

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155668	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/20/2016
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NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF PROVIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 4915 CHARLESTOWN RD NEW ALBANY, IN 47150
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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: 04/20/16</p> <p>Facility Number: 001144 Provider Number: 155668 AIM Number: 200256980</p> <p>At this Life Safety Code survey, Diversicare of Providence 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 sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a total capacity of 172 with 158 certified beds and had a census of 138 at the time of this visit.</p>	K 0000	To the best of my knowledge and belief, as an agent of Diversicare of Providence, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. Preparation and execution of the plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies This plan of correction is prepared and/or executed solely because it is required by provisions of Federal and state law.	
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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 0050 SS=C Bldg. 01	<p>The entire facility was surveyed due to the lack of a 2 hour fire-rated separation.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review completed on 04/28/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills on 04/20/16 at 10:55 a.m. with the</p>	K 0050	<p>Corrective actions accomplished for those residents found to have been affected by the deficient practice:</p> <p>1. A fire drill has been held on 3 of 3 team member shifts at a time different than noted in the 2567.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>1. All residents in the center had</p>	05/20/2016			

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K 0052 SS=F Bldg. 01	<p>Director of Maintenance present, three of four first shift (day) fire drills were performed between 9:15 a.m. and 10:30 a.m., three of four second shift (evening) fire drills were performed between 7:20 p.m. and 8:00 p.m., and four of four third shift (night) fire drills were performed between 11:20 p.m. and 11:36 p.m. During an interview at the time of record review, the Director of Maintenance acknowledged the times of all three shift fire drills were performed and agreed the times were not varied enough.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72.</p>		<p>the potentialof being affected by this practice. Afire drill has been held on 3 of 3 team member shifts at a time different thannoted in the 2567.</p> <p>Measures put into place or systemicchanges made to ensure that the deficient practice does not recur:</p> <p>1. A calendar has been implemented to record fire drill days and times each month to provide for quarterly drills oneach shift at varied times.</p> <p>2. Fire drill dates and times will bereported to the Safety Committee for review and comparison monthly.</p> <p>How the corrective actions will bemonitored to ensure the deficient practice will not recur:</p> <p>1. The Safety Committee will complete anaudit of fire drill dates and times for varied times on 3 of 3 team membershifts monthly continuously.</p> <p>2. All findings will be reviewed andanalyzed then reported to the Quality Assurance and Performance Improvementteam meeting monthly.</p>		

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	<p>9.6.1.4, 9.6.1.7,</p> <p>1. Based on record review and interview, the facility failed to ensure 112 of 112 resident room smoke detectors had been tested for sensitivity within the past two years. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <p>(1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose.</p>	K 0052	<p>Corrective actions accomplished for those residents found to have been affected by the deficient practice:</p> <p>1. All resident room smoke detectors have been sensitivity tested. 2. All 104 smoke detectors have been tested as required annually.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>1. All residents had the potential of being affected by the sensitivity testing and annual testing of smoke detectors. 2. All resident room smoke detectors have been sensitivity tested. 3. All 104 smoke detectors have been tested as required annually.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice does not recur:</p> <p>1. The plan for annual testing of smoke detectors has been revised with the fire alarm company to ensure all 104 center and 112 resident room smoke detectors are tested annually. 2. The 112 resident room smoke detectors have been added to the fire alarm company's records for sensitivity testing every two years. 3. Documentation will be provided at each quarterly inspection listing the locations of</p>	05/20/2016			

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	<p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range.</p> <p>(5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction. Paper or electronic media shall be acceptable. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the smoke detector sensitivity records and quarterly fire alarm system inspection reports in the Fire Quarterly Book II on 04/20/16 at</p>		<p>the smoke detector tested.</p> <p>4. Documentation will be provided showing sensitivity testing of resident room smoke detectors every two years.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>1. The Maintenance Director will perform an audit of smoke detector testing records quarterly continuously noting areas tested over four quarters.</p> <p>2. The Maintenance Director will audit sensitivity testing records in June only as this is an every two year requirement.</p> <p>3. All findings will be reviewed and analyzed then reported to the Quality Assurance and Performance Improvement team meeting.</p>		

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	<p>10:00 a.m. with the Director of Maintenance present, the most recent sensitivity test documentation available was dated 06/27/14 for the 104 smoke detectors located throughout the facility, however, there was no sensitivity test information available for the 112 resident sleeping room smoke detectors. The Director of Maintenance said all resident room smoke detectors were hard wired smoke detectors and were connected to the Nurses' call system and not to the fire alarm panel, furthermore, he said there was no sensitivity test information available for the resident room smoke detectors.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure documentation for the testing of 104 of 104 smoke detectors was correct and complete. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's quarterly</p>			

