

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155501	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/06/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/06/15</p> <p>Facility Number: 000465 Provider Number: 155501 AIM Number: 100273870</p> <p>At this Life Safety Code survey, Signature Healthcare of Bluffton was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility 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 and areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 108 and had a census of 48 at</p>	K 0000	<p>F 000</p> <p>The facility requests that this plan of correction be considered its credible allegation of compliance.</p> <p>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 of federal and state law.</p> <p>The facility also respectfully requests a desk review of this plan of correction.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0025 SS=E Bldg. 01	<p>the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. The facility had a detached garage providing facility services including the maintenance office, maintenance supplies and tools that was not sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 16 residents in one of seven smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the</p>	K 0025	<p>K 025 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Unsealed pipe penetration area in South Hall by Room 8 in Housekeeping Closet was sealed on 8/7/15 using 3M FireBarrier Sealant CP 25WB+ (Red) by Plant Operations Director. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; PlantOperations</p>	09/05/2015

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K 0029 SS=E Bldg. 01	<p>facility with the Plant Operation Director on 08/06/15 at 12:25 p.m., in the ceiling of the housekeeping closet by room 8 there was a half inch unsealed penetration around a pipe. Based on interview at the time of observation, the Plant Operation Director acknowledged and provided the measurement of the penetration.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved</p>		<p>Director to identify other areas within facility by hall for 100% inspection of pipe penetration. No other areas were identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Plant Operations Director to implement inspection log of all potential areas within facility to inspect for compliance. (Log to include Wire Penetration as well). See attachment 1. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Inspection log to include bi-weekly compliance inspections for first 60 days, then 2 quarterly compliance inspections, and then an annual inspection for compliance. Compliance Inspection Log to be signed off by CEO and/or designee along with Plant Operations Director. The Quality Assurance committee will review monthly for 12 months then quarterly thereafter. By what date the systemic changes will be completed. September 5, 2015</p>		

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	<p>automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 4 rooms with a gas-fired hot water heater, a hazardous area, was smoke resistive. This deficient practice could affect 12 residents in the 500 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operation Director on 08/06/15 Between 10:30 a.m. and 11:25 a.m., there was a one fourth of an inch unsealed penetration around a wire in the walls of the maintenance closets by room 505 and by the laundry room, both closets contains a gas-fired hot water heater. Based on interview at the time of observation, the Plant Operation Director acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p>	K 0029	<p>K 029 Whatcorrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Unsealed wire penetration areas in 2 Maintenance Closets were sealed on 8/7/15 using 3M Fire Barrier Sealant CP 25WB+ (Red) by Plant Operations Director. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Plant Operations Director to identify other areas within facility by hall for 100% inspection of wire penetration. No other areas identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Plant Operations Director to implement inspection log of all potential areas within facility to inspect for compliance. (Log to include Pipe Penetration compliance as well). See</p>	09/05/2015

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K 0051 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to 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		Attachment 1. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Inspection log to include bi-weekly compliance inspections for first 60 days, then 2 quarterly compliance inspections, and then an annual inspection for compliance. Compliance Inspection Log to be signed off by CEO and/or designee along with Plant Operations Director. Quality Assurance Committee will review findings monthly for 12 months, then quarterly thereafter. By what date the systemic changes will be completed. September 5, 2015	

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	<p>the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to provide annunciation for 1 of 1 fire alarm systems in accordance with NFPA 72. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operation Director on 08/06/15 at 10:45 a.m., the fire alarm control panel (FACP) was located at the north nurses' station, which was closed down due to low census and was not manned. Based on interview at the time of observation, the Plant Operation Director confirmed the FACP was monitored off site but the onsite audible trouble alarm was not continually monitored after regular business hours when the area housing the FACP was unoccupied.</p> <p>3.1-19(b)</p>	K 0051	<p>K 051 Whatcorrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; An installation agreement has been accepted and work is to be accomplished within 30 days (by 9/21/15) to install a LCD-80 annunciator in the center nurses station. Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; An installation agreement has been accepted and work is to be accomplished within30 days(by 9/21/15) to install a LCD-80 annunciator in the center nurses station.What measures will be put intoplace or what systemic changes will be made to ensure that the deficien tpractice does not recur; A 15minute watch has been initiated until the annunciator is moved to CenterStation. In addition, Plant Ops will test the annunciator monthly during fire drill and document results on log. See attachment 2.How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Fire annunciator checks will be reviewed and</p>	09/21/2015			

