

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>1a</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/26/2016
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NAME OF PROVIDER OR SUPPLIER FAIRWAY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
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K 0000 Bldg. 1a	<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: 05/26/16</p> <p>Facility Number: 004700 Provider Number: 155741 AIM Number: 100266630</p> <p>At this Life Safety Code survey, Fairway Village 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 with a partial basement was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping</p>	K 0000	<p>Dear Life Safety Supervisor, Fairway Village respectfully request Paper Compliance for cited deficiencies. For additional questions please don't hesitate calling me directly 317-787-8951. Thanks in advance Jessica Dickson Executive Director</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 0017 SS=D Bldg. 1a	<p>rooms. The facility has a capacity of 53 and had a census of 47 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached storage shed.</p> <p>Quality Review completed on 06/02/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 business offices open to the corridor was provided with an electrically supervised automatic smoke detection system. Exception No. 1 to LSC Section 19.3.6.1 states smoke</p>	K 0017	<p>K-17 Whatcorrective action (s) will be accomplished for those residents found to havebeen affected by the</p>	06/20/2016

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	<p>compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 shall be permitted to have spaces open to the corridor provided the following criteria are met:</p> <p>(a) the spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) the corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4 or the smoke compartment in which the space is located is protected throughout by quick response sprinklers. (c) the open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4 or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) the space does not obstruct access to required access.</p> <p>This deficient practice could affect two residents, staff and visitors near the Business Office at the front entrance lobby.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor</p>		<p>deficient practice;</p> <p>All residents, staff and visitors found to have beenaffected by this deficient practice.</p> <p>Howother residents have the potential to be affected by the same deficientpractice will be identified and what corrective action (s) will be taken;</p> <p>All residents, staff and visitors found to have beenaffected by this deficient practice. Environmental Services Director contactedIntegrated Electronics and a smoke detector was installed in the BusinessOffice. The installed smoke detector is equipped with quick response and is nowconnected to our electronically supervised automatic smoke detection system.</p> <p>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;</p> <p>Environmental Services Director is responsible forcompleting monthly fire alarm drills which sprinkler system is inspectedquarterly by</p>		

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	<p>during a tour of the facility from 11:10 a.m. to 12:40 p.m. on 05/26/16, the Business Office at the front entrance lobby was not provided with an electrically supervised automatic smoke detection system. The Business Office is open to the corridor because a three foot by four foot wide set of nonrated sliding glass doors was in the separation wall of the Business Office from the front entrance lobby. The automatic sprinkler system observed in the Business Office was not equipped with quick response sprinklers and the Business Office is not arranged and located to allow continuous direct supervision by the facility staff from a nurses' station or similar space. Based on interview at the time of observation, the Environmental Services Supervisor acknowledged the Business Office is open to the corridor and is not provided with an electrically supervised automatic smoke detection system.</p> <p>3.1-19(b)</p>		<p>Integrated Electronics which will confirm function of automaticsprinkler system.</p> <p>Howthe corrective action (s) will be monitored to ensure the deficient practicewill not recur, i.e, what quality assurance program will be put into place and</p> <p>Environmental Services Director is responsible forcompleting monthly fire alarm drills which sprinkler system is inspected quarterlyby Integrated Electronics which will confirm function of automatic sprinkler system.Environmental Services Manger will complete Continuously Quality Improvementtool to verify function weekly times 4 weeks and monthly times 6 months andthen quarterly thereafter. The results of these audits will be reviewed by theCQI committee overseen by the ED. If threshold of 95% is not achieved an actionplan will be developed.</p> <p>Bywhat date the systemic changes will be completed June 20, 2016</p>	

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K 0029 SS=E Bldg. 1a	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors to hazardous areas are self-closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the Administrative Personnel Office.</p> <p>Findings include:</p> <p>Based on observations with the Environmental Services Supervisor during a tour of the facility from 11:10 a.m. to 12:40 p.m. on 05/26/16, a two foot by two foot open grill was noted in the west wall of the Administrative Personnel Office closet which contained one natural gas fired furnace. In addition,</p>	K 0029	<p>K-29 What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; All residents, staff and visitors found to have been affected by this deficient practice. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken; All residents, staff and visitors found to have been affected by this deficient practice. Environmental Services Director contacted Lead Contactor and new door with 0 grill to be installed in</p>	06/20/2016
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	<p>the entry door to the closet was not provided with a self-closing device and would not self-close automatically upon activation of the fire alarm system. The entry door to the closet also had a one foot by two foot open grill in the door. Based on interview at the time of the observations, the Environmental Services Supervisor stated the open grill in the closet wall was needed for periodic maintenance access and acknowledged the Administrative Personnel Office closet hazardous area was not separated from other spaces by smoke resistant partitions and doors.</p> <p>3.1-19(b)</p>		<p>Administrative Personnel Office with self-closing device to be added.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Environmental Services Director will be responsible for conducting monthly environmental rounds to confirm function of new door installed.</p> <p>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 Environmental Services Director is responsible for conducting environmental rounds Environmental Services Manger will complete Continuously Quality Improvement tool to verify function weekly times 4 weeks and monthly times 6 months and then quarterly thereafter. The results of these audits will be reviewed by the CQI</p>	

