Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: D.J. Jacobetti Home for Veterans

Location: 425 Fisher Street, Marquette, MI 49855

Onsite / Virtual: Onsite

Dates of Survey: 5/13/25 – 5/16/25

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 126

Census on First Day of Survey: 101

Surveyed By: Wylona Coleman, RN; Renee Cannon, RN; Susan De Sessa, DrPH, CIC, CPH; Nadia Kinsel, Generalist; Nathan Johns (LSC); Cicely Robinson, VACO.

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from May 13, 2025 through May 16, 2025 at the D. J. Jacobetti Home for Veterans. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.70 (c) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows. **Rating** – Not Met **Scope and Severity** – E **Residents Affected** – Some	Based on interview and record review, the facility failed to conduct a timely final accounting upon the death of residents with funds deposited in a trust account for two (2) of five (5) sampled resident trust accounts (Residents #20 and #21). The findings include: Review of the facility policy number 3.2.001 titled, “Member Trust v4,” with an effective date of 4/13/21, and a revision date of 3/5/24, revealed: “Policy. The Michigan Veteran Homes will hold, safeguard, manage, and account for the personal funds of Members when authorization is granted to do so in writing by the Member, guardian, conservator, POA, or other legally responsible person. This policy provides Members easy access to their personal funds, for their personal needs and usage, helps safeguard Member assets, and ensures compliance with regulations. MVH has no financial interest in the trust and Members are not obligated to open a personal trust account with the Home and maintain their right to receive, retain, and

	manage their own finances, or to have this done by someone they appoint. GUIDELINES Policy Interpretation 1. Member funds will be deposited into an account at PNC bank and safeguarded in a separate, interest-bearing account from the Home's operational account(s)…10. Closing of Accounts…c. For deceased Members, the funds will be provided within [seven] 7 business days, and a final written accounting of the Member's account will be provided within 10 business days of expiration to the individual administering the Member's estate, or if none were appointed, the appropriate next of kin, designated individual, or Probate Court. i. ii. All funds will be distributed to the estate of the deceased." Record review revealed Resident #20 was admitted on 6/27/24, and became deceased on 10/6/24. The account balance on 10/1/24, was $100.45. The account balance reflecting closing interest of $0.04 on 10/7/24, and was $100.49. Check number 2342 was issued to "The Estate of [Resident #20]" on 10/7/24, in the amount of $100.49. Further review of facility documentation showed a certified letter was mailed to Resident #20's responsible party on 3/7/25, and review of the facility's accounting records system showed check number 2342 for $100.49 remained uncashed as of 5/14/25; 220 days following the resident's death. Record review revealed Resident #21 was admitted on 4/8/24, and became deceased on 9/2/24. The account balance on 9/3/24, was $197.95. The account balance reflecting closing interest of $0.06 on 9/4/24, was $198.01. Check number 2319 was issued to "The Estate of [Resident #21]" on 9/5/24, in the amount of $198.01. Further review of facility documentation showed a letter was mailed to Resident #21's responsible party on 5/6/25, and review of the facility's accounting records system showed check number 2319 for $198.01 remained uncashed as of 5/14/25; 254 days following the resident's death. In an interview with Business Manager (BSM) E, on 5/14/25, at 1:54 p.m., he/she said that resident accounts were zeroed out, and the funds "go to the petty cash account" until the checks were cashed. In an interview with the Administrator, on 5/14/25, at 3:55 p.m., he/she acknowledged resident funds should be conveyed within 90 days of a resident's death.
§ 51.190 (b) Preventing spread of infection. (1) When the infection control program determines that a resident needs isolation to prevent the spread of	Based on observations, interviews, record review, and review of facility policies, facility staff failed to prevent the spread of infection by failing to: 1.) utilize proper personal protective equipment (PPE) for one (1) resident of one (1) residents on droplet isolation (Resident #9); and 2.) require staff to wash their hands when indicated by accepted professional practice for two

