

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/02/2016
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NAME OF PROVIDER OR SUPPLIER MADISON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVE INDIANAPOLIS, IN 46227
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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: 02/02/16</p> <p>Facility Number: 012225 Provider Number: 155780 AIM Number: 200983560</p> <p>At this Life Safety Code survey, Madison Health Care Center 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 III (200) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms except in Room 502 which has a smoke detector hard</p>	K 0000		

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>wired to the facility's fire alarm system. The facility has a capacity of 130 and had a census of 87 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 02/05/16 - DA</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 at least a one half hour fire resistance rating. This deficient practice could affect 12 residents, staff and visitors in the vicinity of Room 512.</p> <p>Findings include:</p>	K 0025	The 2 inch diameter hole in the ceiling smoke barrier in the closet of room 512 has been sealed by the maintance director. No residents were effected a facility wide check was completed by the maintance director, no other holes were identified in the ceilings. The maintance director will complete weekly checks of the ceiling, during preventive maintance rounds to ensure facility meets KO25 standards.	03/02/2016

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K 0048 SS=C Bldg. 01	<p>Based on observation with the Maintenance Director and the Housekeeping Supervisor during a tour of the facility from 11:45 a.m. to 1:45 p.m. on 02/02/16, a two inch in diameter hole was noted in the ceiling smoke barrier in the closet for Room 512 which exposed the attic above. Based on interview at the time of observation, the Maintenance Director stated a new sprinkler was installed and positioned in a different location inside the closet, the former sprinkler location was taken out of the closet and acknowledged the aforementioned hole in the closet for Room 512 failed to maintain at least a one half hour fire resistance rating for the ceiling smoke barrier.</p> <p>3.1-19(b)</p> <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 1. 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. (1) Use of alarms</p>	K 0048	<p>This will an ongoing check, results of the monitoring checks will be presented to the QA/PI commette on a monthly basis. Any thing less 100 % compliance will require an action plan for correction</p> <p>The facility has revised the health care occupancy fire safety plan to include the location of smoke barrier doors and fire doors in the facility for the evacuation of smoke compartments. The facility has developed a written fire saftey plan for staff response to the activation of battery operated</p>	03/02/2016

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	<p>(2) Transmission of alarm to the fire department</p> <p>(3) Response to alarms</p> <p>(4) Isolation of fire</p> <p>(5) Evacuation of immediate area</p> <p>(6) Evacuation of smoke compartment</p> <p>(7) Preparation of floors and building for evacuation</p> <p>(8) Extinguishment of fire</p> <p>This deficient practice affects all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of "Fire & Disaster Manual" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:45 a.m. on 02/02/16, the written health care occupancy fire safety plan for the facility did not identify the location of smoke barrier doors and fire doors in the facility for the evacuation of smoke compartments. "Section C Evacuation Procedures" states "Residents, staff and visitors in the wing where the disaster is located must be immediately move beyond the nearest smoke/fire barrier doors" and "A second option, the decision must be made as to the feasibility of evacuating the residents horizontally into another area on the nursing unit behind fire doors or into</p>		<p>smoke detectors installed to meet the standard of K0048. The revised policies have been approved by the QA/PI committee. All residents and visitors have the potential to affected. The maintance director has inserviced all staff on the evacuation of smoke compartments and response to smoke detectors. These policies are also inserviced during the orientation of new staff. The maintance director will monitor to ensure the policy is maintained. The maintace director will monitor and reinforce for compliance with each fire drill. Results of monitoring will be reported to QA/PI committee for additional recommendations.</p>	

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	<p>another fire zone free area free from smoke and fire. (SEE DIAGRAM FOR EVACUATION PROCEDURES IN SECTION A)." In addition, "Section E General Action Fire Plan" states during an evacuation to "Continue moving in sequence all persons in the area until all are past the fire doors. Do not go back through fire doors unless necessary." The diagram for evacuation procedures for Section A did not identify the location of smoke and fire barrier doors. Based on interview at the time of record review, the Maintenance Director acknowledged the location of smoke barrier doors and fire doors are not identified in the written fire safety plan for the facility for evacuation purposes.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to develop a written fire safety plan for staff response to the activation of battery operated smoke detectors installed in 76 of 77 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <p>(1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms</p>			

