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	370054	A. BUILDING **01 - HOSPITAL** B. WING _____	**08/18/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRADY MEMORIAL HOSPITAL	**2220 IOWA STREET** **CHICKASHA, OK 73018**

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K 000	INITIAL COMMENTS An unannounced Life Safety Code survey was performed at Grady Memorial Hospital under NFPA 101, 2000 Edition, Existing, and NFPA 99, 1999 Edition. The facility is partially sprinkled. Deficiencies were cited as a result of this survey. An exit was conducted on 8-18-15 with the engineering supervisor, Vice President of Patient Care Services, and several other facility staff. No additional documentation or paperwork was provided by the facility.	K 000		
K 018	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 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by:	K 018		

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

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K 018	Continued From page 1 Based on observation it was determined that the facility failed to ensure that doors were equipped with positive latching hardware. Findings: On 8-13-15 at 12:16 p.m., it was observed that the fire door located next to engineering office in the basement would not positively latch as required. At 1:13 p.m., it was observed that the magnectic locked doors located at the entrance of the cafe on the 1st floor had no positive latching hardware. At 1:40 p.m., it was observed that the door to the auxillary conference room on the 1st floor had no positive latching hardware.	K 018		
K 020	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and interview staff, the facility failed to seal verticle openings between floors that are enclosed with construction having a fire resistance rating of at least one hour in accordance with 8.2.5.6. 19.3.1.1. Findings: a) Vertical penetrations were found in the corridor east of the double egress doors to the kitchen entrance.	K 020		

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K 020	Continued From page 2 b) Vertical penetrations were found in the boiler rooms. On August 14, 2015 at 2:00 p.m., staff member X stated that you could probably find a lot of locations with penetrations and that the maintenance department fixes them as they find them.	K 020		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation the facility failed to ensure protection to hazardous areas in accordance with 8.4.1 and/or 19.3.5.4. Findings : Door to the purchasing office was not provided with a closure hardware. 19.3.2.1 Based on observation and interview it was determined that the facility failed to ensure fire barriers had no penetrations. Findings: On 08-13-15 at 10:03 a.m., it was observed the	K 029		

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one hour fire barrier enclosing the engineering plant located in the basement which contains fuel fired appliances had 14 penetrations.
At 10:38 a.m., it was observed that 3 doors located in the engineering plant hazardous area did not have self-closing and positive latching hardware.
At 11:52 a.m., the engineering supervisor was interviewed. The engineering supervisor acknowledged the 14 penetrations and 2 vertical penetrations located in the engineering plant hazardous area. He also acknowledged the doors to the engineering plant did not have self-closing devices.
NFPA 101, 2000 Edition, Chapter 8
8.4.1 General
8.4.1.1*
Protection from any area having a degree of hazard greater than that normal to the general occupancy of the building or structure shall be provided by one of the following means:
(1) Enclose the area with a fire barrier without windows that has a 1-hour fire resistance rating in accordance with Section 8.2.
(2) Protect the area with automatic extinguishing systems in accordance with Section 9.7.
(3) Apply both 8.4.1.1(1) and (2) where the hazard is severe or where otherwise specified by Chapters 12 through 42.

NFPA 101, 2000 Edition Chapter 19
19.3.2 Protection from Hazards
19.3.2.1 Hazardous Areas
Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the

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K 029	Continued From page 4 sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction. (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 048	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on observation and interview with staff the facility failed to provide a plan of protection in an	K 048		

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K 048	Continued From page 5 emergency for all patients and occupants of the building in an emergency in accordance with 19.7.1.1. Findings: a) Penetrations in the one-hour floor separation are found and identified as being wide spread throughout the building. Staff had been notified on August 13, 2015 that vertical penetrations existed in the floor, however the governing body failed to declare and implement alternative measures for occupants of the building and an interim evacuation policy created in accordance with NFPA 101 19.7.2.2 (6). Horizontal evacuation across smoke zone is not now a safe place of refuge because of the penetrations found in the floor (vertical penetrations). Based on observation and staff interview the facility failed to ensure all evacuation routes were clear and unobstructed. Findings: On 08-13-15 at 2:28 p.m., it was observed two patient beds were stored at the exit cooridor at the north side of the operating room. The two pateint beds were within the exit access in the egress path. NFPA 101, 2000 Edition, Chapter 7 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 048		
K 051	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to	K 051		

