

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/28/2016
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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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: 01/28/16</p> <p>Facility Number: 000038 Provider Number: 155095 AIM Number: 100274830</p> <p>At this Life Safety Code survey, Heritage Park 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, areas open to the corridors and hard wired smoke detectors in the resident rooms on the 200 hall. The remaining resident rooms have battery operated smoke detectors. The facility</p>	K 0000	Heritage Park submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements It shall not be construed as admission of any alleged deficiency cited or any liability This provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or it s employee, agents, officers or directors. This provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party Any changes to provider policy or procedure should be considered to be subsequent remedial measures as the concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and request a Post Survey Review on or after February 14, 2016	
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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 0018 SS=E Bldg. 01	<p>has a capacity of 180 and had a census of 161 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except one shed used for the maintenance office and general storage.</p> <p>Quality Review completed on 02/01/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure there were no impediments to the closing of 11 of 96 resident room doors in the facility protecting corridor openings. This deficient practice could affect 55 residents in 4 of 12 smoke compartments.</p>	K 0018	K0018 It is the practice of this provider to ensure there are no impediments to the closing of resident room doors. However-based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	02/14/2016

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	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 01/28/16 at between 10:30 a.m. and 1:19 p.m., the corridor doors to resident rooms 302, 305, 705, 708, 709, 710, 712, 801, 902, 904, and 912 were obstructed by trash cans propping the doors open. Based on interview at the time of observation, this was acknowledged by the Maintenance Director.</p> <p>3.1-19(b)</p>		<p>practice: Rooms: 302: The impediment preventing the door from closing was removed. 305: The impediment preventing the door from closing was removed. 705: The impediment preventing the door from closing was removed. 708: The impediment preventing the door from closing was removed. 709: The impediment preventing the door from closing was removed. 710: The impediment preventing the door from closing was removed. 712: The impediment preventing the door from closing was removed. 801: The impediment preventing the door from closing was removed. 902: The impediment preventing the door from closing was removed. 904: The impediment preventing the door from closing was removed. 912: The impediment preventing the door from closing was removed.</p> <p>No resident was individually identified to have been affected by the alleged deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice: Residents living in the facility have the potential to be affected by the same deficient practice. No other residents were found to have been affected. What changes will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Facility staff in all departments</p>		

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K 0025 SS=E Bldg. 01	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		have been re-educated regarding the risk of using items (i.e.trash cans) to prop resident room/facility doors open. Education includes but is not limited to keeping resident room doorways free of any obstruction including trash cans. Education provided by DNS and Clinical Education Co-ordinator by Feb 10, 2016. The facility Safety Committee will make daily rounds x 30 days to visually check room/facility doorways for obstructions and is responsible for oversight. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur: A CQI Monitoring Tool titled "Environmental Safety " will be utilized every week x 4, monthly x 6 and quarterly thereafter. Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed. Non-compliance with facility procedure may result in disciplinary action up to and including termination.	

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	<p>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 were 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 25 residents in the 400 hall.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Director on 01/28/16 at 1:11 p.m., in the ceiling of 400 hall by room 408 there were two unsealed one eighth inch cracks about three feet in length. Based on interview at the time of observation, the Maintenance Director acknowledge and provided the Measurements of the cracks.</p> <p>3.1-19(b)</p>	K 0025	<p>0025 It is the practice of this facility to ensure ceiling smoke barriers are maintained to provide a one half hour fire resistance rating. However, based on the deficient practice the following has been implemented: What corrective action(s) will be accomplished to those residents found to have been affected by the alleged deficient practice: 400 Hall: The two unsealed one eighth inch cracks in the ceiling have been repaired. No other cracks in the ceiling were identified.</p> <p>No residents were individually identified as being affected.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice:</p> <p>Residents residing in the facility have the potential to be affected by the deficient practice. No residents were found to have been affected. The Maintenance Department completed a visual observation of ceilings in the facility and no further cracks were identified. What changes will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: The Maintenance Department will conduct scheduled visualizations of facility ceilings to ensure any cracks are</p>	02/14/2016

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K 0027 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 4 of 11 smoke barrier doors were providing a fire resistance of at least 20 minutes. This deficient practice could affects up to 80	K 0027	repaired immediately. This function has been added to the Preventative Maintenance Log and will be completed weekly. The Maintenance Director/Designee is responsible for oversight. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur: A CQI Monitoring Tool titled "Environmental Safety " will be utilized every week x 4, monthly x 6 and quarterly thereafter. Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed. Non-compliance with facility procedure may result in disciplinary action up to and including termination. K0027 It is the practice of this facility to ensure smoke barrier doors are providing a fire resistance of at least 20 minutes. However, based on the alleged deficient practice the following	02/14/2016