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	<p>(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 This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire & Disaster Manual" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:45 a.m. on 02/02/16, the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in 76 of 77 resident sleeping rooms. Based on observation with the Maintenance Director and the Housekeeping Supervisor during a tour of the facility from 11:45 a.m. to 1:45 p.m. on 02/02/16, battery operated smoke detectors are installed in each resident sleeping room except in Room 502. Based on interview at the time of record review, the Maintenance Director acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms.</p>			

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K 0050 SS=C Bldg. 01	<p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Direct Supply TELS "Logbook Documentation: Fire Drills" and "Fire Drill Report" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:45 a.m. on 02/02/16, third shift (10:00 p.m.</p>	K 0050	<p>The maintance director revised the schedule for fire drills to enusre that the hours are staggared for all shifts. No residents were affected, all residents have the potential to be affected by this deficient practice. The Maintance director has been inserviced on this requirement regarding staggared times. The maintance director has a schedule to follow which now includes times of the fire drills to ensure compliance with K050. The maintance director will summit the times of all fire drills to QA montly x6 months for review. Any thing less than 100%complainece will require and action plan .</p>	03/02/2016

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K 0062 SS=F Bldg. 01	<p>to 6:00 a.m.) fire drills conducted on 03/25/15, 09/30/15 and 12/31/15 were each conducted at 10:00 p.m. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions.</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>Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was clear of blockage once an internal pipe inspection revealed obstruction. NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems at 10-2.3 requires a complete flushing program shall be conducted by qualified personnel. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of SafeCare's "Report of</p>	K 0062	<p>It is the policy of Madison Healthcare Center that the automatic sprinkler systems are continuously maintained in reliable operating conditions and are inspected and tested periodically. All residents have the potential to be affected by this deficient practice. The Madison Healthcare center has schedule this flush to take place beginning June 1 2016 by qualified personnel. Madison is respectfully requesting a waiver on this flush as it is recommended to be done in warmer months. The maintance director and Adminstrator will be responsible for compliance. Results will be presented to</p>	06/01/2016

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K 0067 SS=E	<p>Inspection" documentation dated 01/27/16 with the Maintenance Director during record review from 9:10 a.m. to 11:45 a.m. on 02/02/16, an internal pipe inspection was conducted on 10/28/14 for the facility's sprinkler system. Based on interview at the time of record review, the Maintenance Director stated documentation of the results of the 10/28/14 was not available for review but the facility was in the process of seeking quotes for sprinkler system flushing. SafeCare's sprinkler quote documentation dated 10/22/15 and titled "Purchase Agreement" stated "performing a complete system flush will remove internal debris (rust) that was found during internal pipe inspection." Based on interview at the time of the exit conference at 2:00 p.m., the Administrator stated sprinkler system flushing had not been performed on or after 10/28/14, no purchase agreement for sprinkler system flushing has been finalized as of the date of this survey and acknowledged sprinkler system flushing has not been performed or scheduled on or after 10/28/14.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		QA/PI for further recommendations		

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Bldg. 01	<p>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</p> <p>Based on record review, observation and interview; the facility failed to ensure all fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the Human Resources Office.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:10 a.m. to 11:45 a.m. on 02/02/16, documentation of fire damper inspection and maintenance within the most recent four</p>	K 0067	The fire dampers referred to in life survey in the facility of the human resource office were inspected on Feb 12, 2016. No residents were affected. No other dampers were identified. The maintenance director will keep a schedule of damper checks to ensure compliance with checks at least every 4 years. The maintenance director will report to QA/PI monthly for additional recommendations	03/02/2016

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K 0072 SS=E Bldg. 01	<p>year period was not available for review. Based on observations with the Maintenance Director and the Housekeeping Supervisor during a tour of the facility from 11:45 a.m. to 1:45 p.m. on 02/02/16, three fire dampers were noted in air supply vents in the Human Resources Office. No written documentation was affixed to the fire dampers indicating inspection and maintenance was performed within the most recent four year period. Based on interview at the time of observation, the Maintenance Director acknowledged fire damper inspection and maintenance documentation within the most recent four year period for the aforementioned three fire dampers was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p>			
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	<p>Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use for 1 of 8 exits means of egress. This deficient practice could affect 12 residents, staff and visitors in the vicinity of Room 108.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Housekeeping Supervisor during a tour of the facility from 11:45 a.m. to 1:45 p.m. on 02/02/16, a plastic three drawer chest of drawers containing isolation equipment supplies was stored in the corridor outside Room 108 and projected sixteen inches into the corridor. Based on interview at the time of observation, the Maintenance Director stated the isolation equipment supplies chest of drawers is continuously stored in the corridor and acknowledged corridor storage in the means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the means of egress outside Room 108.</p> <p>3.1-19(b)</p>	K 0072	<p>The facility has policy to address the means of egress are continuously maintained free of all obstructions or impediments in case fire or other emergencies. The 3 drawers chest of drawers with isolation equipment supplies was removed from the corridor outside room 108 room immediately after the survey. All residents and visitors have the potential to be affected by the deficient practice. A facility wide check was completed by the Laundry supervisor. No other chests were identified in the corridor. The maintenance director has inserviced all staff on the importance of keeping the means of egress free of all obstructions. The maintenance director will monitor during daily observational rounds. Results will be presented to the QA/PI committee monthly, anything less than 100% will an action plan for correction.</p>	03/02/2016