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K 051	Continued From page 6 NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation, interview with staff and review of records, the facility failed to install and maintained the fire alarm system in accordance with NFPA 72 , NFPA 101 , Chapter 19.3.4, 9.6. Findings a) In 2011 the facility installed magnetic locks on egress doors, doors to the surgical suite and other areas throughout the facility. The hospital failed to preform re-acceptance testing of the fire alarm system in accordance with NFPA 72, Chapter 7-1.6.2. Permanent record of all inspections were not retained and available for	K 051		

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K 051	Continued From page 7 review in accordance with NFPA 72, Chapter 7-5.2 .2 . Re-acceptance testing was not preformed after added controls that monitor/control the operation of the magnetic locks. Staff member X stated he would look for the re-acceptance testing however at the end of the facility's survey no documentation was available or provided for review. b) The gift shop does not have walls that go to roof deck as required. Areas can be open to the corridor and unlimited in size, provided that the area is fully sprinkled and it is protected by an fire detection system. The gift shop was not provided with a smoke detector in accordance with NFPA 101, 2000 Edition, Chapter 19. 3.6.1, exception No. 1(c).	K 051		
K 067	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, interview with staff and record review the governing body failed to ensure heating, ventilating, and air conditioning systems that comply with the provisions of section 9.2 and were installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2. Findings:	K 067		

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K 067	Continued From page 8 a) Exhaust fan that serves the new hoods installed over the sterilizers were not moved and the fan is in a location that does not meet ANI/ASHE Standard 170-208 Ventilation of Health Care Facilities. The Exhaust fan/exhausted air outlet is within 7 to 9 feet from the operating rooms fresh air intakes located on the roof above the clean work room which serves the surgery suite. The exhaust fan is not located at least 25 feet away in accordance with ANI/ASHE 6.3. The fresh air intakes for the operating rooms brings in air from the sterilizer exhaust and air from the plumbing sewer vent with this installation. All vent exhaust fans and alike equipment shall be 25 feet away and 3 feet above the roof line in accordance with ANI/ASHE 6.3. b) Exhaust fan serving the service side of the sterilizers was in a room with openings to exhaust steam and heat from the room. The room is being used as a plenum, however the room was not sealed and insect and bird screens were not installed to prevent their entry into the hospital. Insect spray was found in the janitor's closet in the surgery suite. An 8 inch to 12 inch round duct that lies below the fan was not mechanically connected. The exhaust fan was not engineered and runs continuously. It was undetermined what the duct served; also there were no stamped set of plans available to show the means and method of engineering and installation. Staff member X did not know what the round duct serves, however he stated that he was in the process of identifying the area. c) Based on a test and balance report conducted on December 17, 2014 by ACP Sheet Metal, the sterile processing room is negative (in regards to	K 067		

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K 067	Continued From page 9	K 067		

airflow) in relationship to the east, west and north corridor of the surgery suite. ANI/ASHE Standard 170-208 Ventilation of Health Care Facilities requires positive air flow with 2 outside air exchanges, 4 total air exchanges in an hour. Staff member X stated that the corrective action was ongoing; however at the conclusion of the survey on August 18, 2015 the deficient practice was not corrected.

d) The HVAC Unit located in the mechanical closet in back of the central storage room of the hospital was not protected from the supply room with a wall or damper that prevents the passage of smoke in accordance with NFPA 101, Chapter 19. 3.2.1 and NFPA 90 A 4-3.10.5.3 does not allow rooms used as plenum return to be used as storage; the mechanical room is not separated from the central store room with a wall or damper.

e) The room re-purposed as a soiled utility room located next to the Director of Surgery Office was not provided with an exhaust duct that takes in air. The room was not a part of the test and balance report conducted on 12/17/2014. Staff member X and staff member HH stated that they did not remember what the room was originally designed as, however the room was observed as being used as a space that surgery waste is being stored. Staff member UU was observed placing two bags of trash in the room on August 13, 2015 at 2:44 p.m.

f) Staff member X was asked if the special procedure room was reviewed by in house staff or was a part of the work performed by the test and balance contractor ACP Sheet Metal on December of 2014.