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	<p>residents in 6 of 12 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 01/28/16 between 11:50 a.m. and 1:00 p.m., the following was noted:</p> <p>a. the double set of smoke barrier doors by room 500 had labels that were painted over and the fire rating could not be determined.</p> <p>b. the double set of smoke barrier doors by room 504 had labels that were painted over and the fire rating could not be determined.</p> <p>c. the double set of smoke barrier doors by room 300 had labels that were painted over and the fire rating could not be determined.</p> <p>d. the double set of smoke barrier doors by room 100 had labels that were painted over and the fire rating could not be determined.</p> <p>Based on interview at the time of observation, the Maintenance Director acknowledged the painted labels, and could not provide other documentation of the smoke doors fire rating.</p> <p>3.1-19(b)</p>		<p>has been implemented: What corrective action(s) will be accomplished to those residents found to have been affected by the alleged deficient practice:</p> <p>Double doors by Room 500: The paint on the label was removed</p> <p>Double doors by Room 504: The paint on the label was removed</p> <p>Double doors by Room 300: The paint on the label was removed</p> <p>Double doors by Room 100: The paint on the label was removed</p> <p>No residents were found to have been affected by the deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Residents living within the facility have the potential to be affected by the alleged deficient practice. No residents were found to have been affected. The Maintenance Department was re-educated on preventing obstruction of fire rating information when painting. Education included not to cover labels/plates with fire rating information and how to remove paint if needed. Education completed by the Executive Director on February 3, 2016. The Maintenance Department completed a visual inspection of doors throughout the facility on February 2, 2016. No additional doors were found to have the fire rating information obstructed. Visual inspection of doors in the facility is now scheduled in the</p>		

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			Preventative Maintenance Log monthly to ensure fire rating labels on doors are free of paint or damage. What measures or what systemic changes you will make to ensure the deficient practice does not recur: The Maintenance Department was re-educated on preventing obstruction of fire rating information when painting. Education included not to cover labels/plates with fire rating information and how to remove paint if needed. Education completed by the Executive Director on February 3, 2016. The Maintenance Department completed a visual inspection of doors throughout the facility on February 2, 2016. No additional doors were found to have the fire rating information obstructed. Visual inspection of doors in the facility is now scheduled in the Preventative Maintenance Log monthly to ensure fire rating labels on doors are free of paint or damage. The Maintenance Department will conduct scheduled rounds to visually check fire rating labels on doors. The Maintenance Director is responsible for oversight. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur: A CQI Monitoring Tool titled "Environmental Safety " will be utilized every week x 4, monthly x 6 and quarterly thereafter. Data will be submitted to the CQI	

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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 1 laundry rooms, a hazardous area, was smoke resistive. This deficient practice could affect up to 50 residents in the dining room and hallway.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Director on 01/28/16 at 12:45 p.m., behind the dryers in the laundry room across from the dining room there was an unsealed one inch hole in the ceiling. Also behind the</p>	K 0029	<p>Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed. Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p> <p>K0029 It is the practice of this facility to ensure hazardous areas are smoke resistive. However, based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished to those residents found to have been affected by the alleged deficient practice: No residents were found to have been affected by the alleged deficient practice. The unsealed one inch hole in the ceiling behind the dryers in the laundry room was repaired. The drywall on the ceiling behind the dryers was repaired. How will you identify other residents having the</p>	02/14/2016

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	dryers in the ceiling, some of the drywall was falling down leaving a quarter inch gap two feet long. Based on interview at the time of observation, the Maintenance Director acknowledged and provided the measurements of the penetrations. 3.1-19(b)		potential to be affected by the same deficient practice and what corrective action will be taken: Residents located in the dining area and hallway have the potential to be affected by the alleged deficient practice. The Maintenance Department completed a visual inspection of the laundry room walls and ceiling on February 2 , 2016. No additional holes/gaps were identified. Visual inspection of the laundry room is now scheduled in the Preventative Maintenance Log monthly to ensure the area is free of holes/gaps. The Maintenance Department will conduct scheduled rounds to identify areas of concern. The Maintenance Director is responsible for oversight. What measures or what systemic changes you will make to ensure the deficient practice does not recur: Visual inspection of the laundry room is now scheduled in the Preventative Maintenance Log monthly to ensure the area is free of holes/gaps. The Maintenance Department will conduct scheduled rounds to identify areas of concern. The Maintenance Director is responsible for oversight. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur: A CQI Monitoring Tool titled "Environmental Safety " will be utilized every week x 4, monthly x		

