

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/08/2015
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NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231
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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: 07/08/15</p> <p>Facility Number: 000393 Provider Number: 155383 AIM Number: 100289340</p> <p>At this Life Safety Code survey, Washington Healthcare 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 V (111) 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 in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 74 at</p>	K 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation, This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review or Post Survey Review on or after 8/6/15,	

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 visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has one detached building providing facility for storage of supplies which 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 at least a one half hour fire resistance rating. This deficient practice could affect 50 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 10:50 a.m. to 12:40 p.m. on 07/08/15, the following was noted:</p> <p>a. the two inch annular space surrounding</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? A, B and C areas were all caulked with flame retardant caulk by Maintenance Director on July 21, 2015. Before and after photographs of areas A, B and C are attached for your review. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? Maintenance Director toured the facility for observation of potential violations of smoke barriers</p>	07/21/2015

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	<p>two one inch in diameter conduits which penetrated the ceiling of the Boiler Room were each not filled with an approved material for maintaining the smoke resistance of a smoke barrier and exposed the attic above.</p> <p>b. the annular space surrounding a one inch in diameter pipe and a two inch in diameter pipe each penetrating the ceiling of the south bathroom in Therapy were each not filled with a approved material for maintaining the smoke resistance of a smoke barrier and exposed the attic above.</p> <p>c. the annular space surrounding a one half inch in diameter conduit and a one inch in diameter conduit each penetrating the ceiling of the sprinkler system riser room were each not filled with a approved material for maintaining the smoke resistance of a smoke barrier and exposed the attic above.</p> <p>Based on interview at the time of the observations, the Administrator acknowledged the aforementioned holes in the ceiling smoke barrier did not maintain at least a one half hour fire resistance rating.</p> <p>3.1-19(b)</p>		<p>throughout the facility and none were located. All residents have the potential to be affected by this alleged deficient practice. Exposed smokebarriers were caulked on Monday, July 21, 2015 by MaintenanceDirector. Before and after photographs of areas A, B and are attached for your review. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur MaintenanceDirector/Designee will apply Class A flame retardant to smoke barriers discovered by visual tours by 8/16/15 and at least monthly thereafter as is necessary when touring facility for potential violations. 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 To ensure compliance, the MaintenanceDirector/Designee is responsible for the completion of the Fire Safety CQI tool weekly times 4 weeks and monthly for six months. 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 to ensure compliance.</p>	

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K 0029 SS=E Bldg. 01	<p>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</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. This deficient practice could affect 26 residents, staff and visitors in the vicinity of the Boiler Room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 10:50 a.m. to 12:40 p.m. on 07/08/15, the Boiler Room contained one natural gas fired boiler. The two inch annular space surrounding two one inch in diameter</p>	K 0029	<p>K 029 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The two inch annular space surrounding two one inch in diameter conduits' which penetrate the ceiling of the Boiler Room and exposed the attic above has been caulked with flame retardant caulking on 7/21/15. Photographs of before and after have been attached for your review. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? Maintenance Director toured the facility for observation of potential</p>	07/27/2015

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K 0052	NFPA 101 conduits which penetrated the ceiling of the Boiler Room and exposed the attic above did not separate this hazardous area from other spaces with smoke resistant partitions. Based on interview at the time of observation, the Administrator and the Maintenance Director acknowledged the aforementioned holes in the Boiler Room ceiling did not separate this hazardous from other spaces by smoke resistant partitions.		violations of smokebarriers throughout the facility and none were located. Allresidents have the potential to be affected by this alleged deficient practice. Exposedsmoke barriers were caulked on Monday, July 21, 2015 by MaintenanceDirector. Photographs of before and after have been attached for your review. What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur MaintenanceDirector/Designee will apply Class A flame retardant to smoke barriersdiscovered by visual tours by 8/16/15 and at least monthly thereafter as isnecessary when touring facility for potential violations. How the corrective action(s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place To ensure compliance, theMaintenance Director/Designee is responsible for the completion of the FireSafety CQI tool weekly times 4 weeks and monthly for six months. The results ofthese audits will be reviewed by the CQI committee overseen by the ED. Ifthreshold of 95% is not achieved an action plan will be developed to ensurecompliance.	