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K 067	Continued From page 10 In review of the report by ACP Sheet Metal, the special procedure room was not a part of the test and balance report. Staff member X stated that he had no reading or documentation of air flow values in the special procedure room. Staff member X and staff member F stated that temperature and humidity was not logged by the engineering department. There was no documentation from infection control or the governing body that requested air flow, temperature or humidity reading reports.	K 067		
K 069	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview with staff the facility failed to ensure cooking facilities were in accordance with 9.2.3. 19.3.2.6, NFPA 96. Findings: The grease duct located over the gas stove in the kitchen was not installed in accordance with NFPA 96, Ventilation Control and Fire Protection of Commercial Cooking Operations, 2008 Edition. a. The access panels were not provided with a gasket or sealant capable of withstanding 1500 degrees F, in accordance with NFPA 96, 2008 Edition , Chapter 7.4.3.2. b. The doors were not provided with bolts or fasteners to hold the doors on without penetrating the duct in accordance with 7.4.3.3. c. Doors were not provided with signs in	K 069		

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K 069	Continued From page 11 accordance with 7.1.6, Access Panel , Do Not Obstruct. d. Access opening were not provided at each change of direction in accordance with 7.3.1.	K 069		
K 075	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observation and interview with staff, the governing body failed to remove soiled linen and trash collection receptacles that exceed 32 gal (121 L) in capacity within any 64 sq. ft. (5.9-sq m) area in rooms, suites, or corridors, not protected in a hazardous area when not attended, in accordance with NFPA 101 chapter 19.7.5.5. Findings: a) Trash receptacles and soiled linen containers greater than 32 gallons were located in rooms, suites, corridors and in the operating rooms. In addition to throughout the facility. It was observed in the basement there was a soiled	K 075		

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K 075	Continued From page 12 linen container approximately 6 feet tall by 6 feet long with wheels located across from engineering office. This use of similar linen containers were observed on each of the floors of the facility. The trash/soiled linen receptacles were observed to be stored where they were open to the cooridor.	K 075		
K 077	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4. This STANDARD is not met as evidenced by: Based on observation and interview with staff, the facility failed to install and maintain piped in medical gas systems that comply with NFPA 99, Chapter 4. Findings: a) The intended use of the patient bed location in the CT scan room was not identified by the governing body in accordance with NFPA 99, Chapter 12.2.6. Staff member F, G and T stated on August 18, 2015 that patients on life support from the intensive care unit receive diagnostic procedures while being connected to mechanical life support. Staff member F was asked to identify the location of the zone valve that serves as emergency shut off for the medical gas outlets in the CT scan room. Staff member F pointed to the zone valve, however staff member F did not identify the required medical gas alarm, she identified a valve that was not marked as serving the CT scan room. Staff member X witnessed the drill. Patient bed locations and critical care areas that provided life support require a medical gas area	K 077		

