnel **(3)** Notation of any unsatisfactory condition and the corrective action taken, including parts replaced **(4)** Testing of any repair for the time as recommended by the manufacturer **8.4 Operational Inspection and Testing.** **8.4.1*** EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. **8.4.1.1** If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, providing the same record as required by 8.3.4. **8.4.2*** Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating **8.4.2.1** The date and time of day for required testing shall be decided by the owner, based on facility operations. **8.4.2.2** Equivalent loads used for testing shall be automatically replaced with the emergency loads in case of failure of the primary source. **8.4.2.3** Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate KW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours.

§ 51.210 (g) Staff qualifications. (1) The facility management must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. (2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Many	Based on interviews and record review, the facility failed to ensure the Veterans Administration VA 10-3567 Staffing Profile form was completed to accurately reflect the professional staff employed necessary to carry out the provisions of these requirements. The findings include: On 1/22/24 at approximately 9:40 a.m., after the entrance conference with facility staff, Administrative Staff A and Administrative Nurse A were sent the five (5) required Veteran Administration (VA) forms for completion. On 1/23/24 at 9:15 a.m., the facility emailed the VA 10-3567 Staffing Profile form to the survey team. The form was reviewed and there were several areas of concern. The facility had issues completing Part II. Consultant Staff A in Part II for Nursing Home Care (NHC) indicated zero (0). Consultant Staff B in Part II for NHC indicated zero (0). Consultant Staff C II for NHC indicated zero (0). The facility was informed these areas should not indicate zero (0). The staff stated they would get additional information to complete the form. On 1/24/24 at approximately 11:44 a.m., Administrative Nurse A explained that the dental section was zero (0) because they were not considered staff. Administrative Nurse A was informed that areas could not indicate zero (0) and that the facility had an in-house pharmacy. On 1/25/24 at approximately 12:45 p.m., the areas of concern were presented to the facility staff.
§ 51.210 (h) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section. (2) Agreements pertaining to services furnished by outside resources must	Based on interview and record review, the facility's management failed to obtain a sharing agreement that governed mental health services provided to 54 of 260 residents by the Veterans Administration Medical Center (VAMC). The findings include: An inquiry was made, on 1/22/24, at approximately 9:24 a.m., regarding the number of residents who received mental health services and whether there was a sharing agreement in place. The facility provided a document labeled as a sharing agreement. Review of document provided by the facility revealed that it was not signed and was not approved by the

specify in writing that the facility management assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. (3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed services and will notify the veteran or the authorized representative of the veteran. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Veterans Administration to provide mental health services for the residents. During an interview, on 1/25/24, at approximately 11:50 a.m., Administrative Staff A confirmed that the document presented as the sharing agreement was unsigned, and dated to start in February, 2024. Administrative Staff A reported that this unsigned, future dated document was what they used.