STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 01 B. WING	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION VALLEY VIEW	333 W MISHAWAKA RD ELKHART, IN 46517

(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 0000 Bldg. 01	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). Survey Date: 02/02/17 Facility Number: 000523 Provider Number: 155496 AIM Number: 100266930 At this Life Safety Code survey, Kindred Nursing and Rehabilitation Valley View 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. 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 smoke detection in the corridors, in areas open to the corridors, and 1 resident room. Battery operated smoke detectors are provided in 74 of 75 rooms resident rooms. The facility has a	K 0000	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. The facility respectfully requests desk review for the deficiencies cited in this survey	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	capacity of 126 and had a census of 81 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has a detached garage providing storage of maintenance equipment and a shed containing storage of wheel chairs and walkers which were not sprinklered. Quality Review completed on 02/06/17 - DA			
K 0100 SS=D Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 1 of 9 smoke barrier doors per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the *Code*, shall be either maintained or removed. This deficient practice could affect staff only because the Hall is closed down. Findings include: Based on observation with the Executive	K 0100	K100 1.The 600 hall smoke barrier doors have been repaired and are now latching properly. 2.All facility smoke barrier doors have been inspected for proper latching. 3.The Maintenance Director or designee will make rounds throughout the facility on a weekly basis to ensure all smoke barrier doors are latching properly. These weekly audits are to be reviewed by the Executive	02/14/2017

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	Director on 02/02/17 at 10:53 a.m., the 600 Hall smoke barrier doors failed to latch when tested. Based on interview at the time of observation, the Executive Director acknowledged the aforementioned condition. 3.1-19(b)		Director to ensure proper compliance. 4.The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained. 5.Completion date 2/14/17.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation, the facility failed to ensure 1 of 2 400 Hall corridors access were in accordance with Chapter 7. LSC 7.1.10.2.1 requires no furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. This deficient practice could affect staff and at least 21 residents in the smoke compartment. Findings include: Based on observation with the Executive Director on 02/02/17 at 11:34 a.m., a	K 0211	K211 1.The “laundry station” set up in the corridor has been removed. 2.All facility corridors have been inspected to ensure no furnishings, decorations, or other objects are obstructing exits. 3.The Maintenance Director or designee will make rounds throughout the facility on a weekly basis to ensure all facility corridors are free from any objects obstructing access to exits. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance.	02/14/2017

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	"Laundry Station" was set up in the corridor including a drawer and a side table. Based on interview at the time of observation, the Executive Director acknowledged the aforementioned condition. 3.1-19(b)		4.The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained. 5.Completion date 2/14/17.	
K 0222 SS=D 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 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			

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	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 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, record review, and interview, the facility failed to ensure 1 of 2 400 Hall exits had a code posted in accordance with 19.2.2.2.5.1. LSC 19.2.2.2.5.1 says door locking arrangements shall be permitted where the clinical needs of patients require	K 0222	K222 1.The entrance to the 400 hall now has a sign posted with instructions for operating the keypad to release the magnetically locked smoke barrier doors.	02/14/2017

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	specialized security measures or where patients pose a security threat, provided that staff can readily unlock doors at all times in accordance with 19.2.2.2.6. LSC 19.2.2.2.6(1)(c) states provisions shall be made for the rapid removal of occupants by other such reliable means available to the staff at all times. This deficient practice could affect staff and up to 2 residents. Findings include: Based on observation with the Executive Director on 02/02/17 at 12:03 p.m., the entrance to the 400 Hall contained smoke barrier doors which were closed and magnetically locked. There was a keypad to release the magnet. No code was posted. Based on an interview at the time of observation, the Executive Director acknowledged the aforementioned condition and confirmed that residents entering the 400 Hall did not have a special need for the additional security measures. 3.1-19(b)		2.All facility exits have been inspected to ensure all can be readily opened as needed . 3.The Maintenance Director or designee will make rounds throughout the facility on a weekly basis to ensure all facility exits can be readily opened as needed. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance. 4.The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained. 5.Completion date 2/14/17.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in			