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K 077	Continued From page 13 alarm in accordance with NFPA 99, 1999 Edition, Chapter 4-3.1.2.2(c)1. b) The patient bed location for special procedures room is not specifically identified by the conscious sedation policy. Staff member F stated that the room was used for sedation, and pain management. This bed location is not provided with an area alarm in accordance with NFPA 99, 1999 Edition, Chapter 4-3.1.2.2(c)1. c) A carbon steel cap screwed on the opening of the oxygen supply line under the grease duct located in the kitchen which is approximately 15 feet north of the kitchen stove. Staff member X did not know any thing about the steel cap, and there was no documentation regarding the cap being installed. d) Oxygen supply piping under the grease duct was not separated from the duct with protection that keeps the copper from rubbing or from electrolysis from erroding a hole in the piping because of the two unlike metals being in contact with each another. e) A chrome valve with a round handle located above ceiling, which was under the grease duct, was leaking oxygen. The handle was bumped when removing the ceiling tile and started blowing off oxygen vapor.	K 077		
K 078	NFPA 101 LIFE SAFETY CODE STANDARD Anesthetizing locations are protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each	K 078		

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anesthetizing location and are arranged so that shutting off one room or location will not affect others.

(b) Relative humidity is maintained equal to or greater than 35%. NFPA 99 4.3.1.2.3(n) and 5.4.1.1, 19.3.2.3

This STANDARD is not met as evidenced by:
Based on observation and interview with staff, the facility failed to protect anesthetizing locations in accordance with NFPA 99, Standard for Health Care Facilities. Finding:

a) A CMS categorical waiver for humidity was used, and then was retracted by the facility in accordance with meeting minutes from July 1, 2015 safety minutes. Staff member A stated that the facility was retracting the previously adopted low humidity waiver since the state has not adopted the 20% values. Staff member A stated in the July 1, 2015 Safety Meeting minutes the recently installed portable humidifier is blowing hot air and has improved the humidity problem in the operating room and special procedures room, but has increased the temperature.

Humidity levels in the operating rooms during the cold months were less than the 20% level with no corrective action. On January 8, and 9 in operating room #2 (in accordance with humidity and temperature logs) the humidity was recorded at 9%. On the following days: January 5, 6, 7, 12, 13, 14, 15, 16, 19, the recorded humidity ranges were less than the 20%. From May until June 10,

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2015 the humidity levels in accordance with operating room and humidity logs recorded humidity levels were higher than 60%. ANI/ASHE Standard 170-208 Ventilation of Health Care Facilities requires humidity ranges to be 30% to 60%. In late May and early June (between May 19 to June 4) the humidity ranges were 70% to 74%.

b) The portable dehumidifier was purchased and installed on a wooden shelf, however the dehumidifier was not in accordance with ANI/ASHE Standard 170-208, Ventilation of Health Care Facilities. A portable dehumidifier is not allowed to be in the facility. Air recirculating by means of room units is forbidden.

The drain line for the unit is forbidden in accordance with International Mechanical Code 2003 edition, 307.2.1 which requires the drain in an approved place of disposal. NFPA 101 4.6.6 requires additions to conform to these provisions for new construction. Staff member X did not submit the addition of the new equipment to the Authority Having Jurisdiction for review and approval.

c) Based on interview with staff members J, E and UU at 2:30 p.m. on August 13, 2015 staff were asked to describe the equipment that was pointed to during interview. The piece of equipment the surveyor pointed to was a line isolation monitor mounted in a stainless steel cabinet located on each of the operating room's walls. Staff members did not know what the equipment was or how it is used. Staff member E stated that UU was a new hire and had not had department orientation, staff member E stated that UU was hired just within the last 2 weeks.

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K 078	Continued From page 16 Staff member UU, who was currently working in the operating room, failed to point out the location of the medical gas shut off for each of the operating rooms. Administrative authorities and the Governing Body failed to ascertain that electrical safeguards were in accordance with NFPA 99 12-4.1.2.4. Physical safeguards were not built into the anesthetizing locations or storage areas to provide protection. Personnel working in anesthetizing locations were not instructed in these electrical safeguards. The facility did not provide any documentation to confirm this training. The governing board of the hospital in its responsibility to enforce requirements contained in Chapter 12 of NFPA 99 failed to see that the creation and implementation of adequate regulations were adopted, tracked and reported with respect to anesthesia practices. The board also failed to determine procedures to be conducted in the anesthetizing locations. The medical staff also failed to adopt regulations with respect to inhalation anesthetizing agents adequate for administrative, nursing, and ancillary personnel of the hospital to inspect, maintain regulations and equipment in an orderly fashion in accordance with NFPA 99 12-4.1.1.3. Staff members J, E and UU stated that documentation for a fire drill was available for review which included all of the provisions of Fire Loss Prevention and Electrical Safety in Anesthetizing Locations to include all staff and Physicians in accordance with NFPA 99, 1999 Edition Chapter 12-4.1.2.10 Fire Loss Prevention. An evaluation was not made of the hazards that could be encountered during surgical procedures. The evaluation shall include hazards associated	K 078		

