

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155304	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/23/2015
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NAME OF PROVIDER OR SUPPLIER WATERS OF NEW CASTLE, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 N 16TH ST NEW CASTLE, IN 47362
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(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
K 000 Bldg. 01	<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: 04/23/15</p> <p>Facility Number: 000201 Provider Number: 155304 AIM Number: 100267910</p> <p>At this Life Safety Code survey, The Waters of New Castle 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>The Waters of New Castle was located on the third floor of a four story sprinkled hospital with a basement and was determined to be of Type I (332) construction. The facility has a fire alarm system with smoke detection on all levels including the basement, the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident</p>	K 000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.</p> <p>This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/23/15.</p>	

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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K 018 SS=A Bldg. 01	<p>sleeping rooms. The facility has a capacity of 66 and had a census of 53 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the communication room. The facility had one detached building housing the 208 emergency generator which is not sprinkled.</p> <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. Based on observation and interview, the facility failed to ensure 1 of 38 resident room corridor doors closed and latched into the door frames. This deficient practice could affects 2 residents who reside in room 314.</p> <p>Findings includes:</p>	K 018	<p>K018</p> <p>It is the intent of this facility to ensure corridor doors will latch and resist the passage of smoke.</p> <p>1. Corrective action for affected residents; The door closure for</p>	05/23/2015	

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K 029 SS=E Bldg. 01	<p>Based on observation with the maintenance supervisor on 04/23/15 at 12:10 p.m., resident room 314 room door would not latch positively into the door frame and had a one half inch gap along the latching side of the door. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 04/23/15 at 12:40 p.m.</p> <p>3.1-19(b)</p> <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</p>		<p>resident room #314 has been adjusted to ensure latching and closure of less than one half inch gap.</p> <p>2. Other residents with potential to be affected; Environmental Supervisor/designee completed an audit for all corridor doors to ensure sufficient closing with gaps measuring less than one half inch with areas of concern corrected.</p> <p>3. Measures to prevent reoccurrence; Environmental Supervisor/designee will do a monthly audit as part of the preventative maintenance program to ensure corridor doors meet the latching and less than one half inch gap requirements.</p> <p>4. Monitoring of corrective action to ensure the practice will not recur; To prevent reoccurrence the QA committee will be responsible for oversight of facility compliance on a monthly basis ongoing.</p> <p>5. Date systematic changes will be completed; 5/23/15</p>	

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	<p>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 the corridor door to 1 of 4 hazardous areas, such as a combustible storage room over 50 square feet, was provided with a self closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect all kitchen staff and any residents and visitors who use the main dining room located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 04/23/15 at 11:30 a.m. with the maintenance supervisor, the kitchen food storage room, which measured one hundred sixty square feet and stored fifteen shelves of cardboard boxes of food supplies, lacked a self closing device on the room door. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 04/23/15 at 12:40 p.m.</p>	K 029	<p>K029</p> <p>It is the intent of this facility to ensure corridor doors to storage rooms over 50 square feet in size are provided a self-closing device.</p> <ol style="list-style-type: none"> Corrective action for affected residents; In regards to the kitchen food storage room located in on the ground floor of Henry County Hospital a self-closing device is scheduled to be installed 5/20/2015 per HCH maintenance staff. Other residents with potential to be affected; no residents are affected due to resident meals are not served in this dining room located on the ground floor of Henry County Hospital. Measures to prevent reoccurrence; Environmental Supervisor/designee will do monthly audits as part of the preventative maintenance program of all corridor doors to storage areas to ensure 	05/23/2015

