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: Clyde E. Lassen State Veterans' Nursing Home

Location: 4650 State Road 16 St. Augustine, FL 32092

Onsite / Virtual: Onsite

Dates of Survey: 12/5/23 – 12/8/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 120

Census on First Day of Survey: 117

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from December 5, 2023, through December 8, 2023, at the Clyde E. Lassen State Veterans' Nursing Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.43 (a) (1)-(2) Drugs and medicines for certain veterans (a) In addition to the per diem payments under §51.40 of this part, the Secretary will furnish drugs and medicines to a State home as may be ordered by prescription of a duly licensed physician as specific therapy in the treatment of illness or injury for a veteran receiving nursing home care in a State home if— (1) The veteran: (i) Has a singular or combined rating of less than 50 percent based on one or more service-connected disabilities and needs the drugs and medicines for a service-connected disability; and	The facility was unable to demonstrate they received only drugs and medicines for Residents who were eligible to receive such medications. Based on record review, one (1) of four (4) sampled Residents was ineligible to have all medications furnished by the VA. One (1) of the four (4) sampled residents was eligible to receive medications only for those service-connected disabilities that were at a singular or combined rating of less than 50 percent. The facility confirmed after clinical review, only one (1) of the medications obtained was for the resident's service-connected disability. The facility confirmed the resident was receiving all medications from the VA Medical Center (VAMC) of jurisdiction. The facility did not pay for medications received for this ineligible Resident. In interview with the facility Administrative Staff A and Administrative Staff B on December 11, 2023, it was identified that the facility failed to ensure only eligible Residents received medications from the VAMC of jurisdiction.

(ii) Needs nursing home care for reasons that do not include care for a VA adjudicated service-connected disability; or (2) The veteran: (i) Has a singular or combined rating of 50 or 60 percent based on one or more service-connected disabilities and needs the drugs and medicines; and (ii) Needs nursing home care for reasons that do not include care for a VA adjudicated service-connected disability. **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Few	
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care. **Level of Harm** – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to implement interventions to prevent weight loss in accordance with each resident's plan of care for one (1) of two (2) residents reviewed for nutrition from a total of 23 residents sampled. The findings include: Cross Reference to § 51.120 (j) Nutrition. A review of Resident #3's medical record revealed an initial admission date of [DATE]. Resident #3's medical history included Excessive Weight Loss. A Quarterly Minimum Data Set (MDS) assessment, dated [DATE], revealed a Brief Interview for Mental Status score of two (2) out of a total 15 possible points, indicating severe cognitive impairment. The assessment identified Resident #3's weight as 121 pounds and identified that Resident #3 had suffered weight loss. Review of Resident #3's comprehensive Care Plan revealed a focus area for nutrition. An intervention, dated [DATE], directed staff to provide double portions of all meals. A review of Resident #3's weight history revealed a documented weight of 142.8 pounds on [DATE], and 122.1 pounds on [DATE], which equated to a 14.4% weight loss over a six (6) month period. On 12/6/23, at 11:41 a.m., an observation of Resident #3's lunch meal was conducted. Resident #3 was observed sitting in