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K 078	Continued From page 17 with the properties of electricity, hazards associated with the operation of surgical equipment, and hazards associated with the nature of the environment. The facility failed to post rules and regulations in the operating room suite necessary to acquaint all personnel with the rules and regulations established and to ensure enforcement in accordance with NFPA 99, 1999 Edition, Chapter 12-4.1.1.4. d) Humidity levels and air flow in special procedures room were not logged. i) The humidifier was turned off, Staff member X stated he did not know why it was turned off. ANI/ASHE Standard 170-208, Ventilation of Health Care Facilities requires 30% to 60% humidity with positive air flow. ii) Design parameters for special procedure room were not available. The facility had not conducted a test and balance report for the special procedure room. iii) Manometers required to monitor HEPA Filters in HVAC Units were not logged. Staff member X stated that they change out filters on a semi yearly basis; however he could not provide documentation regarding the life of these filters.	K 078		
K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation, staff interview and	K 130		

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documentaiton review of policies and procedures the governing body failed to identify patient care areas in accordance with NFPA 99, 1999 Edition Chapter 12-2.6 and 12-2.7. Findings:

a) Areas of a hospital in which patient care is administered are classified as general care areas or critical care areas, either of which is permitted to be classified as a wet location. The governing body of the facility failed to designate patient care areas throughout the hospital in accordance with the type of patient care anticipated for each patient care vicinity using the following definitions of the area classification.

i) General Care Area. See definition in Chapter 2
ii) Critical Care Area. See definition in Chapter 2
iii) Wet Location. See definition in Chapter 2

The facilities CT scan room, special procedure room, operating rooms, were not designated as critical care or wet locations as required.
b) The scope cleaning equipment/medivators, installed in the operating room sterile corridor, adjacent to OR#1 and OR#2, blocked the isolated ground panels which were located in the closet left of the scope cleaning equipment. The grounding panels are used for protection of the patient on the operating table and provides circuit breaker switch for each circuit in each OR. The facility failed to use a design professional to assess the methods and demonstrate that the design will achieve Life Safety & sterile objectives. NFPA 101, 4.6.6 requires additions or alterations to meet new construction. Staff member HH and X could not provide drawings or plans that was used to re-purpose the space.

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K 130	Continued From page 19 c) Staff members G & TT were asked on August 13, 2:38 p.m. if the emergency department used one time battery use portable cautery tool. Staff members G & TT indicated that they had one and presented one to the surveyor. Staff members G&TT were asked for specific training and what is to be considered when using this piece of equipment. Staff members TT & G stated that no area specific training or equipment training for nurses or Physicians had been provided to staff with this piece of equipment. i) The governing body failed to provide appropriate programs of continuing education for its personnel. Personnel concerned with the application and maintenance of electric and battery operated appliances, including physicians, nurses nurse aids, engineers, technicians, and orderlies, were not cognizant of the risks associated with their use. The facility failed to ensure that the use of combustibles such as alcohol and combustible preps used in conjunction with an ignition source (cautery tool) in the emergency department and other departments with similar equipment provided the training necessary to ensure safe and effective treatment in accordance with NFPA 99, 1999 edition, chapter 7-6.5 Qualification and Training of Personnel.	K 130		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, interview with staff, and record review, the facility failed to install and	K 147		