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K 038 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 1 of 1 exit access with stairs was provided with handrail. LSC 7.2.2.4.2 requires stairs and ramps shall have handrails on both sides. In addition, handrails shall be provided within 30 inches of all portions of the required egress width of stairs. The required egress width shall be provided along the natural path. Exception No 3: Existing stairs, existing ramps, stairs within dwelling units and within guest rooms, and ramps within dwelling units and guest rooms shall be permitted to have a handrail on one side only. This deficient practice could affect 18 residents who would use the stairwell #3 exit during an evacuation.</p>	K 038	<p>self-closing devices are in place.</p> <p>4. Monitoring of corrective action to ensure the practice will not recur; To prevent reoccurrence the QA committee will be responsible for oversight of facility compliance on a monthly basis ongoing.</p> <p>5. Date of Compliance; May 23, 2015</p> <p>K038</p> <p>It is the intent of this facility to ensure exit access with stairs is provided with a handrail.</p> <p>1. Corrective action for affected residents; In regards to stairwell #3 exit onto the first floor concrete pad with 4 steps, a handrail is scheduled to be installed 5/20/2015 by Henry County Hospital Maintenance staff.</p> <p>2. Other residents with potential to be affected; no residents were affected.</p> <p>3. Measures to prevent reoccurrence; Environmental Supervisor/designee will do monthly</p>	05/23/2015	

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K 052 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 04/23/15 at 11:15 a.m., the stairwell #3 exit discharged onto the first floor concrete pad. Furthermore, the first floor concrete pad had a concrete stairway leading to the sidewalk surface which was not provided with handrail. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 04/23/15 at 12:40 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 46 of 46 smoke detectors tested for sensitivity included the smoke detectors marked sensitivity range in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year</p>	K 052	<p>audits of the condition of exit #3 to ensure handrail placement as part of the preventative maintenance program.</p> <p>4. Monitoring of corrective action to ensure the practice will not recur; To prevent reoccurrence the QA committee will be responsible for oversight of facility compliance on a monthly basis ongoing.</p> <p>5. Date of Compliance; 5/23/2015</p> <p>K052</p> <p>It is the intent of this facility to ensure smoke detectors tested for sensitivity include the marked sensitivity range in accordance with applicable requirements of NFPA 72.</p> <p>1. Corrective action for affected residents; In regards to the forty six third floor smoke detectors tested</p>	05/23/2015			

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	<p>thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be</p>		<p>by Siemens for sensitivity 12/3/2014, Siemen failed to enter data on the report due to a software computer problem that generated the report. The report from 12/3/2014 will be updated to show the test was completed listing sensitivity ranges and is scheduled to be received 5/21/2015 per Henry County Hospital maintenance staff.</p> <ol style="list-style-type: none"> 2. Other residents with potential to be affected; No residents were affected. 3. Measures to prevent reoccurrence; Environmental Supervisor/designee will do an annual audit as part of the preventative maintenance program of the test log to ensure smoke detectors are within obscuration testing range and the range is listed on the report. 4. Monitoring of corrective action to ensure the practice will not recur; To prevent reoccurrence the QA committee will be responsible for oversight of facility compliance on a monthly basis ongoing.. 5. Date systematic changes will be completed; 5/23/15 	

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	<p>tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction.</p> <p>This deficient practice affects all residents, staff and all visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review on 04/23/15 at 9:30 a.m. with the maintenance supervisor and hospital director of maintenance, the most recent Sensitivity Test Report for forty six third floor smoke detectors from Siemens Inc. was dated 12/03/14. The Sensitivity Test Report listed the test results for each smoke detector as a percent of obscuration with a pass or fail check mark, furthermore, the report failed to list the range of obscuration for each smoke detector tested to ensure the smoke detectors were within their listed range of obscuration. Based on an interview with the hospital director of maintenance on 04/23/15 at 9:50 a.m., when asked if any</p>			

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K 056 SS=E Bldg. 01	<p>other records were available for review for smoke detector sensitivity testing, the hospital director of maintenance stated the only record available for review was the Siemens Inc. report dated 12/03/14. Based on a review of a sample smoke detector provided by the hospital director of maintenance on 04/23/15 at 9:40 a.m., the smoke detector label indicated the obscuration range was .2% to .9% and the Sensitivity Test Report listed the smoke detector results between 1.68% to 3.6%, which was over the listed obscuration testing range of the sample smoke detector provided. Based on an interview with the hospital director of maintenance on 04/23/15 at 9:45 a.m., it was stated the sample smoke detector provided may be an older model smoke detector which may have been replaced over the past few years. The lack of the last two year Sensitivity Test Report listing the range of the smoke detectors obscuration was verified by the maintenance supervisor and hospital director of maintenance at the time of record review and acknowledged by the administrator at the exit conference on 04/23/15 at 12:40 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is</p>			