	a Broda chair at a [LOCATION] table in [LOCATION]. On 12/6/23, at 11:57 a.m., Dietary Staff A prepared Resident #3's lunch on a divided plate. The meal consisted of mashed potatoes with gravy, pureed lasagna with meat sauce, and pureed carrots. Dietary Staff A was observed placing one (1) scoop of mashed potatoes, one (1) scoop of pureed carrots, and one and one-half (1 ½) scoops of pureed lasagna with meat sauce on Resident #3's plate. On 12/6/23, at 12:00 p.m., Resident #3's meal ticket was reviewed. Located at the top of the meal ticket was a statement in bolded red print which read: "HIGH RISK/DOUBLE PORTIONS ALL MEALS." On 12/7/23, at 11:58 a.m., an observation of Resident #3's lunch meal was conducted. The meal consisted of pureed chicken tenders, pureed baked beans, and pureed carrots. Dietary Staff A prepared Resident #3's lunch by placing one and one-half (1 ½) scoops of chicken, one (1) scoop of baked beans, and one (1) scoop of carrots onto a divided plate. During an interview with Dietary Staff A, on 12/7/23, at approximately 12:20 p.m., Dietary Staff A stated they provided Resident #3 with two (2) scoops of each food item while preparing their lunch meal. During an interview with Dietary Staff B, on 12/7/23, at 2:00 p.m., they confirmed that Resident #3 was ordered to receive double portions at all meals to slow or stop Resident #3's continued weight loss. On 12/7/23, at 3:00 p.m., the facility's recorded camera footage of [LOCATION'S] lunch meal service, on 12/27/23, was reviewed with Administrative Staff A, and confirmed that Dietary Staff A provided one (1) scoop of baked beans, one (1) scoop of carrots, and one and one-half (1 ½) scoops of chicken tenders on Resident #3's plate.
§ 51.120 (j) Nutrition. Based on a resident's comprehensive assessment, the facility management must ensure that a resident— (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when a nutritional deficiency is identified	Based on observations, interviews, and record review, the facility failed to ensure residents maintained acceptable nutritional parameters (body weight) by failing to provide double portion sizes at meals for one (1) of two (2) residents reviewed for nutrition from a total of 23 residents sampled. The findings include: Cross Reference to § 51.110 (e) (3) Comprehensive care plans. A review of Resident #3's medical record revealed an initial admission date of [DATE]. Resident #3's medical history included Excessive Weight Loss. A Quarterly Minimum Data

Level of Harm – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	Set (MDS) assessment, dated [DATE], revealed a Brief Interview for Mental Status score of two (2) out of a total 15 possible points, indicating severe cognitive impairment. The assessment identified Resident #3's weight as 121 pounds and identified that Resident #3 has suffered weight loss. A review of Resident #3's weight history revealed a documented weight of 142.8 pounds on [DATE], and 122.1 pounds on [DATE], which equated to a 14.4% weight loss over a six (6) month period. On 12/6/23, at 11:41 a.m., an observation of Resident #3's lunch meal was conducted. Resident #3 was observed sitting in a Broda chair at a [LOCATION] table on [LOCATION]. On 12/6/23, at 11:57 a.m., Dietary Staff A prepared Resident #3's lunch on a divided plate. The meal consisted of mashed potatoes with gravy, pureed lasagna with meat sauce, and pureed carrots. Dietary Staff A was observed placing one (1) scoop of mashed potatoes, one (1) scoop of pureed carrots, and one and one-half (1 ½) scoops of pureed lasagna with meat sauce on Resident #3's plate. After placing Resident #3's plate on the table, Certified Nurse Aide A assisted Resident #3 with eating. Resident #3 ate 100% of all the food items on their plate. On 12/6/23, at 12:00 p.m., Resident #3's meal ticket was reviewed. Located at the top of the meal ticket was a statement in bolded red print which read: "HIGH RISK/DOUBLE PORTIONS ALL MEALS." On 12/6/23, at 12:20 p.m., an interview was attempted with Resident #3. They were a poor historian, but when asked whether their lunch was good, Resident #3 responded, "Yes!" When asked whether they would like more to eat, Resident #3 responded, "Yea!" Review of Resident #3's comprehensive Care Plan revealed a focus area for nutrition. An intervention, dated [DATE], directed staff to provide double portions of all meals. Continued review of Resident #3's medical record revealed a Physician Order, dated [DATE], which directed staff to provide Resident #3 with double portions at all meals. Additionally, Resident #3 had an order for a liquid Megestrol suspension to be administered daily to stimulate their appetite. On 12/7/23, at 11:58 a.m., an observation of Resident #3's lunch meal was conducted. The meal consisted of pureed chicken tenders, pureed baked beans, and pureed carrots. Dietary Staff A prepared Resident #3's lunch by placing one and