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	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 1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. This deficient practice could affect all occupants. Findings include: Based on record review with the Executive Director on 02/02/17 at 9:50 a.m., the sprinkler system was inspected quarterly. No documentation was available for the monthly gauges or	K 0353	K353 1.A. The sprinkler system gauges and control valves have been inspected and were found to be within acceptable ranges. 1.The one sprinkler head on the 100 hall exit discharge overhang is being replaced. 1.A. The documentation of sprinkler system gauges and control valves has now been scheduled for regular monthly inspection and documentation. 1.All sprinkler heads in the facility have been inspected for signs of leakage, corrosion, physical damage, loss of fluid in the glass bulb heat responsive element, loading or painting. 1.The Maintenance Director or designee will make monthly	02/14/2017

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	control valves inspection. Based on interview at the time of record review, the Executive Director acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to replace 1 of 1 corroded sprinkler head under the 100 Hall exit discharge overhang in accordance with LSC 9.7.5. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.1.1.2 requires any sprinkler shall be replaced that show signs of leakage, corrosion, physical damage, loss of fluid in the glass bulb heat responsive element, loading, or painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 23 residents. Findings include: Based on observation with the Executive Director on 02/02/17 at 10:19 a.m., one sprinkler head was corroded and had dried clumps of mud on the glass bulb on the 100 Hall exit discharge overhang. Based on interview at the time of observation, the Executive Director acknowledged the aforementioned		inspection of the sprinkler system gauges and control valves, and make rounds throughout the facility on a weekly basis to monitor and ensure that sprinkler heads are showing no signs of leakage, corrosion, physical damage, loss of fluid in the glass bulb heat responsive element, loading or painting. These audits are to be reviewed by the Executive Director to ensure proper compliance. 2.The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained. 3.Completion date 2/14/17.	

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	condition. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers near resident room 406 was installed correctly in accordance with 19.3.5.12. NFPA 10, the Standard for Portable Fire Extinguishers, 7.2.2, Procedures, requires periodic inspection or electronic monitoring of fire extinguishers shall include a check of six items. (3) Pressure gauge reading or indicator in the operable range or position. This deficient practice could affect staff and at least 21 residents in the smoke compartment. Findings include: Based on observation with the Executive Director on 02/02/17 at 11:37 a.m., the fire extinguisher gauge indicated the fire extinguisher was undercharged. Based on interview at the time of observation, the Executive Director acknowledged the	K 0355	K355 1.The undercharged fire extinguisher has been replaced. 2.All facility fire extinguishers have been inspected to ensure all charged as needed . 3.The Maintenance Director or designee will make rounds throughout the facility on a weekly basis to ensure all facility fire extinguishers are charged as needed. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance. 4.The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained. 5.Completion date 2/14/17.	02/14/2017

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	aforementioned condition. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485			

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	Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 75 resident room corridor doors positively latched into the frame. This deficient practice could affect staff and up to 17 residents. Findings include: Based on observation with the Executive Director on 02/02/17 at 10:34 a.m., resident room 211 failed to latch into the frame when tested. Based on interview at the time of observation, the Executive Director acknowledged the aforementioned condition. 3.1-19(b)	K 0363	K363 1.The door to resident room 211 has been repaired and now latches to the frame. 2.All facility resident room doors have been inspected to ensure all latch as needed . 3.The Maintenance Director or designee will make rounds throughout the facility on a weekly basis to ensure all facility resident rooms are latching as needed. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance. 4.The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained. 5.Completion date 2/14/17.	02/14/2017
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved			

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	sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 9 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff and at least 17 residents. Findings include: Based on observations with the Executive Director on 02/02/17 at 11:58 a.m., a one inch unsealed penetration inside conduit was discovered in the 200 Hall smoke barrier. Based on interview at the time of observation, the Executive Director acknowledged the aforementioned condition and provided the measurement. 3.1-19(b)	K 0372	K372 1.The one inch unsealed penetration inside conduit in the 200 hall smoke barrier has been sealed. 2.All facility smoke barriers have been inspected to ensure all penetrations have been properly sealed . 3.The Maintenance Director or designee will make rounds throughout the facility on a weekly basis to ensure all facility smoke barriers are sealed as needed. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance. 4.The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained. 5.Completion date 2/14/17.	02/14/2017
K 0741 SS=D Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and			

