STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155661	A. BUILDING -- B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OWEN VALLEY REHABILITATION AND HEALTHCARE CENTER	920 W HIGHWAY 46 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/27/23 Facility Number: 010892 Provider Number: 155661 AIM Number: 200229560 At this Emergency Preparedness survey, Owen Valley Rehabilitation Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 113 certified beds, with a current census of 77. Quality Review completed on 03/30/23	E 0000	**We are requesting paper compliance.** Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/27/23 Facility Number: 010892 Provider Number: 155661 AIM Number: 200229560 At this Life Safety Code survey, Owen Valley	K 0000	**We are requesting paper compliance.** Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tim Cooper	Executive Director	04/12/2023

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	Rehabilitation Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 113 and had a census of 77 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 03/30/23		care and to comply with all applicable state and federal regulatory requirements.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the			

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	staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in			

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	accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 delayed egress locks were readily accessible for residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locking Systems, says approved, listed, delayed-egress locking systems shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided: (4*) A readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice could affect at least 10 residents, staff and visitors. Findings include: Based on observations on 03/27/23 between 11:00 a.m. and 1:00 p.m. during a tour of the facility with the Director of Plant Operations, the 300 hall east exit door was equipped with a magnetic lock with 15 second delayed egress. This exit door was not provided with signage that read, PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15	K 0222	**K222: Egress Doors** **The facility requests paper compliance for this citation.*This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*1)Immediate actions taken for those residents identifiedNo resident was found to be affected by the finding.2)How the facility identified other residents:Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice3) Measures put into place/ System changes:a. The Signage was placed on exit door on 300 hall. .b. All exit doors have the key code posted at a visible level near the keypad. 4)How**	04/13/2023

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	SECONDS. Furthermore, this exit door did not have the code posted near the keypad to exit. When tested by maintenance, the door did release from the magnetic holder when pushing on the panic bar and activating the 15 second delayed egress, and by pushing the code. Based on interview at the time of observation, the Director of Plant Operations acknowledged this exit door was not equipped with the proper signage or had the code posted near the keypad. This finding was reviewed with the Director of Plant Operations, Senior Executive Director, and Director of Nursing during the exit conference. 3.1-19(b)		**the corrective actions will be monitored:**The Maintenance Director/designee has re-educated staff members of the location of the key codes. Maintenance Director/designee will audit exit doorways and signage weekly to ensure codes are present and visible for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 04/13/2023**	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure the lighting for 2 of 7 exit means of egress was properly maintained and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect at least 30 residents as well as staff and visitors.	K 0281	**K281: Illumination of Means of Egress** **The facility requests paper compliance for this citation.*This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the**	04/13/2023

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	Findings include: Based on observations on 03/27/23 between 11:00 a.m. and 1:00 p.m. during a tour of the facility with the Director of Plant Operations, there was a connecting sidewalk from the main dining room side exit and the 300 hall exit. There was lighting outside each exit, however, the lighting provided would not provide enough light on the connecting sidewalks to the public way. Based on interview at the time of observations, this was acknowledged by the Director of Plant Operations who agreed the connecting sidewalks need more light provided. This finding was reviewed with the Director of Plant Operations, Senior Executive Director, and Director of Nursing during the exit conference. 3.1-19(b)		***provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*****1)Immediate actions taken for those residents identifiedNo resident was found to be affected by the finding.2)How the facility identified other residents:Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice3) Measures put into place/ System changes:Facility is working with a vendor to provide lighting to the exit egress areas identified. Wood electric will be out 4/11/23 to install lighting. 4)How the corrective actions will be monitored:The Maintenance Director/designee has updated the IDT of the additional lightning. Maintenance Director or designee will audit egress lighting weekly to ensure proper illumination level in designated areas. No additional measures are required for this citation at this time.5) Date of compliance: 04/13/23**	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor doors to 1 of over 10 hazardous area doors, such as an Activity Storage room door, was provided with a properly operating self closing device. This deficient	K 0321	**K321** **Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement**	04/13/2023

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	practice could affect at least 10 residents, staff, and visitors. Findings include: Based on observations on 03/27/23 between 11:00 a.m. and 1:00 p.m. during a tour of the facility with the Director of Plant Operations, the Activity Storage room was over 50 square feet in size, and was full of combustible items such as cardboard boxes, paper, and plastic items. The corridor door to this room was provided with a self closing hinge, however, the door did not self close when tested several times. Based on interview at the time of observation, the Director of Plant Operations agreed the Activity Storage room door did not self close with tested. This finding was reviewed with the Director of Plant Operations, Senior Executive Director, and Director of Nursing during the exit conference. 3.1-19(b)		**with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. 1. Immediate actions taken for those residents identified: Maintenance Director completed a facility wide audit to identify any other areas within the center that would need an automatic closure on rooms designed for storage over 50 sq. feet. The Activity Door Hinge was fixed immediately. 2. How the facility identified other residents:All resident have the potential to be affected. 3. Measures put into place/ System changes: All rooms identified as storage over 50 sq. feet had an automatic closure placed in service on or before 04/13/23. All staff will be educated by the Nurse Educator or designee on or before 04/13/2023 on facility policy regarding supply equipment storage. 4. Measures put into place/ System changes:The responsible party for this plan of correction is the Maintenance Director or Designee. Staff education will**	