	one-half scoops of chicken, one scoop of baked beans, and one scoop of carrots onto a divided plate. On 12/7/23, at approximately 12:20 p.m., an interview was conducted with Dietary Staff A. When asked whether they were familiar with Resident #3, Dietary Staff A stated, "Yes. [They get] double protein portions at all meals." When asked how they knew each resident's diet orders, Dietary Staff A stated, "Everybody has a meal ticket that we use to prepare the food." When asked how much of each food item Resident #3 received for lunch, Dietary Staff A stated they gave Resident #3 two scoops of each food item. On 12/7/23, at 2:00 p.m., an interview was conducted with Dietary Staff B. They confirmed that they were familiar with Resident #3 and added, "I believe we are following weekly weights on that resident due to weight loss." Dietary Staff B explained that the lunch meal, on 12/7/23, was pureed chicken tenders, pureed baked beans, and pureed carrots. When asked about the facility's processes for double meal portions, Dietary Staff B stated, "If the resident is ordered double portions, they would receive two (2) scoops of each of the served items." Dietary Staff B then confirmed that Resident #3 was ordered to have double portions at all meals and acknowledged that the intervention was in place to slow or stop Resident #3's continued weight loss. When asked whether they had ever watched Dietary Staff A prepare Resident #3's meals, Dietary Staff B responded that they had not. Dietary Staff B then clarified that they conducted monthly audits of food distribution at the point of service, but did not have any documentation of the audit findings. Dietary Staff B also stated they were not aware of any concerns with Dietary Staff A meal serving processes. When asked whether any training or in-servicing had been conducted with Dietary Staff A, Dietary Staff B stated, "No, not lately," and they were unable to recall the last time training or in-servicing had been conducted. On 12/7/23, at 3:00 p.m., the facility's recorded camera footage of [LOCATION'S] lunch meal service, on 12/27/23, was reviewed with Administrative Staff A and confirmed that Dietary Staff A provided one scoop of baked beans, one scoop of carrots, and one and one-half scoops of chicken tenders on Resident #3's plate.
§ 51.120 (n) Medication Errors. The facility management must ensure that— (1) Medication errors are identified and reviewed on a timely basis; and	Based on observations, interviews, and record review, the facility failed to ensure that strategies for preventing medication errors were implemented by failing to 1) Ensure injectable insulin was prepared in a safe manner and 2) Administer injectable insulin according to the Physician Orders for one (1) of five (5) residents reviewed for medication administration from a total of 23 residents sampled (Resident #7).

(2) strategies for preventing medication errors and adverse reactions are implemented. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	The findings include: Cross Reference to § 51.180 (a) Procedures. A review of Resident #7's medical record revealed an admission date of [DATE]. Resident #7's medical history included Alzheimer's Disease and Diabetes. Resident #7 required staff assistance with Activities of Daily Living and medication administration. On 12/7/23, at 11:35 a.m., Licensed Nurse A was observed sitting at the [LOCATION] with a wireless earbud in their left ear. Licensed Nurse A was actively engaged in a conversation while simultaneously preparing an insulin injection. After drawing up the insulin into the syringe, Licensed Nurse A recapped the syringe and placed it back into the disposable packaging. Licensed Nurse A then wrote "338" on the packaging with a black marker. Licensed Nurse A placed the syringe back into the top right drawer of the medication cart. While continuing to hold a conversation, Licensed Nurse A began preparing a second insulin injection. After preparing the second injection, Licensed Nurse A recapped the syringe, placed it back into the packaging, and then into the top right drawer of the medication cart. Licensed Nurse A then left the cart and walked out onto the [LOCATION]. A review of Resident #7's [DATE], Medication Administration Records, on 12/7/23, at 12:23 p.m., revealed that Licensed Nurse A documented the administration of Novolog 3 units subcutaneously for the scheduled 11:30 a.m., administration. Additionally, Licensed Nurse A documented the administration of 2 units of Novolog insulin (sliding scale) into Resident #7's abdomen for the 11:30 a.m., administration time. On 12/7/23, at 1:50 p.m., an interview was conducted with Licensed Nurse A regarding Resident #7's insulin administration. Licensed Nurse A stated, "Yes, I'm going to give it to [them] right now. I know I already signed it off in the MAR. I'm sorry about that." Licensed Nurse A confirmed that the insulin injections were ordered to be administered at 11:30 a.m. Licensed Nurse A then removed the two insulin injections that they had prepared at 11:35 a.m., from the medication cart, carried them to Resident #7's room, and administered both insulin injections. Licensed Nurse A did not reassess Resident #7's blood glucose or contact the Medical Provider prior to administering the insulin injections. On 12/7/23, at approximately 3:45 p.m., an interview was conducted with Administrative Nurse A. They explained that Licensed Nurse A was employed by a nurse staffing agency and