infection, the facility management must isolate the resident. (2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease. (3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. **Rating** – Not Met **Scope and Severity** – E **Residents Affected** – Some	(2) of five (5) dining rooms observed (Memory Care and 2 North). The findings include: 1. Review of the facility's policy titled, "Transmission-Based Precautions v5," reviewed 2/20/25, revealed that an order for transmission-based precautions/isolation would specify the type of precaution and reason for the transmission-based precaution. It further directed staff that signage would include instructions for use of specific PPE and would be placed in a conspicuous location outside the resident's room, wing, or home wide. Additionally, either the Centers for Disease Control and Prevention (CDC) category of transmission-based precautions (e.g., contact, droplet, or airborne) or instructions to see the nurse before entering would be included in the signage. Resident #9 was admitted to the facility on 1/21/09, with diagnoses that included History of Latent Tuberculosis, Acute Sinusitis, and Allergic Rhinitis. Review of Resident #9's clinical record revealed an order that was created 5/9/25, for Resident #9 to be placed in droplet precautions due to cough and congestion. The order further directed staff to place a droplet precaution sign on the door, keep the door closed at all times, place a yellow cart with masks, gowns, gloves, and goggles/shields outside of the door to the room. It further directed staff to place a donning ("what is donning") sign (a sign to show how to put on PPE) above the PPE cart. On 5/14/25, at 8:33 a.m., during medication administration observation of Licensed Practical Nurse (LPN) A for Resident #9, it was noted the resident was on droplet precautions, as indicated by a sign posted outside the door. LPN A donned a gown and face shield prior to entering the room, and applied gloves once inside. However, a mask was not donned at any point during the interaction. On 5/14/25, at 10:24 a.m., during an observation outside of Resident #9's room, it was observed that the PPE cart contained face shields and gowns, but surgical masks were outside of the room resting on the hand railing. The door to the room was open, and there was a sign on the door that stated: "Droplet Precautions," and "PRIOR TO ENTERING: wash or gel hands, Wear mask, and Wear eye protection (examples of face shield or goggles listed below)." [sic] On 5/14/25, at 11:25 a.m., an interview was conducted with LPN A. When asked about mask use for residents on droplet precautions, they stated: "100% a mask should have been

	worn." When asked about the signage posted outside the resident's door, they confirmed that it indicated droplet precautions and acknowledged a mask was supposed to be worn. During an interview, on 5/14/25, at 1:53 p.m., with Registered Nurse Manager (RNM) H, he/she stated that care for Resident #9 required droplet precautions, which meant that staff should not enter without a mask and eye protection, for example goggles or a face shield. He/she further stated that staff should always follow the instructions on the sign when entering a resident's room with an isolation sign on the door. During an interview, on 5/14/25, at 2:05 p.m., with Infection Control Nurse (ICN) F, he/she stated that droplet precautions required eye protection and a mask at a minimum, and that a gown was not required but was recommended to prevent exposure to disease. During an interview, on 5/14/25, at 2:25 p.m., with the Director of Nursing (DON), he/she stated that staff should always follow the directions on the sign on the door to prevent the spread of disease. 2. Review of the facility's policy titled, "Handwashing Hygiene (v4)," reviewed 2/19/25, directed that: "Hand Hygiene is indicated: a. immediately before touching a member, b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device), c. after contact with blood, body fluids, or contaminated surfaces. d. after touching a member, e. after touching the member's environment, f. before moving from work on a soiled body site to a clean body site on the same member, and g. immediately after glove-removal." On 5/13/25, at 11:40 a.m., during an observation in the dining room on the second floor (2 North), Resident Care Aide (RCA) G brought a plate to a resident, dropped the plate off, and grabbed milk for the resident by the top, outside rim of the glass where the resident's lips would contact the glass. Without performing hand hygiene, RCA G brought a plate to a second resident seated at the next table over, and then brought drinks to the second resident, took the top off of the milk, and did not perform hand hygiene before bringing a 3rd resident at a 3rd table his/her plate. RCA G then brough a 4th resident food at another table and finally performed hand hygiene after distributing food and drinks to four (4) residents at four (4) separate tables. After performing hand hygiene with alcohol-