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K 0048 SS=C Bldg. 1a	<p>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</p> <p>Based on record review and interview, the facility failed to document a complete written health care occupancy fire safety plan for 1 of 1 plans which incorporated all items listed in NFPA 101, Section 19.7.2.2.</p> <p>(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire</p> <p>This deficient practice affects all residents, staff and visitors in the event of an emergency.</p>	K 0048	<p>committeeoverseen by the ED. If threshold of 95% is not achieved an action plan will bedeveloped.</p> <p>Bywhat date the systemic changes will be completed June 20, 2016</p> <p>K-48 Whatcorrective action (s) will be accomplished for those residents found to havebeen affected by the deficient practice; All residents, staff and visitors found to have beenaffected by this deficient practice. Howother residents have the potential to be affected by the same deficientpractice will be identified and what corrective action (s) will be taken; All residents, staff and visitors found to have beenaffected by this deficient practice. Facility posted a sign identifyinglocation of smoke</p>	06/20/2016

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	<p>Findings include:</p> <p>Based on review of "Disaster Manual" documentation with the Environmental Services Supervisor during record review from 9:10 a.m. to 11:10 a.m. on 05/26/16, the written health care occupancy fire safety plan for the facility did not identify the location of smoke barrier doors, fire doors and fire compartments in the facility for the evacuation of smoke compartments. Item 1.a of "Section E Specific Hazards Emergency Plan, Continuity of Operation Plan" states "Keep all smoke/fire doors closed." Item 1.b states "Continue past fire door with evacuated persons" and "Continue removing in sequence all people in the area until all are past the fire compartment doors. Do not go back through fire doors. Move residents to an area away from the fire to an adjacent fire compartment." In addition, the written fire safety plan stated the "fire alarm system is connected to the Local Fire Department through Vanguard (812-415-2616)." Based on interview at the time of record review, the Environmental Services Supervisor stated Vanguard is no longer the current monitoring company for the facility and acknowledged the location of smoke barrier doors, fire doors and fire compartments are not identified in the</p>		<p>barrier doors as well as updating facility floor plan and Disaster Manual to reflect smoke barrier doors.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Environmental Services Director will be responsible for conducting monthly environmental rounds to confirm barrier doors are identified on facility floor plan and Disaster Manual to reflect smoke barrier doors.</p> <p>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 Environmental Services Director is responsible for conducting environmental rounds Environmental Services Manger will complete Continuously Quality Improvement tool to verify the signage of barrier doors are identified on facility floor plan and Disaster Manual to reflect smoke barrier doors location.</p>	

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K 0062 SS=F Bldg. 1a	<p>written fire safety plan for the facility for evacuation purposes.</p> <p>3.1-19(b)</p> <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>1. Based on record review, observation and interview; the facility failed to ensure quarterly sprinkler inspections were conducted for the sprinkler system for 1 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code to be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire</p>	K 0062	<p>This will be checked weekly times 4 weeks and monthly times 6 months and then quarterly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed.</p> <p>By what date the systemic changes will be completed June 20, 2016</p> <p>K-62 What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; All residents, staff and visitors found to have been affected by this deficient practice. How other residents have the potential to be affected by the same deficient practice will be identified and what</p>	06/20/2016	

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	<p>Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Vanguard Alarm Services, Dalmatian Fire Inc. and P.I.P.E.'s "Quarterly Sprinkler Inspection Report" documentation dated 07/31/15, 10/14/15, 12/10/15 and 04/24/16, with the Environmental Services Supervisor during record review from 9:10 a.m. to 11:10 a.m. on 05/26/16, documentation of quarterly sprinkler inspection for the first quarter (January, February, March) 2016 was not available for review. Based on observations with the Environmental Services Supervisor during a tour of the facility from 11:10 a.m. to 12:40 p.m. on 05/26/16, hanging tags affixed to the sprinkler system riser by Vanguard Alarm Services, Dalmatian Fire Inc. and P.I.P.E. to document sprinkler inspections did not indicate a quarterly sprinkler inspection was documented for the first quarter of 2016. Based on interview at the time of record review and of the observations, the Environmental Services Supervisor</p>		<p>corrective action (s) will be taken;</p> <p>All residents, staff and visitors found to have been affected by this deficient practice. Environmental Services Director contacted Vanguard, P.I.P.E and Dalmatian to obtain documentation to verify first quartersprinkler inspection was conducted. Facility was terminating contract with Vanguard and transitioning into our new partnership with Integrated Electronicwho now manages our quarterly sprinkler inspections and inspection wascompleted 4/24/16.</p> <p>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;</p> <p>Environmental Services Director will be responsiblefor verifying quarterly sprinkler inspections are conducted by managementpartners timely, documentation is secured to verify and spare sprinklercomponents are placed in cabinets.</p> <p>Howthe corrective action (s)</p>	