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K 0062 SS=B Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to maintain 2 of 3 sprinklers in the employee lounge. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice was not in a resident area but can affect any staff in the employee lounge.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operation Director on 08/06/15 at 11:25 a.m., two automatic sprinklers in the employee lounge where completely covered with dust and lint. Based on interview, this was acknowledged by the Plant Operation Director at the time of observation.</p>	K 0062	<p>findings presented to the Quality Assurance Committee for further recommendations if indicated. By what date the systemic changes will be completed. 9/21/15</p> <p>K 062 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The 2 of 3 automatic sprinklerheads in Employee Lounge were cleaned of dust and lint on August 7, 2015 by Plant Operations Director.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Plant Operations Director to identify other sprinkler areas that could potentially affect staff. No other areas identified.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Plant Operations Director to implement inspection log of all potential areas within facility to inspect sprinklerheads for dust and/or lint for compliance.</p>	09/05/2015

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K 0074 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance</p>		<p>See attachment 1.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Inspection log to include bi-weekly compliance inspections for first 60 days, then 2 quarterly compliance inspections, and then an annual inspection for compliance. Compliance Inspection Log to be signed off by CEO and/or designee along with Plant Operations Director. Quality Assurance committee will review monthly for 12 months, then quarterly thereafter.By what date the systemic changes will be completed. September 5, 2015</p>		

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	<p>with the method cited in 10.3.2 (3) , 10.3.4.19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure curtains in 1 of 1 resident rooms were flame retardant. This deficient practice could affect 2 residents.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operation Director on 08/06/15 at 11:45 a.m., in resident room 404 there was a hanging curtain covering a closet that lacked attached documentation confirming it was inherently flame retardant. Based on interview at the time of observation, the Plant Operation Director confirmed there was no documentation regarding flame retardancy for the curtain available for review.</p> <p>3.1-19(b)</p>	K 0074	<p>K 074 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Hanging curtain covering closet in room 404 removed on August 7, 2015. Received Inspecta-Shield Plus Fire Retardant Coating Chemical from FESCO on August 11, 2015. 14 ounces of Fire Retardant Coating applied to 66 square feet of curtain area in Maintenance shop August 11, 2015 and curtain reinstalled in resident room August 12, 2015. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other residents were found to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Admissions/Marketing Director and/or Social Services Director to notify Plant Operations Director in the event of any such like materials enter facility for inspection of fire retardancy Plant Operations Director to verify material(s) tag for compliance of Fire Retardancy. All newly introduced material(s) needing fire retardant chemical applied</p>	09/05/2015			

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K 0144 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators were provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to</p>	K 0144	<p>will be done by Plant Operations Director prior to installationHow the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Only approved fire retardant material(s) will be approved/allowed and Housekeeping/Laundry Staff to be notified of such item(s). Housekeeping/Laundry Staff to notify Plant Operations Director in the event the item(s) have been washed so that Plant Operations Director reapplies fire retardant coating to item(s) prior to reinstallation after washing. By what date the systemic changes will be completed. September 5, 2015</p> <p>K 144 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; An installation agreement has been accepted and work is to be accomplished within 30 days (by 9/21/15) to install an annunciator in the center nurses station. How other</p>	09/21/2015

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	<p>operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals shall indicate:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient</p>		<p>residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; An installation agreement has been accepted and work is to be accomplished within 30 days (by 9/21/15) to install an annunciator in the center nurses station.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; A 15 minute watch has been initiated until the annunciator is moved to Center Station. In addition, Plant Ops will test the annunciator weekly during generator test and document results on log. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Annunciator checks will be reviewed and findings presented to the Quality Assurance Committee monthly for further recommendations if indicated.</p> <p>By what date the systemic changes will be completed. 9/21/15</p>				