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maintain Electrical wiring and equipment is in accordance with NFPA 70, NFPA 1999 Edition, and the National Electrical Code. 9.1.2. Findings:

a) The facility failed to conduct impedance ground testing of patient care areas in accordance with NFPA 99, chapter 3-3.3 Performance Criteria and Testing. Staff member X stated that they had not created a work order for Impedance Ground Testing.

b) The governing body failed to designate, wire and protect the cat scan room located in radiology for the type of patient care provided. NFPA 99 chapter 3-2.4.2, states that "Need to Maintain Power". Staff members F, G, and T stated that patients in intensive care unit are transported to CT scan room, and are connected to and maintained on ventilator/life support while receiving diagnostic procedures. The governing body failed to ensure that the patient bed location in the cat room was wired in accordance with NFPA 99, chapter 3-3.2.1.2, "All Patient Care Areas: The critical care bed location was not served by circuits from (1) critical branch panel(s) served from a single automatic transfer switch and (2) a minimum of one circuit served by the normal power distribution system or by a system originating from a second critical branch transfer switch."

i) Receptacle in cat scan room located on the north wall lacked the retention force for the grounding blade to hold the power cord tightly in the receptacle. Staff member F was asked to verify the condition of the receptacle on August 18, 2015 at 3:00 p.m. She stated that the cord would not stay plugged in tightly in the receptacle, and verified that the power cord would lay or drop

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K 147	Continued From page 21 down; also the receptacle was not hospital grade. ii) The minimum numbers of receptacles for patient bed locations in critical care bed locations are six receptacles within the patient care vicinity. Patient care vicinity is the space within a location intended for the examination and treatment of patients, extending 6 ft. (1.8 m) beyond the normal location of the bed, chair table, treadmill, or other device that supports the patient during examination and treatment. 2) Based on observation, interview with staff, review of policies and procedures, the governing body failed to establish policies and protocols for the type of test and testing intervals for each appliance. All appliances used in patient care areas shall be tested in accordance with 7-5.1.3 or 7-5.2.2.1 before being put into service for the first time and after repair or modification. Patient care related electrical appliances were not re-tested at intervals determined by their normal location or areas of normal use, and exceed the intervals listed below: a. General care areas-12 months b. Critical care areas-6 months c. Wet locations-6 months i) Based on statement by staff member V on August 18, 2015 at 2:30 p.m., the biomedical devices located in the cat room were not tested every six months. Staff member V stated that he did not know the room was a critical care bed location. The governing body failed to adopt policies and procedures to identify patient bed locations as critical care, general care or wet locations.	K 147		

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K 147	Continued From page 22 ii) Biomedical equipment in the cat scan room were not tested on a six months intervals : suction pump, located on the crash cart. The suction pump was tested on December of 2014 and was scheduled for retest on December 2015. Trigger Monitor 3150 & Cardiac Monitor did not have a sticker that indicated it was ever tested. On August 13, 2015 at 1:00 p.m., Staff member V stated that he did not know why it was not checked and did not know why it was not taken out of service. Staff member V stated that biomedical equipment was not tested in the CT scan room because it was just over looked. The line isolation monitor located in the Special Procedures room was not tested in accordance with NFPA 99, 1999 Edition, Chapter 3-3.3.4.2. Staff member X stated to both surveyors that he did not know that this piece of equipment existed. 3) Staff member X stated that the isolated ground in OR #1 and #2 were not tested. Impedance Ground Testing Documentation was not available for OR'S rooms 1&2. Shelves and doors were blocking the Isolated Ground. In an emergency staff could not have access to the breaker. On August 13, 2015 2 staff members removed the storage shelves that blocked entrance to the breakers located on a closet between OR #1 and the scope cleaning equipment. Staff members J, D, UU were asked what this equipment was . Staff members J, D, & UU was unable to describe the equipment or its use. Staff member X stated that the Isolated Ground was to be replaced with a line isolation monitor. Staff member had the quote for replacement, however submission of plans and construction was not on the schedule.	K 147		