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SS=E Bldg. 01	<p>LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 3 duct detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked); the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the</p>	K 0052	<p>K 052 -A What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A new maintenance vendor, Vanguard Alarm Systems, located the third duct detector and will be coming to the facility on Monday, July 27, 2015, to perform detector sensitivity tests. This test will be performed on all three duct detectors within the facility.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? All residents have the potential to be affected by this alleged deficient practice. A new maintenance vendor, Vanguard Alarm Systems, located the third duct detector and will be coming to the facility on Monday, July 27, 2015, to perform detector sensitivity tests. This test will be performed on all three duct detectors within the facility. The new company that is currently in place with facility will do inspections on a regularly quarterly</p>	07/27/2015

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	<p>following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Integrated Electronics of Indiana's "Sensitivity Test" documentation dated 10/02/14 with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 10:50 a.m. on 07/08/15, a total of two facility duct detectors located in the Dining Room were sensitivity tested within the most recent two year period. Based on review of Vanguard Alarm Services "Inspection and Testing Certificate" documentation dated</p>		<p>scheduledbasis and any deficiencies noted at the time of inspections will be addressedto make sure we remain in compliance.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficientpractice does not recur</p> <p>MaintenanceDirector/Designee will check with new maintenance vendor, Vanguard AlarmSystems, monthly to ensure all tests related to duct detectors within thefacility have been scheduled for any maintenance/tests necessary to ensuredeficient practice does not recur. The new company that is currently inplace with facility will do inspections on a regularly quarterly scheduledbasis and any deficiencies noted at the time of inspections will be addressedto make sure we remain in compliance.</p> <p>How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place</p> <p>To ensure compliance, theMaintenance Director/Designee is responsible for the completion of the FireSafety CQI tool weekly times 4 weeks and monthly for six months. The results ofthese audits will be reviewed by the CQI committee overseen by the ED. Ifthreshold of 95% is not achieved an action plan will be developed to ensurecompliance.</p>	

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	<p>04/27/15, a total of three duct detectors are located in the facility which includes the duct detector identified as "Lobby Mechanical Room." In addition, Vanguard Alarm Services sensitivity tested facility smoke detectors 04/27/15 as documented in "Smoke Detector Sensitivity Test Report" but did not include any of the three facility duct detectors in the sensitivity test report. Based on interview at the time of record review, the Maintenance Director stated he was unaware of when the lobby mechanical room duct detector was installed in the facility. Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 10:50 a.m. to 12:40 p.m. on 07/08/15, a duct detector was located in the lobby mechanical room with no manufacture date or installation date affixed to the duct detector. Based on interview at the time of observation, the Maintenance Director acknowledged there was a total of three duct detectors located in the facility and acknowledged sensitivity testing documentation for the lobby mechanical room duct detector within the most recent two year period was not available for review.</p> <p>3.1-19(b)</p>			

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K 0062 SS=F 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>1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was inspected every five years as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 10-2.2 states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of P.I.P.E.'s internal pipe inspection letter dated 04/27/09 with the Administrator and the Maintenance Director during record review from 9:20</p>	K 0062	<p>K 062 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>1. Pipe Internal pipe inspection 1. New maintenance vendor, Vanguard Alarm Systems, will be in the facility on Monday, July 27, 2015 to conduct the Internal Pipe Inspection. Documentation of performance of inspection will be forwarded to ISDH once completed.</p> <p>2. Quarterly sprinkler inspections 1. After speaking with new maintenance vendor, Vanguard Alarm Systems, it has been determined that the test in question (Quarterly Sprinkler Inspection Report) had been performed by their company on January 20, 2015. A copy of the inspection is attached for your review.</p> <p>3.A. Data cable was attached to a sprinkler pipe. Maintenance Director removed</p>	07/27/2015

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	<p>a.m. to 10:50 a.m. on 07/08/15, it has been more than five years since the most recent documented internal pipe inspection for the facility's automatic sprinkler system. Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 10:50 a.m. to 12:40 p.m. on 07/08/15, "Internal Pipe Inspection 04/03/14" was written on the sprinkler system riser but no documentation of what the 04/03/14 inspection entailed or the results of the inspection were available for review. Based on interview at the time of record review and of the observation, the Administrator acknowledged it has been more than five years since the most recent documented internal pipe inspection for the facility's automatic sprinkler system.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure quarterly sprinkler inspections were conducted for the sprinkler system for 2 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,</p>		<p>the cable from the sprinkler pipe.</p> <p>B. Two cable television cables where looped around the sprinkler pipe. Maintenance Director removed the cable by the nurses' station near the main lobby.</p> <p>How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</p> <p>1. Pipe Internal pipe inspection</p> <p>1. All residents, staff and visitors had the potential to be affected by alleged deficient practice however they were not since we have not experienced any issues within the facility.</p> <p>2. New maintenance vendor, Vanguard Alarm Systems, will be in the facility on Monday, July 28, 2015 to conduct the Internal Pipe Inspection.</p> <p>Documentation of performance of inspection will be forwarded to ISDH once completed.</p> <p>2. Quarterly sprinkler inspections</p> <p>1. All residents, staff and visitors had the potential to be affected by alleged deficient practice however they were not since we have not experienced any issues within the facility.</p> <p>2. After speaking with new</p>	