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K 0147 SS=E Bldg. 01	<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 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.6 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 1999 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a 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. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or</p>	K 0147	<p>The facility has a policy governing the use of extension cords including power strips used as a substitute for fixed wiring. The power strips were removed from room 705, 607, 502. All residents and staff have the potential to be affected by the deficient practice. The maintenance director conducted a facility walk through inspection and observation of all areas of the facility to ensure power strips are not being used as fixed wiring. No other locations were identified. The maintenance director has added this to his daily observational rounds checks. Monitoring results will be reported to the QA/PI committee on a monthly basis, anything less than 100 % will require an action plan for correction.</p>	03/02/2016

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(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>office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 40 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Housekeeping Supervisor during a tour of the facility from 11:45 a.m. to 1:45 p.m. on 02/02/16, the following was noted:</p> <p>a. a telephone charger was plugged into a power strip on the floor one foot from the resident bed nearest the window in Room 705.</p> <p>b. a Resmart respiratory medical device was plugged into a power strip on the floor underneath the resident bed in Room 607.</p> <p>c. an Invacare respiratory medical device and a CD player were plugged into a power strip on the floor underneath the resident bed nearest the window in Room 502.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned three locations.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/02/2016
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K 0154 SS=C Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler 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 system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 87 of 87 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire & Disaster Manual: Fire Watch Policy and Procedure" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:45 a.m. on</p>	K 0154	The facility has revised fire watch (policy and procedure). The fire watch policy now states the building shall be evacuated or a fire watch shall be conducted should the automatic sprinkler system be impaired for 4 hours or more in a 24 hours period. All residents and vistors have the potential to be affected. The facility staff have been inserviced by the maintance director on the revised policy. The maintance director and Adminstator will monitor for compliance. Monitoring results will be reported to the QA/PI anything less that 100% will require an action plan for correction.	03/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/02/2016	
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K 0155 SS=C Bldg. 01	<p>02/02/16, the fire watch policy did not state the building shall be evacuated or a fire watch shall be conducted should the automatic sprinkler system be impaired for four hours or more in twenty four hour period. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire watch policy did not state the building shall be evacuated or a fire watch shall be conducted should the automatic sprinkler system be impaired for four hours or more in twenty four hour period.</p> <p>3.1-19(b)</p> <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 Based on record review and interview, the facility failed to provide a complete written policy containing procedures to</p>	K 0155	The facility has revised the fire watch (policy and procedure). The fire watch policy now states the building shall be evacuated or	03/02/2016			

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	<p>be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 87 of 87 residents. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire & Disaster Manual: Fire Watch Policy and Procedure" documentation with the Maintenance Director during record review from 9:10 a.m. to 11:45 a.m. on 02/02/16, the written fire watch policy did not state the building shall be evacuated or a fire watch shall be conducted should the fire alarm system be impaired for four hours or more in twenty four hour period. Based on interview at the time of record review, the Maintenance Director acknowledged the written fire watch policy did not state the building shall be evacuated or a fire watch shall be conducted should the fire alarm system be impaired for four hours or more in twenty four hour period.</p> <p>3.1-19(b)</p>		<p>a fire watch shall be conducted should the fire alarm system be placed out of service for 4 hours or more in a 24 hours period. All residents and vistors have the potential be affected be deficient practice. The facility staff have been inservice by the maintance director on the revised policy. The maintance director and Adminstrator will monitor for compliance. Monitoring results will be reported to the QA/PI, anything less that 100% complince will require and action plan to correct.</p>		