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	shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents was maintained in accordance with 19.7.4. LSC 19.7.4 requires ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. Metal containers with a self-closing cover devices into which ashtrays can be emptied shall be readily available to all	K 0741	K741 1.The trash can containing the cigarette butts has been emptied. 2.Facility staff are being in-serviced on the proper procedure for safely disposing of cigarette butts. The designated smoking area of the facility has been equipped with the proper receptacles for disposal of combustible materials 3.The Maintenance Director or designee will make rounds	02/14/2017

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	155496	A. BUILDING 01 B. WING	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION VALLEY VIEW	333 W MISHAWAKA RD ELKHART, IN 46517

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	areas were smoking is permitted. This deficient practice could affect staff and one residents allowed to smoke. Findings include: Based on observations with the Executive Director on 02/02/17 at 10:43 a.m., there were at least 30 cigarette butts in the trash can with other combustible materials in the smoking area. Based on interview at the time of observation, the Executive Director acknowledged the aforementioned condition. 3.1-19(b)		throughout the facility on a weekly basis to ensure all combustible materials are being disposed of properly. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance. 4.The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained. 5.Completion date 2/14/17.	
K 0753 SS=D Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: * Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. * Decorations meet NFPA 701. * Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. * Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. * The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6 Based on observation and interview, the	K 0753	K753	02/14/2017

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	facility failed to ensure 1 of 1 Activities was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect staff and up to 3 residents. Findings include: Based on observations with the Executive Director on 02/02/17 at 10:49 a.m., the Activities room contained a candle with a wick. Based on interview at the time of observation, the Executive Director acknowledged the aforementioned condition. 3.1-19(b)		1.The candle with a wick has been removed from the facility. 2.Facility staff are being in-serviced on the prohibition of combustible decorations on facility property. The facility has been inspected for any other combustible decorations, and any found were removed immediately 3.The Maintenance Director or designee will make rounds throughout the facility on a weekly basis to ensure there are no combustible decorations on the premises. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance. 4.The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained. 5.Completion date 2/14/17.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics),			

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	except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure 1 of 1 multiplug was not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. This deficient practice affects staff and up to 20 residents in the 200 Hall smoke compartment. Findings include: Based on observation with the Executive Director on 02/02/17 at 11:48 a.m., a multiplug was powering a refridgerator and a lamp in resident room 302. Based on interview at the time of observation, the Executive Director acknowledged the aforementioned condition.	K 0920	K920 1.A. The multiplug found in room 302 has been removed from the facility. 1.The GFCI receptacle in the 200 hall clean utility room has been repaired. The GFCI receptacle in the 300 hall clean utility room has been repaired. 1. A. The facility has been inspected for power cords and extension cords and any found have been removed from the facility. 1.The facility has been inspected to ensure all GFCI receptacles are working properly 1.The Maintenance Director or designee will make rounds throughout the facility on a weekly basis and will monitor to ensure	02/14/2017

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 200 Hall Clean Utility room and 1 of 1 300 Hall Clean Utility room was provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff only. Findings include: Based on observation with the Executive Director on 02/02/17 at 10:26 a.m. then again at 11:42 a.m., the 200 Hall Clean Utility room had one GFCI receptacle within three feet of the hand sink. When the GFCI tester button was pressed, power was not interrupted on the GFCI receptacle. Then again, the 300 Hall		that no power cords or extension cords are improperly being used, and to ensure all GFCI receptacles are working properly. These weekly audits are to be reviewed by the Executive Director to ensure proper compliance. 2.The results of these audits will be forwarded to the facility Safety Committee for follow up as needed. The Safety Committee will monitor for 6 months or longer if substantial compliance is not maintained. 3.Completion date 2/14/17.	

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	Clean Utility room had one GFCI receptacle within three feet of the hand sink. When the GFCI tester button was pressed, power was not interrupted on the GFCI receptacle. Based on interview at the time of each observation, the Executive Director acknowledged each aforementioned condition. 3.1-19(b)			