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	<p>fire alarm system inspection reports in the Quarterly Book II on 04/20/16 at 10:00 a.m. with the Director of Maintenance present, the number of smoke detectors tested on the four most recent quarterly fire alarm system inspection reports was not the same as the number of smoke detectors listed on the most recent sensitivity test report dated 06/27/14. The following was noted:</p> <ol style="list-style-type: none"> 1. The quarterly report dated 04/28/15 indicated there were 7 of 96 smoke detectors tested 2. The quarterly report dated 07/24/15 indicated there were 17 of 96 smoke detectors tested 3. The quarterly report dated 10/23/15 indicated there were 33 of 96 smoke detectors tested, plus a separate report with the same date indicating 5 of 5 smoke detectors in The Center were tested 4. The quarterly report dated 01/30/16 indicated there were 15 of 96 smoke detectors tested <p>Each quarterly fire alarm system inspection report indicated at "Number Installed" there were 96 smoke detectors, however, there were only 77 smoke detectors tested visually/functionally over the past four quarters. Furthermore, the most recent sensitivity test report dated</p>			

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K 0056 SS=E Bldg. 01	<p>06/27/14 indicated there were 104 smoke detectors tested, which included 5 smoke detectors in The Center. There was no report available for the visual/functional testing of 112 of 112 resident room smoke detectors during the past four quarters.</p> <p>Finally, all four quarterly fire alarm system inspection reports were only the equivalent of a cover page listing the devices as "Number Installed" and "Number Tested". There was no itemized list of devices tested by location.</p> <p>This was acknowledged by the Director of Maintenance at the time of record review.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the</p>	K 0056	Corrective actions accomplished	05/20/2016			

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K 0062 SS=F	<p>facility failed to provide an automatic sprinkler system that provided complete coverage in 1 of 15 smoke compartments. This deficient practice could affect mostly staff, plus any residents and visitors while in the front entrance lobby smoke compartment.</p> <p>Findings include:</p> <p>Based on observation on 04/20/16 at 1:20 p.m. during a tour of the facility with the Director of Maintenance, there was no sprinkler head in the coffee maker area. This was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>				<p>forthose residents found to have been affected by the deficient practice:</p> <p>1.A sprinkler head has been added inthe one smoke compartment located in coffee area off the front entrance lobby.</p> <p>How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective actions will be taken:</p> <p>1.All residents in the front lobby atany time had the potential of being affected by the practice. A sprinkler head has been added in the onesmoke compartment located in the coffee area off the front entrance lobby.</p> <p>Measures put into place or systemicchanges made to ensure that the deficient practice does not recur:</p> <p>1.The sprinkler head will be tested quarterlyas required.</p> <p>How the corrective actions will bemonitored to ensure the deficient practice will not recur:</p> <p>1.The Maintenance Director will performan audit of sprinkler head testing records quarterly continuously notingtesting of the additional sprinkler head.</p> <p>2.All findings will be reviewed andanalyzed then reported to the Quality Assurance and Performance Improvementteam meeting monthly.</p>		

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Bldg. 01	<p>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 observation, record review and interview; the facility failed to ensure 1 of 4 sprinkler system riser gauges were replaced or recalibrated within the past 5 years. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-3.2 requires gauges to be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, as well as staff and visitors while in The Center.</p> <p>Findings include:</p> <p>Based on observation on 04/20/16 at 12:20 p.m. during a tour of the facility with the Director of Maintenance, two of the three pressure gauges on The Center sprinkler system riser had dates of 2005 and 2010. Based on record review between 9:30 a.m. and 11:30 a.m. there was no documentation to show the sprinkler system gauges had been replaced or recalibrated. During an interview at the time of observation, the</p>	K 0062	<p>Corrective actions accomplished for those residents found to have been affected by the deficient practice:</p> <p>1. The two pressure gauges on the sprinkler system riser in The Center that were outdated have been replaced.</p> <p>2. The three sprinkler heads in the 400 hall breezeway and TV area have been replaced.</p> <p>3. Gaps found in the mechanical closet in the 500 hall lounge were caulked so that the sprinkler head can function to its full capability in the event of a fire.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>1. All residents using The Center, in the 400 hall breezeway and TV area or on the 500 hall had the potential to be affected by this practice.</p> <p>2. The two pressure gauges on the sprinkler system riser in The Center that were outdated have been replaced.</p> <p>3. The three sprinkler heads in the 400 hall breezeway and TV area have been replaced.</p> <p>4. Gaps found in the mechanical closet in the 500 hall lounge were</p>	05/20/2016			

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	<p>Director of Maintenance acknowledged the two pressure gauges on The Center sprinkler system riser had not been replaced since 2005 and 2010.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 3 of over 1000 sprinkler heads in the facility were free of corrosion. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint and corrosion. Any sprinkler shall be replaced that is painted or corroded. This deficient practice could affect over 6 residents, as well as staff and visitors while in the 400 hall Breezeway and TV area.</p> <p>Findings include:</p> <p>Based on observation on 04/20/16 at 12:45 p.m. during a tour of the facility with the Director of Maintenance, there were 3 sprinkler heads in the 400 hall Breezeway and TV area covered with green corrosion. This was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p>		<p>caulked so that the sprinkler head can function to its full capability in the event of a fire.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice does not recur:</p> <ol style="list-style-type: none"> 1. The pressure gauges on the sprinkler system risers will be checked annually for replacement or recalibration with documentation reviewed. 2. Sprinkler heads will be checked quarterly continuously for corrosion. 3. Smoke compartments will be checked for penetrations after any work is performed within the compartment. <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 1. The Director of Maintenance will perform an audit of the pressure gauges on the sprinkler system risers annually continuously for replacement or recalibration. 2. The Director of Maintenance will perform an audit of the sprinkler heads quarterly continuously for corrosion. 3. The Director of Maintenance will perform an audit of smoke compartments for penetrations after work is performed. 4. All findings will be reviewed and analyzed then reported to the Quality Assurance and Performance Improvement team meeting monthly. 		

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K 0130 SS=E Bldg. 01	<p>3. Based on observation and interview, the facility failed to ensure the ceiling in 1 of 15 sprinklered smoke compartments were maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect more than 10 residents, as well as staff and visitors while in the 500 hall west lounge.</p> <p>Findings include:</p> <p>Based on observation on 04/20/16 at 12:55 p.m. during a tour of the facility with the Director of Maintenance, the Mechanical closet in the 500 hall lounge had gaps of one half inch around two conduits which penetrated the ceiling which would not allow the sprinkler head to function to its full capability in the event of a fire. This was acknowledged by Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, interview and record review; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire door was in accordance with NFPA 80. LSC 4.5.7 requires any device,</p>	K 0130	<p>Corrective actions accomplished for those residents found to have been affected by the deficient practice:</p> <p>1. The rolling fire door for The</p>	05/20/2016

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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>equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect over 50 residents, as well as staff and visitors while in The Center.</p> <p>Findings include:</p> <p>Based on record review on 04/20/16 between 9:15 a.m. and 11:30 a.m. with the Director of Maintenance present, there was no record of an annual rolling fire door inspection for The Center kitchen rolling fire door. Based on observation during a tour of The Center kitchen on 04/20/16 at 12:15 p.m., The Center kitchen rolling fire door did not have an attached inspection tag indicating an annual rolling fire door inspection was conducted. The lack of an annual kitchen</p>		<p>Centerkitchen has been inspected and inspection tag attached.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>1. All residents using The Center had the potential to be affected by the practice.</p> <p>2. The rolling fire door for The Centerkitchen has been inspected and an inspection tag attached.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice does not recur:</p> <p>1. The rolling fire door for The Centerkitchen will be inspected annually.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>1. The Maintenance Director will perform an audit of the rolling fire door for inspection annually continuously.</p> <p>2. All findings will be reviewed and analyzed then reported to the Quality Assurance and Performance Improvement team meeting monthly.</p>				

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K 0147 SS=D Bldg. 01	<p>rolling fire door inspection was verified by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure power strips were not used as a substitute for fixed wiring in 1 of 112 resident sleeping rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. 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. This deficient practice could affect 2 residents in resident room 905.</p> <p>Findings include:</p> <p>Based on observation on 04/20/16 at 12:00 p.m. during a tour of the facility with the Director of Maintenance, resident room 905 had a lift chair and nebulizer plugged into a power strip. This was acknowledged by the Director of Maintenance at the time of</p>	K 0147	<p>Corrective actions accomplished for those residents found to have been affected by the deficient practice:</p> <p>1. The lift chair and nebulizer for resident room 905 has been plugged into fixed wiring in the room and the power strip has been removed.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:</p> <p>1. A visual audit of all resident rooms has been completed to check that all medical equipment was plugged into fixed wiring. All equipment found not plugged into fixed wiring was corrected at the time of the audit.</p> <p>Measures put into place or systemic changes made to ensure that the deficient practice does not recur:</p> <p>1. A letter has been added to the admission packet to inform all</p>	05/20/2016

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	observation. 3.1-19(b)		<p>new residents and families of proper use of power strips. (Exhibit A)</p> <p>2. An article has been placed in the center newsletter to remind all residents and families of proper use of powerstrips. (Exhibit B)</p> <p>3. Nursing team members have been educated on proper use of power strips and what equipment needs to be plugged into fixed wiring.</p> <p>How the corrective actions will be monitored to ensure the deficient practice will not recur:</p> <p>1. The Maintenance Director will perform audits to check that all medical equipment is plugged into fixed wiring for 50% of resident rooms weekly for four weeks, monthly for four months and then quarterly continuously.</p> <p>2. All findings will be reviewed and analyzed then reported to the Quality Assurance and Performance Improvement team meeting monthly.</p>		