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K 0147 SS=E Bldg. 01	<p>practice could affect all the residents.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Plant Operation Director on 08/06/15 at 10:45 a.m., the remote alarm annunciator for the generator was located at the north nurses' station, which was closed down due to low census and was not manned. Based on interview at the time of observation, the Plant Operation Director confirmed the remote alarm annunciator for the generator was not continually monitored after regular business hours when the area housing the remote alarm annunciator was unoccupied.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords in the in the facility were not used as a substitute for fixed wiring to provide power for medical equipment and equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that,</p>	K 0147	K 147 What corrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; a.) Two refrigerators were unplugged from powerstrip within 10 minutes of observation by Housekeeping/Laundry	09/05/2015			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF BLUFFTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1529 W LANCASTER ST BLUFFTON, IN 46714		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 6 residents.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Plant Operations Director on 08/06/15 between 10:50 a.m. and 11:52 a.m., the following was observed:</p> <p>a.) in resident room 505 two refrigerators were supplied with electricity by an extension cord power strip.</p> <p>b.) in resident room 412 a medical suction machine and a nebulizer were supplied with electricity by an extension cord power strip.</p> <p>c.) in resident room 24 an oxygen concentrator was supplied with electricity by an extension cord power strip. Based on interview, the Plant Operations Director acknowledged that medical equipment and equipment with a high current draw were supplied power by extension cord power strips at the time of observation.</p> <p>3.1-19(b)</p>		<p>Manager and room rearranged with both units being plugged into outlets directly and surveyor was notified immediately. b.) Medical equipment in room 412 removed from power strip and plugged directly into wall outlets on August 7, 2015 by Plant Operations Director. c.) Medical equipment in room 24 removed from power strip and plugged directly into wall outlets on August 7, 2015 by Plant Operations Director.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; No other residents were found to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Plant Operations Director educated Department Heads on August 7, 2015 regarding: under no circumstances can any medical equipment and/or heat generating devices such as refrigerators be plugged into a power strip. Admissions/Social Services/Nursing/Housekeeping/Laundry Staff to notify Plant Operations Director of all new admits and/or room moves that they are having difficulty arranging such items within</p>		

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			<p>room to be plugged directly into an outlet. ; Plant Operations Director to implement inspection log of all potential areas within facility to inspect for compliance. See attachment 3. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Plant Operations Director educated Department Heads on August 7, 2015 regarding: under no circumstances can any medical equipment and/or heat generating devices such as refrigerators be plugged into a power strip. Admissions/Social Services/Nursing/Housekeeping/Laundry Staff to notify Plant Operations Director of all new admits and/or room moves that they are having difficulty arranging such items within room to be plugged directly into an outlet. ; Plant Operations Director to implement inspection log of all potential areas within facility to inspect for compliance. See attachment 3. Inspection log to include bi-weekly compliance inspections for first 60 days, then 2 quarterly compliance inspections, and then an annual inspection for compliance. Compliance Inspection Log to be signed off</p>	

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K 0155 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 written fire watch policy addressed all procedures to be followed in this facility in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on a review of the Fire Alarm, Sprinkler System, and Smoke Detection System Policy with the Plant Operations Director on 08/06/15 at 10:00 a.m., the written policy lacked notification of the local fire department, the alarm company,</p>	K 0155	<p>byCEO and/or designee along with Plant Operations Director. Quality Assurance committee to monitor monthly for compliance. By what date the systemic changes will be completed. September 5, 2015</p> <p>K 155 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Policy revised in-house per Corporate directive on August 10, 2015 by Plant Operations Director.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Plant Operations Director updated Facility Policy Manual and Emergency Response Plan Books for all Nurse Stations August 10, 2015. All staff will be educated on Policy change by 9/4/15.See attachment 4 and 5. What measures will be into place or what systemic changes will be made to ensure that the deficient</p>	09/05/2015

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	the insurance carrier, and the Indiana State Department of Health. Based on interview, this was verified by the Plant Operations Director at the time of record review. 3.1-19(b)		practice does not recur; Plant Operations Director to implement revisions as necessary upon changes made by contracted vendors via Corporate. New staff will be educated on policy during orientation and annually thereafter. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Annual review of Facility Policy Manual by facility Quality Assurance Committee and/or as directed of notification of change to policy via Governing body. Quality Assurance committee will make any further recommendations as needed. By what date the systemic changes will be completed. September 5, 2015		