

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155243	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/04/2013
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF LAFAYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 300 WINDY HILL DR LAFAYETTE, IN 47905
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K010000	<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: 11/04/13</p> <p>Facility Number: 000147 Provider Number: 155243 AIM Number: 100266900</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist; Liberty Fruth, Life Safety Code Specialist; Brett Overmyer, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Signature Healthcare of Lafayette 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 hard wired smoke detection in corridors and in areas open to the</p>	K010000	<p>November 19, 2013 This Plan of Correction is the center's credible allegation of compliance for the recent survey of November 4, 2013 at Signature Healthcare of Lafayette, IN. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Date of compliance November 25, 2013. Signature Healthcare of Lafayette, IN respectfully requests paper compliance with this Plan of Correction</p>	

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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	<p>corridor. Battery powered smoke detectors are provided in all 81 resident rooms. The facility has the capacity for 160 and had a census of 116 at the time of this visit.</p> <p>All areas where residents have customary access and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/12/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010018 SS=E	<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 3 of 90 corridor doors latched into the door frame. This deficient practice could affect at least 10 residents on the C wing west hall or staff on the service hall.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 11/04/13 during the tour from 2:15 p.m. to 4:30 p.m., the doors to resident rooms 232 and 236 as well as the women's employee locker room corridor door did not latch into the door frame. Based on interview during the times of observation, the Plant Operations Director acknowledged the aforementioned doors did not latch.</p>	K010018	<p>K 018 Plan of Correction 11/15/2013 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The latches to resident's rooms 232, 236, and the door latch to the women's locker room have been repaired. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An inspection of the facility doors to ensure they latched properly was conducted by the Plant Operations Director and Administrator. Area's identified with similar issues that were observed during the Survey have been corrected. What measures will be put into place or what systemic changes will be made to</p>	11/25/2013

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	3.1-19(b)		ensure that the deficient practice does not reoccur? Plant Operations Director and Assistant have been in-serviced on Room Inspection Checklist. The Room inspection includes Door Inspections. This inspection will be conducted on all occupied rooms 1x weekly for 30 days. Then 2 x monthly for 30 days. Progress will be reviewed after 60 days and returned to normal Inspection frequency of 2x annually unless findings determine otherwise. All staff has been re-in-serviced to the "Work Order" process. This allows any employee to document areas that need repaired and emphasizes their responsibility with Life Safety. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Plant Operations Director will conduct room inspections on all occupied rooms 1x weekly for 30 days. Then 2 x monthly for 30 days. Progress will be reviewed after 60 days. Findings will be submitted to the Executive Director. Findings will be reviewed with the Performance Improvement Committee monthly for 6 months to ensure ongoing compliance. Completion Date: 11/15/2013		

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K010029 SS=E	<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>1. Based on observation and interview, the facility failed to ensure 2 of 10 doors serving hazardous areas closed and latched to prevent the passage of smoke. This deficient practice would not directly affect residents but would affect staff using the service hall.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 11/04/13 during the tour from 2:15 p.m. to 4:30 p.m., the following was noted:</p> <p>a. The Housekeeping Utility closet exceeded 50 square feet in size and the door which was provided with a door closer did not latch into the door frame. The room was used for the storage of combustible boxes and paper supplies.</p> <p>b. The clean laundry room door was provided with a door closer but it did not</p>	K010029	<p>K 029 Plan of Correction 11/18/2013 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Housekeeping Utility closet door closer along with the, clean laundry room door's door closer were adjusted so they latch correctly. Bolts have been placed in the holes and sealed where the plate had been removed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An inspection of the facility doors to ensure they latched properly was conducted by the Plant Operations Director and Administrator. Area's identified with similar issues that were observed during the Survey have been corrected. What measures will be put into place or what systemic changes will be made to</p>	11/25/2013			

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	<p>latch into the door frame.</p> <p>Based on interview during the times of observation, the Plant Operations Director acknowledged the aforementioned doors did not latch.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 10 hazardous areas was separated from other spaces by smoke resisting doors. This deficient practice could affect 10 residents on the C wing center hall as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 11/04/13 during the tour from 2:15 p.m. to 4:30 p.m., the C wing west central shower room had three pencil size holes through the door and had a two-hamper soiled linen cart exceeding 32 gallons in capacity stored in the room. Based on interview during the times of observation, the Plant Operations Director acknowledged the holes in the door indicating a plate had been removed from the door.</p> <p>3.1-19(b)</p>		<p>ensure that the deficient practice does not reoccur? Plant Operations Director and Assistant have been in-serviced on Room Inspection Checklist. The Room inspection includes Door Inspections. This inspection will be conducted on all occupied rooms 1x weekly for 30 days. Then 2 x monthly for 30 days. Progress will be reviewed after 60 days and returned to normal Inspection frequency of 2x annually unless findings determine otherwise. All staff has been re-in-serviced to the "Work Order" process. This allows any employee to document areas that need repaired and emphasizes their responsibility with Life Safety. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Plant Operations Director will conduct room inspections on all occupied rooms 1x weekly for 30 days. Then 2 x monthly for 30 days. Progress will be reviewed after 60 days. Findings will be submitted to the Executive Director. Findings will be reviewed with the Performance Improvement Committee monthly for 6 months to ensure ongoing compliance. Completion Date: 11/18/2013</p>		

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 17 exit doors were accessible. Health care occupancies permit delayed egress locks if all the conditions of LSC, Section 7.2.1.6.1 are met. LSC 7.2.1.6(c) states an irreversible process shall release the lock within 15 seconds upon application of a force to the release device. The initiation of the release process shall activate an audible signal in the vicinity of the door. This deficient practice could affect at least 30 residents using the main dining room and any visitors.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 11/04/13 during the tour from 2:15 p.m. to 4:30 p.m., the north exit door from the main dining room was magnetically locked and provided with signage on the door identifying the door could be opened in 15 seconds by pushing on the door. When a force was applied to the release device for the door, an audible signal was not activated and the door did not release. Based on interview during the time of observation, the Plant Operations Director</p>	K010038	<p>K 038 Plan of Correction 11/18/2013 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The magnetic lock to the north exit door from the main dining room has been re-adjusted so the alarm will activate and release in 15 seconds as it is intended. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. An inspection of the facility doors to ensure they latched properly was conducted by the Plant Operations Director and Administrator. Area's identified with similar issues that were observed during the Survey have been corrected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Plant Operations Director and Assistant have been in-serviced on Room Inspection Checklist. The Room inspection includes Door Inspections. This inspection will be conducted on all occupied rooms 1x weekly for 30 days. Then 2 x monthly for 30 days. Progress will be reviewed after 60 days and returned to normal</p>	11/25/2013			

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	acknowledged the aforementioned door should have released and needed adjustment. 3.1-19(b)		Inspection frequency of 2x annually unless findings determine otherwise. All staff has been re-in-serviced to the "Work Order" process. This allows any employee to document areas that need repaired and emphasizes their responsibility with Life Safety. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Plant Operations Director will conduct room inspections on all occupied rooms 1x weekly for 30 days. Then 2 x monthly for 30 days. Progress will be reviewed after 60 days. Findings will be submitted to the Executive Director. Findings will be reviewed with the Performance Improvement Committee monthly for 6 months to ensure ongoing compliance. Completion Date: 11/25/2013		

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K010048 SS=E	<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 Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 19.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire safety plan and policy and procedures regarding fire extinguisher maintenance and inservices with the Plant Operations Director during record review from 10:55 a.m. to 1:00 p.m. on 11/04/13, the fire safety plan did not address the use of the</p>	K010048	<p>K 048 Plan of Correction 11/18/2013 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Kitchen staff has been in-serviced on how to activate the K fire extinguisher. The written fire safety plan has been updated to include instructions to train the kitchen staff. This will be conducted during their specific orientation and annually thereafter. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. A review of the Fire Plan was conducted by the Administrator and Plant Operations Director. No other issues were identified at that time. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Plant Operations Director and Administrator will review the written fire safety plan monthly for the next 6 months, when a drill is conducted. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Plant Operations Director and Administrator will conduct a review of written fires safety plan</p>	11/25/2013			

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	<p>K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on interview at the time of record review, the Plant Operation Director acknowledged the written fire safety plan for the facility did not address kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K-class fire extinguisher.</p> <p>3.1-19(b)</p>		<p>each month for 6 months. It will then be reviewed annually thereafter. Findings will be submitted to the Executive Director. Findings will be reviewed with the Performance Improvement Committee monthly for 6 months to ensure ongoing compliance. Completion Date: 11/25/2013</p>		

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K010050 SS=F	<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>1. Based on interview and record review, the facility failed to conduct quarterly fire drills on each shift for 1 of 4 quarters. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire/Disaster Drill Reports" with the Plant Operations Director from 10:55 a.m. to 1:00 p.m. on 11/04/13, a fire drill was not documented for the first shift of the third quarter of 2013. Based on interview at the time of record review, the Plant Operations Director acknowledged the first shift fire drill for the third quarter of 2013 was missed and there was no other documentation available for review to verify this drill was conducted.</p> <p>3.1-19(b)</p>	K010050	<p>K 050 Plan of Correction 11/18/2013 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Plant Operations Director has conducted a Fire Drill each month. The schedule has been modified to ensure that drills are conducted on a different shift each month. This modified schedule includes changes in the times so they will be unexpected How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. The modifications to the fire drill schedule ensure that the corrective action is for all residents who have the potential to be affected by the identified deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? The Plant Operations Director will</p>	11/25/2013	

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	<p>3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to conduct fire drills at unexpected times in 9 of 11 fire drills. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of "Fire/Disaster Drill Reports" with the Plant Operations Director from 10:55 a.m. to 1:00 p.m. on 11/04/13, the following was noted:</p> <p>a) Three of three first shift fire drills were conducted on 3/26/13, 6/25/13 and 12/26/12.</p> <p>b) Three of four second shift fire drills were conducted on 5/30/13, 8/28/13 and 11/30/12.</p> <p>c) Four of four third shift fire drills were conducted on 1/23/13, 4/25/13, 7/31/13 and 10/25/13.</p> <p>Based on interview at the time of review, the Plant Operations Director acknowledged the fire drills were often held near the end of the month.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>submit a copy of the fire drill to the Administrator each month. The Administrator will audit these fire drills each month for six months. Administrator will maintain fire drill binder with this second copy to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. The Plant Operations Director will submit a copy of the fire drill to the Administrator each month. The Administrator will audit these fire drills each month for 6 months. Findings will be reviewed with the Performance Improvement Committee monthly for 6 months to ensure ongoing compliance. Completion Date: 11/25/2013</p>		

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K010051 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on record review and interview, the facility failed to ensure 2 of 79 smoke detectors that had failed a sensitivity test were replaced or recalibrated. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72 at 7-3.2.1 states, "Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced." This deficient practice could affect approximately 10 residents as well as staff and visitors.</p> <p>Findings include: Based on review of "Smoke Detector</p>	K010051	K 051 Plan of Correction 11/18/2013 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The 2 smoke detectors that failed the sensitivity test have been replaced. The Plant Operations Director has obtained documentation from our Inspection vendor, Safe Care, confirming this has been completed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. A review of other Inspections has been completed to ensure any other similar issue has been	11/25/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155243	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 11/04/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF LAFAYETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 300 WINDY HILL DR LAFAYETTE, IN 47905		
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	<p>Sensitivity Test" dated 05/16/2013 on 11/04/13 during record review from 10:55 a.m. to 1:00 p.m., two smoke detectors failed the sensitivity test and the test report indicated the the two detectors needed to be replaced. Based on further review and interview with the Plant Operations Director, there was no documentation available to document the failed smoke detectors had been replaced.</p> <p>3.1-19(b)</p>		<p>addressed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Administrator has in-serviced the Plant Operations Director regarding inspections. Specifically the need to: 1. Repair any issue identified. 2. Obtain and maintain documentation of the repair. Inspections will be reviewed by the Administrator and Plant Operations Director. Administrator will "sign off" on Inspections. How the corrective action(s) will be monitored to ensure the deficient practice will not recur. Plant Operations Director will bring Inspections to the monthly PI meetings. Findings will be reviewed with the Performance Improvement Committee monthly for 6 months to ensure ongoing compliance. Completion Date: 11/25/2013</p>		

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K010064 SS=D	<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 2 of 36 portable fire extinguishers 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 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 was not in a resident care areas but could affect any number of staff in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Director on 11/04/13 during the tour from 2:15 p.m. to 4:30 p.m., the following was noted:</p> <p>a. The monthly inspection tag on the fire extinguisher located outside at the</p>	K010064	<p>K 064 Plan of Correction 11/18/2013 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Plant Operations Director has inspected the fire extinguishers located outside of the ambulance entrance and the extinguisher located in the service hall attic mechanical room. They have been signed off as operable.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. A review of other inspections has been completed to ensure any other similar issue has been addressed. No other issues identified at this time. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Plant Operations Director has modified the fire extinguisher inspection form. This modification will allow the Plant Operations Assistant to complete a secondary check. This secondary check will ensure that extinguisher inspections are not missed. This will be on-going.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</p>	11/25/2013			

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	<p>ambulance entrance lacked documentation of a monthly inspection for the months of September and October of 2013</p> <p>b. The monthly inspection tag on the fire extinguisher located in the service hall attic mechanical room lacked documentation of a monthly inspection for the month of October of 2013</p> <p>Based on interview, this was acknowledged by the Plant Operation Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>Plant Operations Director will bring inspections to the monthly PI meetings. Findings will be reviewed with the Performance Improvement Committee monthly for 6 months to ensure ongoing compliance. Completion Date: 11/25/2013</p>		