	based hand rub, RCA G then brought a 5th resident food at the 2nd table, but RCA G's thumb was on the food surface of the plate next to the resident's food. On 5/15/25, at 11:25 a.m., during an observation in the dining room on the second floor (2 North), RCA G was observed distributing trays to six (6) residents without performing hand hygiene between any of these trays. During an interview, on 5/15/25, at 11:50 a.m., RCA I stated that staff should be sanitizing their hands between trays. During an interview, on 5/15/25, at 11:53 a.m., RNM H stated that staff were required to sanitize their hands between each tray being distributed. On 5/15/25, at 12:06 p.m., during the meal service observation on the Memory Care Unit, Activity Aide (ATA) B was observed wearing gloves while assisting residents in the dining area. At 12:06 p.m., the staff member touched his/her face with gloved hands. At 12:07 p.m., the same staff member was observed using the same gloved hands to lower his/her eyeglasses from the top of his/her head, and then to use his/her gloved hand to wipe perspiration from his/her forehead by contacting his/her scrub top. Immediately following, the staff member handled a bottle of ketchup and mustard and proceeded to serve a bowl of soup to a resident's family member while the resident was actively consuming their meal. The family member declined the soup, and the staff member then offered the soup to the resident. The staff member then retrieved salt packets for another resident and collected used packets of salt and pepper from another table, continuing to wear the same gloves throughout these tasks. At 12:08 p.m., the staff member discarded the empty seasoning packets into a large, uncovered trash receptacle. At 12:09 p.m., he/she collected a finished soup bowl from a resident and placed it into the designated dirty dish bin. At 12:10 p.m. the staff member collected another used bowl from a different resident and placed it in the dirty dish bin. At 12:11 p.m. the staff member removed his/her gloves and was observed washing his/her hands with soap and water. On 5/15/25, at 12:20 p.m., an interview was conducted with ATA B, regarding facility hand hygiene and glove changing practices. When asked if they were familiar with, or knew the facility policy, the staff member stated: "Every time you touch your face, or your clothing, or someone else's hand, you should hand sanitize or perform hand hygiene. You should perform hand hygiene before putting on gloves-you wash your hands-which I didn't do that. And you should also do it after you change your gloves."

	The surveyor then asked ATA B why hand hygiene was important. The staff member responded, "for infection control." During an interview, on 5/15/25, at 1:57 p.m., with RCA G, he/she stated that hand hygiene should be done after each tray was passed and before the next tray was passed. He/she stated that they always performed hand hygiene, and it was not possible that two (2) separate surveyors on two (2) separate days observed missed opportunities for hand hygiene. RCA G then pointed out the location of the hand hygiene dispenser that he/she always used and denied ever missing an opportunity for hand hygiene. On 5/16/25, at 10:00 a.m., during an interview with ICN F, he/she stated that hand hygiene should be performed by staff between each resident being given a tray, because the staff entered the resident zone/environment. He/she stated retraining would be initiated.
§ 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. **Rating** – Not Met **Scope and Severity** – F **Residents Affected** – Many	**Means of Egress Requirements** 1. Based on observation and interview, the facility failed to properly maintain illumination of means of egress, including exit discharge, and ensure it was arranged in accordance with 7.8 to be either continuously in operation or capable of automatic operation without manual intervention as required. The deficient practice affected one (1) of ten (10) smoke compartments in the Original Building, and zero (0) of two (2) smoke compartments of the Part F Building, staff, and 71 residents. The facility had a capacity for 126 beds with a census of 101 on the first day of the survey. The findings include: Observation during the building inspection tour, on 5/15/25, at 9:40 a.m., of the exit discharge at the main entrance revealed there were several lights under the awning on normal power. An interview, on 5/15/25, at 9:40 a.m., with the Facilities Director revealed the exit discharge lighting fixtures located under the awning at the main entrance of the facility were not on emergency generator backup power, nor did they have emergency battery backed up lighting as required by section 19.2.8 and 7.8.1.1 of NFPA 101 Life Safety Code. The census of 101 was verified by the Administrator on 5/13/25, at 9:00 a.m. The findings were acknowledged by the Administrator and verified by the Facilities Director during the exit interview on 5/16/25, at 10:45 a.m.

Actual NFPA Standard: NFPA 101, Life Safety Code (2012)
19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.
7.8 Illumination of Means of Egress.
7.8.1 General.
7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 43. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.