	that this would "likely be the last time they worked in the facility." Administrative Nurse A confirmed that licensed nurses should minimize disruptions during the preparation of medications, and that medications should be administered at the times ordered by the Medical Provider.
§ 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 observations, interviews, and review of the facility policy, the facility staff failed to store and prepare food under sanitary conditions. This affected 117 residents who received meals from the [LOCATION]. The findings include: Review of the facility policy titled, "Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices," last revised 11/27/17, revealed: "II. Procedures…6. Employees must wash their hands: …f. After handling soiled equipment and utensils;…8. Contact between ready-to-eat-food and bare (ungloved) hands is prohibited." Review of the undated facility policy titled, "Safe Food Holding Temperatures," revealed: "II. Procedures- Holding Cold Foods… For salad bars and display units, set the food containers in ice to keep them cold…Keep a cover on foods held in cold holding units to help maintain temperatures when not serving…Use a clean, sanitized thermometer to check the temperature of foods." Review of the facility policy titled, "Food Receiving and Storage," last revised 11/27/17, revealed: "II. Procedures…d. Beverages must be dated when opened and discarded after twenty-four (24) hours." Observations of the [LOCATION], on 12/5/23, at 11:20 a.m., revealed Dietary Staff A was asked to record temperatures of the hot holding foods on the steam table. Prior to taking temperatures of the first item, Dietary Staff A did not sanitize the thermometer. During an interview with Dietary Staff A, on 12/5/23, at 11:22 a.m., Dietary Staff A revealed they did not sanitize the thermometer; however, they assumed the last person to use it sanitized it after use. Dietary Staff A continued to record temperatures of the remaining items on the steam table. Dietary Staff A hands were visibly soiled while taking temperatures of the starch (mashed potatoes). In the presence of the surveyor, Dietary Staff B, Dietary Staff C, and Dietary Staff A continued to temp the mashed potatoes with their opposite hand. Dietary Staff A was observed wiping their hand on their shirt. Dietary Staff A did not wear gloves while recording the temperatures of the foods on the steam table. At this time, the surveyor stopped Dietary Staff A and asked was their hand soiled, and Dietary Staff A stated, "oh yeah." Dietary

	Staff B immediately stopped Dietary Staff A and instructed them to wash their hands. During an interview with Dietary Staff B, on 12/5/23, at 11:35 a.m., they stated Dietary Staff A should have worn gloves while recording the temperatures of ready to eat foods. Dietary Staff B further stated, when Dietary Staff A hands became visibly soiled with food particles, they should have stopped and washed their hands. Dietary Staff B stated they needed to provide all dietary staff with an immediate in-service. Dietary Staff B did not provide any previous in-service provided to dietary staff on proper procedures of recording temperatures. Observations of the [LOCATION], on 12/5/23, at 11:00 a.m., and 12/6/23, at 10:30 a.m., revealed several unlabeled pitchers of beverages. Dietary Staff B confirmed the pitchers contained lemonade, unsweetened tea, and sweetened tea. During an interview with Dietary Staff B, on 12/7/23, at 2:17 p.m., they stated they expected staff to follow the facility's storage and labeling procedures when labeling and dating all beverages in the walk-in refrigerator. Observation of the [LOCATION], on 12/6/23, at 10:45 a.m., revealed six (6) small salad bowls uncovered on the preparation (prep) table. Dietary staff were not observed prepping the salads. Dietary Staff B confirmed the dietary staff (Dietary Staff D) was washing dishes at this time and should have covered the salads before attending to another tasks. At 10:48 a.m., Dietary Staff D began to prepare the remaining salads for meal service. Dietary Staff D started by peeling several cucumbers. During this time, Dietary Staff D removed the baking sheet cover that was placed by Dietary Staff B, and continued to peel the cucumbers. Once Dietary Staff D finished peeling the cucumbers, Dietary Staff D and Dietary Staff E began to dice the cucumbers. 12 uncovered salads with lettuce and carrots were observed on the preparation table. Dietary Staff D and Dietary Staff E finished dicing the cucumbers and left the salads uncovered and unrefrigerated. Dietary Staff D and Dietary Staff E began to dice several tomatoes. While the salads remained uncovered and unrefrigerated, both cooks placed the left-over diced cucumbers and tomatoes in clear plastic containers. At 11:24 a.m., Dietary Staff D and Dietary Staff E began to assemble the uncovered salads with cucumbers and tomatoes. Once the salads were finished, each salad was labeled/dated and placed into the reach-in refrigerator. During an interview with Dietary Staff B, on 12/7/23, at 2:20 p.m., they stated they expected staff to cover all foods if they have other tasks to attend to. Dietary Staff B stated the salads that were observed sitting out uncovered on the preparation table should not have been assembled until the dietary staff finished with peeling/dicing cucumbers and cutting the