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	<p>acknowledged documentation of quarterly sprinkler inspection for the first quarter (January, February, March) 2016 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observations with the Environmental Services Supervisor</p>		<p>will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place and</p> <p>Environmental Services Director is responsible for verifying quarterly sprinkler inspections are conducted timely. Environmental Services Manger will complete Continuously Quality Improvement tool to verify documentation is in place for quarterly sprinkler system checks and spare sprinkler components are placed in cabinets. This will be checked weekly times 4 weeks and monthly times 6 months and then quarterly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed.</p> <p>By what date the systemic changes will be completed June 20, 2016</p>	

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	<p>during a tour of the facility from 11:10 a.m. to 12:40 p.m. on 05/26/16, the following was noted:</p> <p>a. green liquid in bulb automatic sprinklers were installed in the north attic of the facility. Manufacturer's information stamped on the sprinklers stated a temperature rating of 200 F.</p> <p>b. automatic sprinklers with white frame arms were noted in the south attic of the facility. Manufacturer's information stamped on the sprinklers stated a minimum temperature rating of 175 F.</p> <p>c. one blue liquid in bulb automatic sprinkler was installed in the Laundry behind the dryers. Manufacturer's information stamped on the sprinkler stated a minimum temperature rating of 286 F.</p> <p>A total of six spare sprinklers were noted in the spare sprinkler cabinet at the sprinkler system riser none of which were representative of the sprinklers installed in the attic and in the Laundry behind the dryers.</p> <p>Based on interview at the time of the observations, the Environmental Services Supervisor acknowledged a minimum of two sprinklers of each type and temperature rating installed in the facility was not provided on the premises in the spare sprinkler cabinet.</p> <p>3.1-19(b)</p>			

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K 0068 SS=E Bldg. 1a	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 natural gas fired water heaters in the Laundry was provided with combustion air taken directly from the outside. This deficient practice could affect two 24 residents, staff and visitors in the vicinity of the Laundry.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor during a tour of the facility from 11:10 a.m. to 12:40 p.m. on 05/26/16, the natural gas fired water heater in the soiled side of the Laundry was not provided with combustion air supply taken directly from the outside. Based on interview at the time of observation, the Environmental Services Supervisor stated makeup combustion air is taken from behind the dryers in the adjoining clean side of the Laundry but acknowledged the natural gas fired water heater in the clean side of the Laundry was not provided with combustion air supply taken directly from the outside.</p>	K 0068	<p>K-68</p> <p>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; All residents, staff and visitors found to have been affected by this deficient practice.</p> <p>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken; All residents, staff and visitors found to have been affected by this deficient practice. Facility to install ventilation "make-up air" to prevent natural gas water heater from combustion on soiled side of facility laundry room.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>	06/20/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>1a</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/26/2016
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NAME OF PROVIDER OR SUPPLIER FAIRWAY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
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	3.1-19(b)		<p>practice does not recur; Environmental Services Director will be responsible for conducting monthly environmental rounds to confirm ventilation system “make-upair” is working properly on soiled laundry side to prevent natural gas waterheater from combustion.</p> <p>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 Environmental Services Director is responsible for conducting environmental rounds Environmental Services Manger will complete Continuously Quality Improvement tool to verify ventilation “make up air” is operating properly. This will be checked weekly times 4 weeks and monthly times 6 months and then quarterly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will</p>	

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K 0143 SS=E Bldg. 1a	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage and transfilling rooms was provided with continuous mechanical ventilation. This deficient practice could affect 22 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room.</p>	K 0143	<p>be developed.</p> <p>By what date the systemic changes will be completed June 20, 2016</p> <p>K-143</p> <p>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice; All residents, staff and visitors found to have been affected by</p>	06/20/2016	

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	<p>Findings include:</p> <p>Based on observation with the Environmental Services Supervisor during a tour of the facility from 11:10 a.m. to 12:40 p.m. on 05/26/16, the oxygen storage and transfilling room which was used to store one liquid oxygen container was not provided with continuous mechanical ventilation.</p> <p>Based on interview at the time of observation, the Environmental Services Supervisor acknowledged the oxygen storage and transfilling room was not provided with continuous mechanical ventilation.</p> <p>3.1-19(b)</p>		<p>this deficient practice.</p> <p>Howother residents have the potential to be affected by the same deficientpractice will be identified and what corrective action (s) will be taken;</p> <p>All residents, staff and visitors found to have beenaffected by this deficient practice. Facility Environmental Services Directorto install ventilation “exhaust air” to prevent combustion in our facilityliquid oxygen storage room.</p> <p>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;</p> <p>Environmental Services Director will be responsiblefor conducting monthly environmental rounds to confirm ventilation system “exhaustair” is working properly to prevent combustion in our facility liquid oxygenstorage room.</p> <p>Howthe corrective action (s) will be monitored to ensure the deficient practicewill not recur, i.e, what quality</p>		

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			<p>assurance program will be put into place and Environmental Services Director is responsible for conducting environmental rounds Environmental Services Manger will complete Continuously Quality Improvement tool to verify ventilation "exhaust air" is operating properly in our facility liquid oxygen storage room. This will be checked weekly times 4 weeks and monthly times 6 months and then quarterly thereafter. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed.</p> <p>By what date the systemic changes will be completed June 20, 2016</p>	