

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155156	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2013
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NAME OF PROVIDER OR SUPPLIER ARBORS AT MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 E COOLSPRING AVE MICHIGAN CITY, IN 46360
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/25/13</p> <p>Facility Number: 000076 Provider Number: 155156 AIM Number: 100271060</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist, Liberty Fruth, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Arbors at Michigan City was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility determined to be of Type V (111) construction was fully sprinklered with the exception of one resident room closet. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the</p>	K010000	Please accept the following as the facility's credible allegation of compliance. The following plans of correction do not constitute an admission of guilt or liability by the facility and are submitted only in response to the regulatory requirements. The facility is requesting a desk review for this survey	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>corridors and hardwired smoke detectors in all 115 resident rooms. The facility has a capacity of 180 and had a census of 144 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/03/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010015 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation and interview, the facility failed to ensure materials used as an interior finish in a lounge area had a flame spread rating of Class A or Class B in order to protect 30 of 144 residents. LSC 101 10.2.3.2 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development.</p> <p>(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire.</p> <p>(b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any</p>	K010015	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. There were no residents mentioned on the CMS 2567. The maintenance director treated the cedar planks on the ceiling of the 100 unit porch lounge on 12/9/13 using class A fire rated treatment (please see the attached photos and product description). All of the residents on the unit had the potential to be affected by the alleged deficient practice. Maintenance staff was inserviced on 11/25/13 on the need to acquire and maintain documentation regarding flame spread classifications on all finishing materials in the facility (see attached inservice sign in sheet). The maintenance director or designee will submit a monthly report to the QA committee for 6 months stating if the facility is	12/09/2013	

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	<p>material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale.</p> <p>(c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect any resident on the 100 wing as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Services during a tour of the facility on 11/25/13 from 10:00 a.m. to 1:30 p.m., the 100 wing porch lounge had cedar planks on the ceiling used as an interior finish. Interview with the Director of Plant Services after the time of observation revealed no documentation was immediately available to demonstrate the cedar planks exhibited a flame spread classification of Class A or B.</p> <p>3.1-19(b)</p>		<p>lacking such documentation on all the required material. The committee will monitor for compliance. The QA committee meets monthly at the facility. Completion date: 12/9/13</p>				

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 115 resident room doors was capable of resisting smoke. This deficient practice had the potential to affect 12 residents on the 200 west hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Services during a tour of the facility on 11/25/13 from 10:00 a.m. to 1:30 p.m., resident room door 205 had a pencil size hole through the door above the door handle. Based on interview at the time of observation, the Director of Plant Services acknowledged the hole in the door to resident room 205 would not resist the passage of smoke.</p>	K010018	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. There were no residents mentioned on the CMS 2567. The hole in the door to room 205 was repaired on 12/5/13 (see attached photograph). The wooden wedge in the 200 unit manager's office was removed during the survey process. All residents of the facility had the potential to be affected by the same alleged deficient practice. All employees who have offices were inserviced on 11/25/13 regarding not propping open their doors in any way (see attached inservice sign in sheet). The maintenance director or designee will monitor	12/05/2013			

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 200 corridor doors did not have an impediment to closing. This deficient practice had the potential to affect 12 residents on the 200 east hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Services during a tour of the facility on 11/25/13 from 10:00 a.m. to 1:30 p.m., the 200 Unit Manger's office door was propped open with a wooden wedge under the door. Based on interview at the time of observation, the Director of Plant Services acknowledged the the door should not be propped open, and wedges were not allowed.</p> <p>3.1-19(b)</p>		<p>for compliance by using the attached QA tool to randomly audit areas throughout the facility to ensure compliance. These audits will be done weekly for 6 months. The results of these audits will be presented to the members of the QA committee. The QA committee meets monthly at the facility. Completion date: 12/5/13</p>				

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K010025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure the passage of cable through 6 of 12 smoke barriers was protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect at least 100 residents as well as staff and visitors if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Services during a tour of the facility</p>	K010025	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. There were no residents mentioned on the CMS 25671. The penetrations in the 400 unit E. attic smoke barrier were sealed on 12/11/13 using fire rated caulk 2. The penetrations in the 400 unit W. attic smoke barrier near room 439 were sealed on 12/11/13 using fire rated caulk3. The penetrations in the 300 unit W. attic smoke barrier were sealed on 12/11/13 using fire rated caulk4. The penetrations in the 300 unit E. attic smoke barrier were sealed on 12/11/13 using fire rated caulk5. The penetrations in the 300 unit center attic smoke barrier near the 300 dining room were sealed on 12/11/136. The penetrations in</p>	12/11/2013	