	tomatoes. Dietary Staff B stated they could not believe the staff did that, and they would have to conduct an immediate in-service with dietary staff.
§ 51.180 (a) Procedures. (a) Procedures. The facility management must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to ensure that strategies for preventing medication errors were implemented by failing to 1) Ensure injectable insulin was prepared in a safe manner and 2) Administer injectable insulin according to the physician's orders for one (1) of five (5) residents reviewed for medication administration from a total of 23 residents sampled (Resident #7). The findings include: Cross Reference to § 51.120 (n) Medication Errors. A review of Resident #7's medical record revealed an admission date of [DATE]. Resident #7's medical history included Alzheimer's Disease and Diabetes. Resident #7 required staff assistance with Activities of Daily Living and medication administration. On 12/7/23, at 11:35 a.m., Licensed Nurse A was observed sitting at the nurse's station with a wireless earbud in their left ear. Licensed Nurse A was actively engaged in a conversation while simultaneously preparing an insulin injection. After drawing up the insulin into the syringe, Licensed Nurse A recapped the syringe and placed it back into the disposable packaging. Licensed Nurse A then wrote "338" on the packaging with a black marker. Licensed Nurse A placed the syringe back into the top right drawer of the medication cart. While continuing to hold a conversation, Licensed Nurse A began preparing a second insulin injection. After preparing the second injection, Licensed Nurse A recapped the syringe, placed it back into the packaging, and then into the top right drawer of the medication cart. Licensed Nurse A then left the cart and walked out onto the [LOCATION]. A review of Resident #7's [DATE], Medication Administration Records, on 12/7/23, at 12:23 p.m., revealed that Licensed Nurse A documented the administration of Novolog 3 units subcutaneously for the scheduled 11:30 a.m., administration. Additionally, Licensed Nurse A documented the administration of 2 units of Novolog insulin (sliding scale) into Resident #7's abdomen for the 11:30 a.m., administration time. On 12/7/23, at 1:50 p.m., an interview was conducted with Licensed Nurse A regarding Resident #7's insulin administration. Licensed Nurse A stated, "Yes, I'm going to give it to [them] right now. I know I already signed it off in the MAR. I'm sorry about that." Licensed Nurse A confirmed that the