Smoke Barriers and Sprinklers

2. Based on observation and interview, the facility failed to install Dutch doors in accordance with the code. The deficient practice affected one (1) of ten (10) smoke compartments in the Original Building, and zero (0) of two (2) smoke compartments of the Part F Building, staff, and 20 residents. The facility had a capacity for 126 beds with a census of 101 on the first day of the survey.

The findings include:

Observation during the building inspection tour, on 5/15/25, at 2:22 p.m., revealed a Dutch door installed in the corridor at the Nurse Office on the second floor. The meeting edges of the upper and lower leaves of the Dutch door were not equipped with an astragal, rabbet, or a bevel, as required by section 19.3.6.3.1.3 of NFPA 101, Life Safety Code.

An interview, on 5/15/25, at 2:22 p.m., with the Facilities Director revealed the facility was not aware of the requirements for Dutch doors.

The census of 101 was verified by the Administrator on 5/13/25, at 9:00 a.m. The findings were acknowledged by the Administrator and verified by the Facilities Director during the exit interview on 5/16/25, at 10:45 a.m.

Actual NFPA Standard: NFPA 101, Life Safety Code (2012)
19.3.6.3.13 Dutch doors shall be permitted where they conform to 19.3.6.3 and meet all of the following criteria:
(1) Both the upper leaf and lower leaf are equipped with a latching device.

	(2) The meeting edges of the upper and lower leaves are equipped with an astragal, a rabbet, or a bevel. **(3)** Where protecting openings in enclosures around hazardous areas, the doors comply with NFPA 80, Standard for Fire Doors and Other Opening Protectives. **Smoke Barriers and Sprinklers** 3. Based on observations and interview, the facility failed to maintain the smoke barrier walls. The deficient practice affected one (1) of ten (10) smoke compartments in the Original Building, and one (1) of two (2) smoke compartments of the Part F Building, staff, and 50 residents. The facility had a capacity for 126 beds with a census of 101 on the first day of the survey. The findings include: During the building inspection tour, on 5/15/25, at 2:30 p.m., an observation of the smoke/fire barrier between the original building and Building F revealed four (4) penetrations, which were not protected to resist the spread of fire for a time period equal to the required fire resistance rating of the assembly and restrict the transfer of smoke, as required by section 8.5.7.4 of NFPA 101, Life Safety Code. The observed penetrations around the outer side of electrical conduit revealed blue cabling and were not sealed with any intumescent caulks or sealants. An interview, on 5/15/25, at 2:30 p.m., with the Facilities Director revealed the one (1) side of the barrier that had the penetrations was hard to reach, and they were not sealed as required. The census of 101 was verified by the Administrator on 5/13/25, at 9:00 a.m. The findings were acknowledged by the Administrator and verified by the Facilities Director during the exit interview on 5/16/25, at 10:45 a.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.7.3** Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1⁄2-hour fire resistance rating, unless otherwise permitted by one of the following: **(1)** This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: **(a)** Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). **(b)** Not less than two separate smoke compartments shall be provided on each floor.

	(2) ***Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. **8.5 Smoke Barriers. **8.5.6 Penetrations.** **8.5.6.1** The provisions of 8.5.6 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations of smoke barriers. **8.5.6.2** Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. **8.5.6.3** Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless the requirements of 8.5.6.4 are met. **8.5.6.4** Where sprinklers penetrate a single membrane of a fire resistance–rated assembly in buildings equipped throughout with an approved automatic fire sprinkler system, noncombustible escutcheon plates shall be permitted, provided that the space around each sprinkler penetration does not exceed 1⁄2 in. (13 mm), measured between the edge of the membrane and the sprinkler. **8.5.6.5** Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be securely set in the smoke barrier, and the space between the item and the sleeve shall be filled with a material capable of restricting the transfer of smoke. **8.5.6.6** Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: **(1)** It shall be provided on either side of the smoke barrier. **(2)** It shall be designed for specific purposes. **8.5.7 Joints.** **8.5.7.1** The provisions of 8.5.7 shall govern the materials and methods of construction used to protect joints in between and at the perimeter of smoke barriers or, where smoke barriers meet other smoke barriers, the floor or roof deck above, or the outside walls. The provisions of 8.5.7 shall not apply to approved existing materials and methods of construction used to protect existing joints in smoke barriers, unless otherwise required by Chapters 11 through 43.