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	<p>Standard for the Inspection, Testing, and Maintenance of Water-Based Fire 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 in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 10:50 a.m. on 07/08/15, the fourth quarter (October, November, December) 2014 and the first quarter (January, February, March) 2015 sprinkler system inspection reports were not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility switched sprinkler system contractors in 2014 and Vanguard Alarm Systems performed its first inspection under the contract as documented in "Quarterly Sprinkler Inspection Report" dated 04/27/15.</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 10:50 a.m. to 12:40 p.m. on 07/08/15, calendar quarter sprinkler inspection tags</p>		<p>maintenance vendor, Vanguard Alarm Systems, it has been determined that the test in question (Quarterly Sprinkler Inspection Report) had been performed by their company on January 20, 2015. A copy of the inspection is attached for your review.</p> <p>3. Maintenance Director will be with cable contractors when they come into the facility to perform any duties and remind them to never loop their cables around the sprinkler pipes within the facility.</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>Maintenance Director corrected the issue. Photographs of correction are attached for review.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ol style="list-style-type: none"> New Maintenance vendor, Vanguard Alarm Services, has been contracted to perform all duties related to the facility in regards to the systems in question. The Maintenance Director will also be responsible for maintaining regular schedules to ensure we are complying with all codes and regulations regarding the systems in question. New Maintenance vendor, Vanguard Alarm Services, has been contracted to perform all duties 	

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	<p>affixed to the sprinkler system riser did not document sprinkler inspections were conducted in the fourth quarter of 2014 and in the first quarter of 2015. Based on interview at the time of record review and of the observation, the Administrator and the Maintenance Director acknowledged documentation for the fourth quarter 2014 and for the first quarter 2015 sprinkler system inspections were not available for review.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 9.7.1 states all automatic sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 states sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect 40 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Director during a tour of the facility from</p>		<p>related to the facility in regards to the systems in question. The Maintenance Director will also be responsible for maintaining regular schedules to ensure we are complying with all codes and regulations regarding the systems in question.</p> <p>3. Maintenance Director/Designee will conduct rounds monthly to ensure all sprinkler pipes within facility do not have any cables wrapped around them. 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</p> <p>To ensure compliance, the Maintenance Director/Designee is responsible for the completion of the Fire Safety CQI tool weekly times 4 weeks and monthly for six months. 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 to ensure compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155383	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/08/2015
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NAME OF PROVIDER OR SUPPLIER WASHINGTON HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8201 W WASHINGTON ST INDIANAPOLIS, IN 46231
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K 0064 SS=E Bldg. 01	<p>10:50 a.m. to 12:40 p.m. on 07/08/15, the following was noted:</p> <p>a. a data cable was attached to a fifteen foot length of sprinkler pipe with three plastic cable ties in the attic near the roof line above the attic smoke barrier wall access door above the Main Dining Room.</p> <p>b. two cable television cables were looped around a five foot length of sprinkler pipe in the attic above the attic access door by the nurses ' station near the main lobby.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned sprinkler pipe locations were being used to support nonsystem components.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to inspect 1 of 21 portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing</p>	K 0064	<p>K 064</p> <p>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?</p> <p>Map of all portable fire extinguishers within the facility has beencreated for Washington Healthcare Center and all 21 portable fire extinguishershave been identified.</p>	07/24/2015

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	<p>being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect 22 residents, staff and visitors in the vicinity of the Alzheimer wing dining room.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 10:50 a.m. to 12:40 p.m. on 07/08/15, the annual maintenance tag attached to the portable fire extinguisher located across the hall from the nurses' station in the Alzheimer wing dining room indicated a monthly inspection was not documented for May and June 2015. Based on interview at the time of observation, the Maintenance Director stated no additional documentation of monthly fire extinguisher checks was available for review and acknowledged a monthly inspection for the portable fire extinguisher located across the hall from</p>		<p>This map will be used by the Maintenance Director to use when reviewing each portable fire extinguisher monthly for location. This is attached for your review. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?</p> <p>All portable fire extinguishers within the facility will be placed on internal location map and map will be used monthly when reviewing portable fire extinguishers for being fully charged and operational. All residents have the potential to be affected by this alleged deficient practice.</p> <p>Map of portable fire extinguishers within the facility has been attached for review.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <p>Maintenance Director/Designee will conduct rounds monthly using the map of all portable fire extinguishers within the facility to ensure none of them are missed during the monthly routine inspections.</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</p> <p>To ensure compliance, the Maintenance Director/Designee is responsible for the completion of</p>	

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	the nurses ' station in the Alzheimer wing dining room was not documented for May and June 2015. 3.1-19(b)		the Fire Safety CQI toolweekly times 4 weeks and monthly for six months. The results of these auditswill be reviewed by the CQI committee overseen by the ED. If threshold of95% is not achieved an action plan will be developed to ensure compliance.		