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			be provided to staff currently employed by the center by the Nurse Educator or designee on or before 04/13/2023. All new Hires will be educated during the Center Specific orientation. The Maintenance Director will audit the center rooms for door hinges that should automatic shut 3 times per week for 4 weeks, then 1 time per week for the next 8 weeks. The Executive Director or designee will report findings of audits monthly times 6 months to the Quality Assurance Performance Improvement Committee (QAPI) which includes the Center Executive Director, Center Nurse Executive, Assistant director of Nursing, Medical Director, Social Service Food Service Director, Dietitian, Health Information Manager, Business Office Manager, Therapy Program Director, Maintenance Director, Activity Director and Certified Aides for additional follow up and/or in servicing until the issue is resolved and ongoing thereafter as determined by the QAPI committee. Compliance Date: 04/13/2023	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in			

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	accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	Based on observation and interview, the facility failed to ensure the cook top in 1 of 1 Garden Unit kitchenette was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a	K 0324	**K324: Cooking Facilities** **The facility requests paper compliance for this citation.*This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*1)Immediate actions taken for those residents identifiedNo**	04/13/2023

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	restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect staff and residents in the Garden Unit kitchenette. Findings include: Based on observations on 03/27/23 between 11:00 a.m. and 1:00 p.m. during a tour of the facility with the Director of Plant Operations, there was a cooktop stove in the Garden Unit kitchenette. When asked, the Director of Plant Operations pointed out the stove disconnect in a cabinet above the stove, however, the stove was not being used at the time of observation and the power to the stove was still on. Based on interview at the time of observation, the Director of Plant Operations confirmed the cooktop stove was not deactivated when not in use. This finding was reviewed with the Director of Plant Operations, Senior Executive Director, and Director of Nursing during the exit conference. 3.1-19(b)		**resident was found to be affected by the finding.2)How the facility identified other residents:Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice3) Measures put into place/ System changes:1. Facility has ensured the cooktop stoves in the Garden Unit Kitchenette have been deactivated accordingly. No other stoves of this nature exist in this building.**2. Staff have been educated to deactivate stove when not in use.**How the corrective actions will be monitored:**The Maintenance Director/designee has re-educated staff members on proper use of the stove deactivation button in the Garden Unit Kitchenette. Maintenance Director/designee will audit stove deactivation weekly to ensure proper usage for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 04/13/2023**	
K 0353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing			

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Bldg. 01	Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on observation and interview, the facility failed to ensure sprinkler heads in 2 of 6 smoke compartments covered with corrosion or loaded, were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect at least 30 resident, as well as kitchen staff and visitors within the smoke compartments. Findings include: Based on observations on 03/27/23 between 11:00	K 0353	**K353: Sprinkler System-Maintenance and Testing** **The facility requests paper compliance for this citation.*This Plan of Correction is the center's credible allegation of compliance.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*1)Immediate actions taken for those residents identifiedNo resident was found to be**	04/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155661	A. BUILDING 01 B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OWEN VALLEY REHABILITATION AND HEALTHCARE CENTER	920 W HIGHWAY 46 SPENCER, IN 47460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	a.m. and 1:00 p.m. during a tour of the facility with the Director of Plant Operations, the following was noted: a. There was one sprinkler head in the Service Hall Mechanical Room covered with corrosion. b. There was one sprinkler head under the main dining room side exit porch overhang loaded with a foreign substance that appeared to be dust/dirt. c. There were two sprinkler heads under the Garden Unit courtyard east porch overhang covered with corrosion. Based on interview at the time of each observation, the Director of Plant Operations agreed the previously mentioned sprinkler heads were covered with corrosion/loading and should be replaced. This finding was reviewed with the Director of Plant Operations, Senior Executive Director, and Director of Nursing during the exit conference. 3.1-19(b)		**affected by the finding.2)How the facility identified other residents:Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice3) Measures put into place/ System changes:1. Sprinkler heads noted to have corrosion in 2 of 6 areas are on order to be replaced.a. Sprinkler escutcheon in the service hall room on order to be replaced.b. Sprinkler escutcheon in the main dining on order to be replaced. c. Sprinkler escutcheon in the 2 sprinkler heads on the garden unit on order to be replaced.4)How the corrective actions will be monitored:The Maintenance Director/designee will audit 5 random sprinkler heads weekly to ensure they are in proper working order for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 04/13/2023**	

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 2 of over 20 wet locations, were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments	K 0511	**K511: Utilities- Gas and Electric** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **Visitors, staff and residents**	04/13/2023

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	only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. 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 mostly staff. Findings include: Based on observations on 03/27/23 between 11:00 a.m. and 1:00 p.m. during a tour of the facility with the Director of Plant Operations, the following		**that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **The two electric receptacles by the bistro and the one by the sink were repaired.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will audit 5 electrical receptacles weekly to ensure proper integrity and functional status for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 04/13/2023**	

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	was noted: a. There was a double electric receptacle within three feet of the sink in the Pantry that on the left side of the double receptacle was provided with GFCI protection. When tested with a GFCI testing device, the left side did break the electrical circuit, however, when testing the receptacle on the right side the electrical circuit was not broken and was not provided with GFCI protection. b. There were two electric receptacles within three feet of the sink in the Bistro area with no GFCI protection provided. When tested with a GFCI tester, the circuit on both receptacles was not broken. Based on interview at the time of each observation, the Director of Plant Operations agreed the receptacles in question were not properly GFCI protected. This finding was reviewed with the Director of Plant Operations, Senior Executive Director and Director of Nursing during the exit conference. 3.1-19(b)			