	8.5.7.2 Joints made within or at the perimeter of smoke barriers shall be protected with a joint system that is capable of limiting the transfer of smoke. **8.5.7.3** Joints made within or between smoke barriers shall be protected with a smoke-tight joint system that is capable of limiting the transfer of smoke. **8.5.7.4** Smoke barriers that are also constructed as fire barriers shall be protected with a joint system that is designed and tested to resist the spread of fire for a time period equal to the required fire resistance rating of the assembly and restrict the transfer of smoke. **8.5.7.5** Testing of the joint system in a smoke barrier that also serves as fire barrier shall be representative of the actual installation suitable for the required engineering demand without compromising the fire resistance rating of the assembly or the structural integrity of the assembly. **Fire Safety and Operations** 4. Based on observations and interview, the facility failed to ensure soiled waste containers did not exceed 32 gallons and were attended, as required. The deficient practice affected ten (10) of ten (10) smoke compartments in the Original Building, and two (2) of two (2) smoke compartments of the Part F Building, staff, and all residents. The facility had a capacity for 126 beds with a census of 101 on the first day of the survey. The findings include: Observations during the building tour, on 5/15/25, at 2:45 p.m., revealed each nursing unit was provided with a 32-gallon Rubbermaid container and two (2) bin, wheeled, plastic framed hamper bags for soiled linen/clothes, and each of the soiled linen/clothes containers were not attended while present in the exit access corridors. An additional observation revealed that each of the soiled linen/clothes containers exceeded 32 gallons in capacity, and none were located in a room protected as a hazardous area, when not attended by staff, as required by section 19.7.5.7.1(2)(3) of NFPA 101, Life Safety Code. An interview with the Facilities Director, on 5/15/25, at 2:45 p.m., revealed the facility staff was unaware of the requirements for soiled linen and waste containers over 32 gallons that were stored unattended in the corridors, and were not stored in a room protected as a hazardous area. The census of 101 was verified by the Administrator on 5/13/25, at 9:00 a.m. The findings were acknowledged by the Administrator and verified by the Facilities Director during the exit interview on 5/16/25, at 10:45 a.m.

	Actual NFPA Standard: NFPA 101, Like Safety Code (2012) **19.7.5.7 Soiled Linen and Trash Receptacles.** **19.7.5.7.1** Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity and shall meet all of the following requirements: (1) The average density of container capacity in a room or space shall not exceed 0.5 gal/ft2 (20.4 L/m2). (2) A capacity of 32 gal (121 L) shall not be exceeded within any 64 ft2 (6 m2) area. (3) * Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. (4) Container size and density shall not be limited in hazardous Areas **<u>Electrical Systems</u>** 5. Based on records review, observation, and interview, the facility failed to maintain documentation of inspections and testing of the Patient-Care Related Electrical Equipment (PCREE). The deficient practice affected ten (10) of ten (10) smoke compartments in the Original Building, and two (2) of two (2) smoke compartments of the Part F Building, staff, and all residents. The facility had a capacity for 126 beds with a census of 101 on the first day of the survey. The findings include: Records review, on 5/15/25, at 9:00 a.m., revealed the bio med vendor inspected the facility's PCREE, but did not document required electrical leakage testing, as required by section 10.5.6.2.1 of NFPA 99, Health Care Facilities Code. An interview with the Facilities Director, on 5/15/25, at 1:00 p.m., revealed facility staff was unaware the bio med vendor did not document the required electrical leakage testing, but would make certain in the future it was documented. Observation during the building inspection tour, on 5/15/25, from 12:30 p.m., to 3:00 p.m., revealed that the facility provided electric beds to all residents, and there was other PCREE within the facility such as O2 concentrators and ECG monitors. . The census of 101 was verified by the Administrator on 5/13/25, at 9:00 a.m. The findings were acknowledged by the Administrator and verified by the Facilities Director during the exit interview on 5/16/25, at 10:45 a.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.