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	<p>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 ensure 1 of 1 communication room was completely sprinkled. This deficient practice could affect all residents in the facility in the event of a fire in the communication room next to the elevator.</p> <p>Findings include:</p> <p>Based on observation on 04/23/15 at 12:05 p.m. with the maintenance supervisor, the communication room was not provided with sprinkler coverage. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 04/23/15 at 12:40 p.m.</p> <p>3.1-19(b)</p>	K 056	<p>K056</p> <p>It is the intent of this facility to ensure the communication room is completely sprinkler.</p> <ol style="list-style-type: none"> Corrective action for affected residents; In regards to the third floor communication/electrical room sprinkler system is scheduled to be installed for the room 5/22/2015 per Henry County Hospital maintenance staff. Other residents with potential to be affected; no residents were affected. Measures to prevent reoccurrence; Environmental Supervisor/designee will do a monthly audit as part of the preventative maintenance program to ensure complete sprinkler coverage for all portions of the facility. 	05/23/2015

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K 062 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affects staff who work in the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 04/23/15 at 10:50 a.m. with the maintenance supervisor and hospital director of maintenance, the kitchen food storage room had a four inch sprinkler pipe</p>	K 062	<p>4. Monitoring of corrective action to ensure the practice will not recur; To prevent reoccurrence the QA committee will be responsible for oversight of facility compliance on a monthly basis ongoing.</p> <p>5. Date systematic changes will be completed; 5/23/15</p> <p>K062</p> <p>It is the intent of this facility to ensure the sprinkler system shall not be used to support nonsystem components.</p> <p>1. Corrective action for affected residents; The zip ties used to tie down a red fire alarm system wire to the sprinkler pipe is scheduled to be removed 5/19/2015 by Henry County Hospital maintenance staff.</p> <p>2. Other residents with potential to be affected; No residents were affected.</p> <p>3. Measures to prevent reoccurrence; Environmental Supervisor/designee will do a</p>	05/23/2015

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K 130 SS=E Bldg. 01	<p>above the east wall with zip strip ties used to tie down a red fire alarm system wire along the four foot length of sprinkler pipe. This was verified by the maintenance supervisor and hospital director of maintenance at the time of observation and acknowledged by the administrator at the exit conference on 04/23/15 at 12:40 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, interview and record review, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the</p>	K 130	<p>monthly audit as part of the preventative maintenance program to ensure sprinkler piping is not used to support nonsystem components.</p> <p>4. Monitoring of corrective action to ensure the practice will not recur; To prevent reoccurrence the QA committee will be responsible for oversight of facility compliance on a monthly basis ongoing.</p> <p>5. Date systematic changes will be completed; 5/23/15</p> <p>K130</p> <p>It is the intent of this facility to ensure the care and maintenance of rolling fire doors.</p> <p>1. Corrective action for affected residents; The rolling fire door located at the opening from the kitchen to the main dining room is scheduled to be removed 5/22/2015 by Henry County Hospital maintenance staff.</p> <p>2. Other residents with potential to be affected; no residents were affected.</p> <p>3. Measures to prevent reoccurrence; the rolling door is</p>	05/23/2015

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K 144 SS=F Bldg. 01	<p>manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any residents using the main dining room along with staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 04/23/15 at 11:35 a.m. with the maintenance supervisor and hospital director of maintenance, there was a rolling fire door protecting the opening from the kitchen to the main dining room without an attached inspection tag. Based on interview at the time of observation, the hospital director of maintenance verified there was no documentation of an annual inspection or test for the rolling kitchen fire door and the facility is planning on removing the door this year. The lack of an annual rolling fire door inspection was verified by the maintenance supervisor and hospital director of maintenance at the time of interview and acknowledged by the administrator at the exit conference on 04/23/15 at 12:40 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per</p>		<p>scheduled to be removed.</p> <p>4. Monitoring of corrective action to ensure the practice will not recur; If in the future the rolling door is re-installed, at that time to prevent reoccurrence the QA committee will be responsible for oversight of facility compliance on a monthly basis ongoing.</p> <p>5. Date systematic changes will be completed; 5/23/15</p>		