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	<p>on 11/25/13 from 10:00 a.m. to 1:30 p.m., there were exposed penetrations through the smoke barriers in the attic at the following locations that were not firestopped:</p> <p>a. The 400 hall east attic smoke barrier had five penetrations that were not sealed. Two penetrations by wire bundles were at the base of the removable panel which was not secured in place and had one inch annular space around the wire bundles that were not sealed. The three other conduit penetrations were up and to the left of the panel and had similar one inch gaps.</p> <p>b. The 400 hall west attic smoke barrier near room 439 had three penetrations which were not sealed. Two of the penetrations were by sprinkler pipe with one inch annular space around each sprinkler pipe that was unsealed and the third penetration was a pipe sleeve with wires running through it. The end of the pipe sleeve was not sealed to be smoke resistant.</p> <p>c. The 300 hall west attic smoke barrier had two penetrations by pipe sleeves with wires running through with the ends not sealed to be smoke resistant.</p> <p>d. The 300 hall east attic smoke barrier had four penetrations which were not sealed. Two penetrations were by pipe sleeves with wires running through with the ends not sealed to be smoke resistant.</p>		<p>the 200 unit S. attic smoke barrier were sealed on 12/11/13 using fire rated caulkPlease see the attached photographs, and description of the caulk used for the sealing.All residents in the facility had the potential to be affected by the same alleged deficient practice.Maintenance staff was inserviced on 11/25/13 regarding the need to have smoke barriers fully sealedThe maintenance director or designee will monitor for compliance by randomly inspecting smoke barriers weekly for 6 months using the attached QA tool. Results of these inspections will be presented to the members of the QA committee. The QA committee meets monthly at the facility. Completion date: 12/11/13</p>				

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	<p>One penetration was a blue wire through the smoke barrier which had a one inch annular gap that was not sealed and a sprinkler pipe that had a one inch annular gap that was not sealed.</p> <p>e. The 300 hall center attic smoke barrier near the 300 hall south dining room door had a two by two foot square section open with the drywall panel laying on duct work below the opening.</p> <p>f. The 200 hall south attic smoke barrier had two penetrations which were not sealed. One of the penetrations was by a pipe sleeve with wires running through with the ends not sealed to be smoke resistant and the other penetration was a conduit through the smoke barrier that had a one inch annular gap that was not sealed.</p> <p>Based on interview during the times of observation, the Director of Plant Services acknowledged the unprotected openings through the smoke barriers.</p> <p>3.1-19(b)</p>				

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 3 of 16 doors serving hazardous areas such as rooms larger than 50 square feet in size and storing combustible materials closed and latched to prevent the passage of smoke. This deficient practice could affect 75 residents, visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Services during a tour of the facility on 11/25/13 from 10:00 a.m. to 1:30 p.m., the following was noted:</p> <p>a. The housekeeping office which exceeded 50 square feet in area contained at least 30 cardboard boxes and the corridor door to this room lacked a door closer.</p> <p>b. The medical records storage room which exceeded 50 square feet in size had</p>	K010029	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. There were no residents mentioned on the CMS 2567A self closing hinge was installed on the doors to the housekeeping office, medical records storage room and human resource storage room on 12/4/13 (see attached photo of the product used). The hole in the wall in the 300 unit E soiled utility room was repaired on 12/11/13 (see attached photo) All of the residents in the facility had the potential to be affected by the same alleged deficient practice. Maintenance staff was inserviced on 11/25/13 regarding the need to have door closers on doors serving hazardous areas and on the need to have hazardous	12/11/2013	

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	<p>at least 75 cardboard boxes and the corridor door to this room lacked a door closer.</p> <p>c. The human resource storage room which exceeded 50 square feet contained at least 20 cardboard boxes and the corridor door to this room lacked a door closer.</p> <p>Based on interview during the time of observation, the Director of Plant Services acknowledged the aforementioned hazardous area corridor doors did not have a self closer to ensure the door closed and latched into the door frame.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 16 hazardous areas such as a soiled linen room was separated from other spaces by smoke resisting partitions. This deficient practice could affect 25 residents, visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Services during a tour of the facility on 11/25/13 from 10:00 a.m. to 1:30 p.m., the 300 east soiled linen room had four by twelve inch opening in the wall at the bottom of the mop sink where the ceramic</p>		<p>areas separated from other areas by smoke resisting partitions. The maintenance director or designee will monitor for compliance by randomly inspecting hazardous areas weekly for 6 months using the attached QA tool. Results of these inspections will be presented to the members of the QA committee. The QA committee meets monthly at the facility. Completion date: 12/11/13</p>				

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	<p>tile and the drywall were missing. Based on interview during the time of observation, the Director of Plant Services acknowledged the opening in the wall of the soiled linen room.</p> <p>3.1-19(b)</p>			

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on interview and record review, the facility failed to conduct quarterly fire drills on each shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Reports" with the Director of Plant Operations from 8:30 a.m. to 10:00 a.m. on 11/25/13, a fire drill was not documented for the second shift of the fourth quarter of 2012. Based on interview at the time of record review, the Director of Plant Operations acknowledged the second shift fire drill for the fourth quarter of 2012 was missed and there was no other documentation available for review to verify this drill was conducted.</p> <p>3.1-19(b)</p>	K010050	<p>Plan of correction: Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. The fourth quarter of 2012 has passed and a fire drill cannot be completed for a second shift for that quarter. There were no residents mentioned on the CMS 2567. All residents had the potential to be affected by the same alleged deficient practice. Maintenance staff was inserviced on 11/25/13 regarding the need to have fire drills quarterly each shift (see attached inservice sign in sheet). The administrator or designee will monitor for compliance by reviewing all fire drill reports to ensure that there is one completed quarterly per shift. All fire drill reports will be submitted to the QA committee for review as well. The QA committee meets</p>	12/04/2013	

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	3.1-51(c)		monthly at the facility. Completion date 12/4/13 IDR: The Arbors at Michigan City requests that the deficiency known as K50 be removed from the CMS form 2567 in consideration of the following: During review of the fire drills for the fourth quarter of 2012 during the survey process, it was noted that there was no drill conducted for the second shift. There were 2 drills noted to be completed for the third shift that quarter. Upon review of the fire drill report dated 12/31/12 (attached- exhibit A) the time of the drill is indicated as 2:51 AM and the shift is indicated as "3ND". Review of the signatures of the staff present for the fire drill when matched up with the nursing schedule for that day (attached- exhibit B) shows that the staff who signed the fire drill report worked the second shift that day. The facility contends that the drill was indeed done on the second shift but was erroneously recorded as 2:51 AM instead of PM, and the 3ND initially stated 2ND but was erroneously corrected to a 3 due to the time stating 2:51 AM. Considering the fact that this appears to be nothing more than a typographical error, the facility requests that K50 be removed from the record. If the reviewer declines to remove the tag from the record and penalize the facility for this error, the facility requests that the scope and		

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			severity of the deficiency be changed from that of a F as this typographical error was not widespread nor did it place any of the residents of the facility in any sort of harm.	

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K010051 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation with the Director of</p>	K010051	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. There were no residents mentioned on the CMS 2567. The circuit breaker for the fire alarm system was marked in red on 12/6/13 (see attached photos). All residents had the potential to be affected by the same alleged deficient practice. Maintenance staff was inserviced on 11/25/13 regarding the need to have the fire alarm system circuit breakers identified. The maintenance director or designee	12/06/2013			

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	<p>Plant Services during a tour of the facility on 11/25/13 from 10:00 a.m. to 1:30 p.m., the fire alarm system circuit breaker could not be located. Based on interview during the time of observation, the Director of Plant Services acknowledged all electrical circuit breaker panels in the facility are locked but he did not know where the fire alarm system circuit breaker was or if it was identified.</p> <p>3.1-19(b)</p>		<p>will monitor for compliance by ensuring that the panel remains identifiable. Completion date: 12/6/13</p>	

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K010056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 115 resident room closets. This deficient practice affects 2 of 144 residents.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Services during a tour of the facility on 11/25/13 from 10:00 a.m. to 1:30 p.m., the closet in resident room 423 lacked a sprinkler head to provide sprinkler coverage. Based on interview at the time of observation, the Director of Plant Services acknowledged the closet in resident room 423 lacked a sprinkler head.</p> <p>3.1-19(b)</p>	K010056	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. There were no residents mentioned on the CMS 2567A sprinkler head was installed in the closet of room 423 on 12/11/13 (see attached photo)The maintenance director rounded throughout the facility and all required areas were sprinklered (as stated on page 1 of the CMS 2567)The maintenance director or designee will monitor for compliance by using the attached QA tool to randomly audit areas throughout the facility to ensure compliance. These audits will be done weekly for 6 months. The results of these audits will be presented to the</p>	12/11/2013

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			members of the QA committee. The QA committee meets monthly at the facility. Completion date: 12/11/13	

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K010147 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure ground fault circuit interrupter (GFCI) receptacles in staff areas in 2 of 4 units were provided and operated properly to protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. These deficient practices were not in a resident area and would not directly affect residents but could affect staff.</p> <p>Findings include:</p> <p>Based on observation with the Director of Plant Services during a tour of the facility on 11/25/13 from 10:00 a.m. to 1:30 p.m., the following was noted:</p> <p>a. There were two GFCI electrical</p>	K010147	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. There were no residents mentioned on the CMS 2567. The GFCI receptacles in the 300 pantry were replaced on 12/5/13 (see attached photos). GFCI receptacle were installed in the 200 hall pantry and medication room on 12/5/13 (see attached photos). As stated on the CMS 2567 all deficiencies were in secured areas. Maintenance staff was inserviced on 11/25/13 regarding the need for GFCI receptacles for outlets in close proximity to water. The maintenance director or designee will monitor for compliance by using the attached QA tool weekly for 6 months. These audits will be presented to the QA committee at the QA meetings which are held monthly at the facility. Completion date: 12/5/13</p>	12/05/2013	

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	<p>receptacles on the wall within two feet of the sink in the 300 hall pantry. When tested with the test button on the receptacle, power was not interrupted.</p> <p>b. There was an electrical receptacle on the wall within two feet of the sink in the 200 hall pantry. The outlet was not identified as being protected by a GFCI. When tested with a circuit tester, power was not interrupted.</p> <p>c. There was an electrical receptacle on the wall within two feet of the west sink in the 200 hall medication room. The outlet was not identified as being protected by a GFCI. When tested with a circuit tester, power was not interrupted. Based on interview at the times of observation, the Director of Plant Services acknowledged the aforementioned wet location areas were not provided with GFCI protection.</p> <p>3.1-19(b)</p>			