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K 0046 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 3 of 14 battery powered emergency lighting fixtures in the facility would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice could affect up to 30 residents in 2 of 12 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with Maintenance Director on 01/28/16 between at 10:35 a.m. and 12:20 p.m., the battery operated emergency lights located at the 700 hall exit, oxygen room exit, and the dish washer room exit failed to illuminate when tested. Based on interview, this was acknowledged by the Maintenance</p>	K 0046	<p>6 and quarterly thereafter. Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed.</p> <p>Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p> <p>K-0046 It is the practice of this provider to ensure battery powered emergency lighting fixtures in the facility operate. However, based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished to those residents found to have been affected by the alleged deficient practice: No specific residents were identified to be affected by the deficient practice. The battery was replaced in the 700 hall emergency light. The oxygen room exit emergency light was replaced with a new unit. The dish washer room emergency light was replaced with a new unit. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Residents residing in the facility have the</p>	02/14/2016

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K 0066 SS=E Bldg. 01	<p>Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location,</p>		<p>potential to be affected by the deficient practice. No residents were found to be affected. The Maintenance Department tested all battery operated emergency lights throughout the facility on January 29, 2016. No additional emergency lights failed to illuminate. What measures or what systemic changes you will make to ensure the deficient practice does not recur: The Preventative Maintenance Log includes testing emergency lights monthly in addition to an annual 90 minute test. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur: A CQI Monitoring Tool titled "Environmental Safety " will be utilized every week x 4, monthly x 6 and quarterly thereafter. Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed.</p> <p>Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p>	

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	<p>and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to enforce 1 of 1 smoking policies for the facility. This deficient practice could affect 20 residents evacuating through the 800 hall exit.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Director on 01/28/15 at 10:58 a.m., outside the 800 hall exit, a non-smoking area, there was a plastic bucket containing salt, trash, and 25 cigarette butts. Based on an interview at the time of observation, the Maintenance Director acknowledged cigarette butts were disposed in a plastic bucket in a non-smoking area.</p> <p>3.1-19(b)</p>	K 0066	<p>K-0066 It is the practice of this facility to ensure smoking policies are enforced However, based on the alleged deficient practice the following has been implemented:</p> <p>What corrective action(s) will be accomplished to those residents found to have been affected by the alleged deficient practice:</p> <p>No individual residents were identified to have been affected The plastic bucket was removed. A Smokers Post was placed at the 800 hall exit to provide an area to properly dispose of smoking material.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>Residents using the 800 hall exit during evacuation could be affected. No residents were found to have been affected. A Smokers Post was placed at</p>	02/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/28/2016
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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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K 0147 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 wet location provided with ground fault circuit interrupter (GFCI) protection	K 0147	the 800 hall exit to provide an area to properly dispose of smoking material. Plastic salt buckets are no longer placed outside the building at entrances What measures or what systemic changes you will make to ensure the deficient practice does not recur: A Smokers Post was placed at the 800 hall exit to provide an area to properly dispose of smoking material. Plastic salt buckets are no longer placed outside the building at entrances How will the corrective actions(s) be monitored to ensure the deficient practice will not recur: A CQI Monitoring Tool titled "Environmental Safety " will be utilized every week x 4, monthly x 6 and quarterly thereafter. Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed. Non-compliance with facility procedure may result in disciplinary action up to and including termination. K-0147 It is the practice of this facility to ensure wet locations are provided with a ground fault circuit interrupters (GFCI) to protect against electric shock.	02/14/2016

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NAME OF PROVIDER OR SUPPLIER HERITAGE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805		
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	<p>against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 2 residents in the room 809.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Director on 01/28/16 at 11:15 a.m., the restroom in room 809 had a GFCI electrical receptacle on the wall within three feet of a sink. When tested using a GFCI testing device, the GFCI receptacle did not trip. Also, when the test button on GFCI receptacle was pressed the receptacle did not trip. Based on interview at the time of observation, the Maintenance Director confirmed the receptacle was a GFCI receptacle and did not trip when tested.</p> <p>3.1-19(b)</p>		<p>However, based on the alleged deficient practice the following has been implemented: What corrective action(s) will be accomplished to those residents found to have been affected by the alleged deficient practice: No specific residents were identified to be affected by the deficient practice. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Residents living within the facility have the potential to be affected by the alleged deficient practice. The Maintenance Department utilized a GFCI testing device to check all GFCI outlets for functioning on January 29, 2016. No additional outlets failed to trip when tested. Testing GCFI outlets has been added to the Preventative Maintenance Log to be completed on a monthly basis to ensure GFCI outlets function properly. The Maintenance Director is responsible for oversight. What measures or what systemic changes you will make to ensure the deficient practice does not recur: Testing GFCI outlets has been added to the Preventative Maintenance Log to be completed on a monthly basis to ensure GFCI outlets function properly. The Maintenance Director is responsible for oversight. How will the corrective actions(s) be monitored to ensure</p>		

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			the deficient practice will not recur: A CQI Monitoring Tool titled "Environmental Safety " will be utilized every week x 4, monthly x 6 and quarterly thereafter. Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 100% is not met, an action plan will be developed. Non-compliance with facility procedure may result in disciplinary action up to and including termination.		