	insulin injections were ordered to be administered at 11:30 a.m. Licensed Nurse A then removed the two insulin injections that they had prepared at 11:35 a.m., from the medication cart, carried them to Resident #7's room, and administered both insulin injections. Licensed Nurse A did not reassess Resident #7's blood glucose or contact the Medical Provider prior to administering the insulin injections. On 12/7/23, at approximately 3:45 p.m., an interview was conducted with Administrative Nurse A. They explained that Licensed Nurse A was employed by a nurse staffing agency and that this would "likely be the last time [they] worked in the facility." Administrative Nurse A confirmed that licensed nurses should minimize disruptions during the preparation of medications, and that medications should be administered at the times ordered by the Medical Provider.
§ 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** – Many	**Fire Safety and Operations** 1. Based on records review and interview, the facility failed to conduct all required fire drills. The deficient practice affected six (6) of six (6) smoke compartments, staff, and all residents. The facility had a capacity for 120 beds with a census of 117 on the first day of the survey. The findings include: Records review of the fire drill reports from the 12 months preceding the survey revealed the facility conducted the 6/28/23, day shift fire drill without sounding the facility fire alarm, as required by section 19.7.1.4 of NFPA 101, Life Safety Code. Additional record review revealed that the fire drill was conducted at 7:50 a.m., and no other fire drills were conducted during this shift in this quarter. Additional records review, on 12/7/23, at 12:11 p.m., of the Fire Watch documentation, revealed that a Fire Watch was in place at the facility from 5/30/23, through 6/20/23. An interview with Maintenance Staff A, on12/7/23, at 12:10 p.m., revealed the facility was aware that fire drills after 6:00 a.m., and before 9:00 p.m., required the use of the fire alarm or audible alarms. The facility did not sound the fire alarm during this fire drill because the fire alarm was not working properly. A fire watch was in place at the time of the fire drill. An interview with Administrative Staff A, on 12/7/23, at 4:05 p.m., revealed the facility was aware that the facility fire alarm was required to be used during fire drills during the first shift hours. The fire alarm was not used during this drill because the fire alarm was sounding often during this period, and residents were agitated when the alarm sounded.

The census of 117 was verified by Administrative Staff A on 12/7/23, at 12:10 p.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 12/8/23, at 1:15 p.m.

Actual NFPA Standard: NFPA 101 (2012) Life Safety Code
19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.
19.7.1.5 Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.
19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.
19.7.1.7 When drills are conducted between 9:00 p.m. and 6:00 a.m. (2100 hours and 0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.

Electrical Systems

2. Based on record reviews and interviews, the facility failed to test the electrical receptacles in patient bed locations. The deficient practice affected five (5) of six (6) smoke compartments, staff, and 75 residents. The facility had a capacity for 120 beds with a census of 117 on the first day of the survey.

The findings include:

Record review, on 12/7/23, at 11:32 a.m., of the receptacle testing logs revealed hospital grade electrical receptacles located in patient bed locations did not have initial installation physical integrity, continuity, polarity, or retention testing documentation, as required by section 6.3.4.1.1 and 6.3.4.1.2 of NFPA 99, Health Care Facilities Code. Additional records review revealed that 53 electrical receptacles were listed as failed testing on 8/4/23, and were replaced on 8/15/23.

An interview with Maintenance Staff A, on 12/7/23, at 11:32 a.m., revealed hospital grade receptacles were provided at the facility at all patient bed locations. The facility was not aware that when they replaced failed, hospital grade receptacles after testing with new, hospital grade ones, that they were required to conduct and document initial installation testing of those hospital grade receptacles.

	The census of 117 was verified by Administrative Staff A on 12/7/23, at 12:10 p.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 12/8/23, at 1:15 p.m. **Actual NFPA Standard NFPA 99, Health Care Facilities Code (2012)** **3.3.136 Patient Bed Location.** The location of a patient sleeping bed, or the bed or procedure table of a critical care area. **3.3.138 * Patient Care Room.** Any room of a health care facility wherein patients are intended to be examined or treated. **6.3.3.2 Receptacle Testing in Patient Care Rooms** **6.3.3.2.1** The physical integrity of each receptacle shall be confirmed by visual inspection. **6.3.3.2.2** The continuity of the grounding circuit in each electrical receptacle shall be verified. **6.3.3.2.3** Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. **6.3.3.2.4** The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz). **6.3.4.1 Maintenance and Testing of Electrical System.** **6.3.4.1.1** Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. **6.3.4.2 Record Keeping.** **6.3.4.2.1*** General. **6.3.4.2.1.1** A record shall be maintained of the tests required by this chapter and associated repairs or modification. **6.3.4.2.1.2** At a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter.