

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K0000	<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: 02/17/12</p> <p>Facility Number: 000399 Provider Number: 155750 AIM Number: 100289100</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Morgantown Health Care-Inn 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 with a basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridor. The facility has a capacity of 39 and had a census of 37 at</p>	K0000		
-------	--	-------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>the time of this visit.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/20/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/17/2012	
NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN				STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K0029 SS=E	<p>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>Based on observation and interview, the facility failed to ensure 1 of 1 kitchen doors opening into the corridor would close and latch into the door frame. This deficient practice could affect any residents, staff and visitors in 1 of 1 smoke compartments where the kitchen is located.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor during the tour of the facility from 10:55 a.m. to 12:10 p.m. on 02/17/12, the kitchen door which opens into the corridor is not equipped with a latching mechanism and would not latch into the door frame. Based on interview at the time of observation, the Environmental Services Supervisor acknowledged the kitchen door opening into the corridor is not equipped with a latching mechanism and would not latch into the door frame.</p>	K0029	<ol style="list-style-type: none"> 1. A latching mechanism has been installed so that the Dietary Door will latch into the frame. 2. Any resident have the potential to be affected. 3. New door latch has been installed to make sure that kitchen door latches @ the time of closure. 4. Maintenance will monitor daily to make sure that kitchen door latches properly. To be reported to Q.A. on quarterly basis and reviewed in QA for 6 months. 	03/10/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------------	--	---------------------	--	----------------------------

	3.1-19(b)			
--	-----------	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/17/2012	
NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN				STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K0048 SS=E	<p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan titled "Emergency Preparedness Plan: Fire and Safety" during record review with the Environmental Services Supervisor from 9:30 a.m. to 10:55 a.m. on 02/17/12, the fire safety plan did not address the use of the K class fire extinguisher located in the</p>	K0048	<p>1. The facility Disaster policy was reviewed and up-dated on February 17, 2012 and included the use of the K class fire extinguisher.2. Any resident has the potential to be affected.3. Policy updated to include K class fire extinguisher to be used with overhead extinguisher system.4. Food Service Supervisor will instruct food service employees in proper procedure with an in-service as well as any new employee. To be reported by the Food Service Supervisor at the quarterly QA meeting for 6 months.</p>	02/17/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Environmental Services Supervisor acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K class fire extinguisher.</p> <p>3.1-19(b)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/17/2012
NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN			STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0050 SS=C	<p>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 record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice affects all occupants in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Record" documentation with the Environmental Services Supervisor during record review from 9:30 a.m. to 10:55 a.m. on 02/17/12, third shift fire drills conducted on 03/14/11, 06/16/11 and 12/27/11 were conducted at, respectively, 10:35 p.m., 11:00 p.m. and 10:35 p.m. Based on interview at the time of record review, the Maintenance Director acknowledged third shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p>	K0050	<ol style="list-style-type: none"> ESD was in-serviced on importance of staggard times for third (3rd) shift on 02/17/2012 for fire drills. Any resident has the potential to be affected. Fire Drills will be conducted by ESD or maintenance personnel at staggard times for third shift, monthly. ESD to keep records of Third Shift fire drills and report quarterly to QA the times of these drills for 6 months and will monitor monthly. 	02/28/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/17/2012
NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN			STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K0076 SS=E	<p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas of greater than 3000 cubic feet are enclosed by a 1 hour fire resistive construction and equipped with a self closing or automatic closing door. LSC 7.2.1.8.1 requires any door which is normally required to be kept closed shall not be secured in the open position at any time and shall be self closing or automatic closing in accordance with 7.2.1.8.2.</p> <p>This deficient practice could affect residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p> <p>a. Based on observation with the Environmental Services Supervisor during the tour of the facility from 10:55 a.m. to 12:10 p.m. on 02/17/12, the oxygen storage room contained one liquid</p>	K0076	<p>1. The oxygen storage area has been upgraded to include a one hour resistive ceiling and a self closure on the door.2. Any resident has the potential to be affected.3. The storage area has been placed on the maintenance checklist for monthly monitoring to ascertain that the door is closing correctly. The ESD will monitor daily and report to the QA committee quarterly for 6 months. All staff are responsible to make sure the door is closed and locked when not in use.</p>	03/18/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>oxygen canister which was 25% full. The ceiling for the oxygen storage room consists of one layer of five eighths inch thick drywall. Based on interview at the time of observation, the Environmental Services Supervisor acknowledged the ceiling did not provide 1 hour fire resistive construction for the oxygen storage room.</p> <p>b. Based on observation with the Environmental Services Supervisor during the tour of the facility from 10:55 a.m. to 12:10 p.m. on 02/17/12, the oxygen storage room door is not provided with a self closing device on the door. Based on interview at the time of observation, the Environmental Services Supervisor acknowledged the oxygen storage room door is not equipped with a self closing device on the door.</p> <p>3.1-19(b)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K0143 SS=E	<p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction, and equipped with a self closing or automatic closing door. LSC 7.2.1.8.1 requires any door which is normally required to be kept closed shall not be secured in the open position at any time and shall be self closing or automatic closing in accordance with 7.2.1.8.2. This deficient practice could affect residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p> <p>Findings include:</p>	K0143	<p>1. Self closing device has been ordered for door on the oxygen storage area.2. Any resident has the potential to be affected.3. New self closing device to be installed so that door is closed @ all times when transferring of oxygen takes place. 4. All should monitor daily and ESD will report to QA quarterly meeting on a 6 months basis.</p>	03/17/2012
---------------	---	-------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>a. Based on observation with the Environmental Services Supervisor and the Director of Nursing (DON) during the tour of the facility from 10:55 a.m. to 12:10 p.m. on 02/17/12, the oxygen storage and transfilling room contained one liquid oxygen canister which was 25% full. The ceiling for the oxygen storage and transfilling room consists of one layer of five eighths inch thick drywall. Based on interview at the time of observation, the DON stated oxygen transfilling does occur in the room and the Environmental Services Supervisor acknowledged the ceiling did not provide 1 hour fire resistive construction for the oxygen storage and transfilling room.</p> <p>b. Based on observation with the Environmental Services Supervisor and the DON during the tour of the facility from 10:55 a.m. to 12:10 p.m. on 02/17/12, the oxygen storage and transfilling room door is not provided with a self closing device on the door. Based on interview at the time of observation, the DON stated oxygen transfilling occurs in the room and the Environmental Services Supervisor acknowledged the room door is not equipped with a self closing device on the door.</p> <p>3.1-19(b)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/17/2012	
NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN				STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
K0147 SS=E	<p>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 1 of 26 wet location resident care areas was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subject 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 ground fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect two residents, staff and visitors in the vicinity of Resident Room # 2.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor during the tour of the facility from 10:55 a.m. to 12:10 p.m. on 02/17/12, an electric receptacle was on the wall within</p>	K0147	<ol style="list-style-type: none"> 1. Light switch as replaced (new) and the plug-in was removed from receptacle. 2. Any resident has the potential to be affected. 3. Receptacles to be placed on a check list on a monthly basis by maintenance and ESD. 4. ESD and all staff will monitor. ESD will report to quarterly QA for 6 months. 	02/17/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155750	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORGANTOWN HEALTH CARE-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 140 W WASHINGTON ST MORGANTOWN, IN 46160
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>two feet of the bathroom sink in Resident Room # 2 which did not have GFCI protection. Based on interview with the Environmental Services Supervisor at the time of observation, neither the electrical receptacle in Resident Room # 2 nor the circuit breaker for the receptacle was provided with GFCI protection.</p> <p>3.1-19(b)</p>			
--	---	--	--	--