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	<p>month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review, the facility failed to maintain a complete written record of monthly generator load testing including a monthly test of the transfer switch for 12 of the past 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems. Chapter 6-4.5 of NFPA 110 requires the monthly test of a transfer switch shall consist of electrically operating the transfer switch from the normal position to the alternate position and then a return to the normal position. This deficient practice affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on a review of Henry County Hospital Generator Test Monthly Load Test Preventive Maintenance reports on 04/23/15 at 9:15 a.m. with the maintenance supervisor and hospital director of maintenance, the monthly load test reports lacked a monthly test of the transfer switch. This was verified by the maintenance supervisor and hospital director of maintenance at the time of record review and acknowledged by the</p>	K 144	<p>K144</p> <p>It is the intent of this facility to ensure monthly generator load testing including a monthly test of the transfer switch is completed.</p> <ol style="list-style-type: none"> Corrective action for affected residents; the generator transfer switch test log has been updated to include the recording time of the transfer switch test by Henry County Hospital maintenance staff. Other residents with potential to be affected; no residents were affected. Measures to prevent reoccurrence; Environmental Supervisor/designee will do a monthly audit as part of the preventative maintenance program to ensure the generator transfer switch test is completed. Monitoring of corrective action to ensure the practice will not recur; To prevent reoccurrence the QA committee will be responsible for oversight of facility compliance on a monthly basis ongoing. Date systematic changes will be completed; 5/23/15 	05/23/2015

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K 147 SS=E Bldg. 01	<p>administrator at the exit conference on 04/23/15 at 12:40 p.m.</p> <p>3.1-19(b)</p> <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>1. Based on observation, the facility failed to ensure extension cords including powerstrips and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 40 residents who use the resident living room.</p> <p>Findings include:</p> <p>Based on observations on 04/23/15 during the tour of the facility from 10:20 am to 12:40 p.m. with the maintenance supervisor, the following locations used either power strips or extension cords:</p> <p>a) The office manager office used a</p>	K 147	<p>K147</p> <p>It is the intent of this facility to ensure extension cords including power strips and non-fused multi plug adapters are not used as a substitute for fixed wiring. It is the intent of the facility to ensure GFCI protection is in place in wet locations.</p> <p>1. Corrective action for affected residents; In regards to power strips/extension cords all were removed from the office manager office, resident living room, social service office, therapy room, resident rooms 330 and 357. In regards to the GFCI protection in a wet area in the kitchen, the outlet was removed by Henry County Hospital maintenance staff 5/18/15.</p> <p>2. Other residents with potential to be affected; no residents were affected.</p> <p>3. Measures to prevent reoccurrence; Environmental</p>	05/23/2015

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	<p>power strip to power the copier machine and a computer router.</p> <p>b) The resident living room used a gray extension cord to power a television and radio.</p> <p>c) The social service office used a power strip to power a telephone and computer.</p> <p>d) The therapy room used a power strip to power a set of speakers and a computer.</p> <p>e) Resident room 330 used a power strip to power an oxygen concentrator.</p> <p>f) Resident room 357 used a power strip to power a bed side light.</p> <p>The above listed locations using power strips and extension cords was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 04/23/15 at 12:40 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 46 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 that are subject to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of</p>		<p>Supervisor/designee will do a monthly audit as part of the preventative maintenance program to ensure there are no power strips/extension cords in use in any areas of the facility and GFCI protection is used in wet areas.</p> <p>4. Monitoring of corrective action to ensure the practice will not recur; To prevent reoccurrence the QA committee will be responsible for oversight of facility compliance on a monthly basis ongoing.</p> <p>5. Date systematic changes will be completed; 5/23/15</p>	

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	<p>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 affects all kitchen staff.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor and hospital director of maintenance on 04/23/15 at 11:20 a.m., the kitchen had one electric outlet three feet from the two compartment sink with no ground fault circuit interrupter on the electric outlet. Based on observation of the main electrical breaker panel with the maintenance supervisor and hospital director of maintenance at the time of observation, the circuit breaker for the electric outlet near the two compartment sink was not provided with GFCI protection. This was verified by the maintenance supervisor and hospital director of maintenance at the time of observation and acknowledged by the administrator at the exit conference on 04/23/15 at 12:40 p.m.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/20/2015

FORM APPROVED

OMB NO. 0938-0391

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