

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155171	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/25/2015
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NAME OF PROVIDER OR SUPPLIER FRANKLIN MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1285 W JEFFERSON ST FRANKLIN, IN 46131
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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: 09/25/15</p> <p>Facility Number: 000087 Provider Number: 155171 AIM Number: 100289890</p> <p>At this Life Safety Code Survey, Franklin Meadows 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 (000) construction and is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. Battery operated smoke detectors are installed in all resident sleeping rooms. The facility has a capacity of 114 and had a census of 86 at</p>	K 0000	<p>The creation and submission of this Plan of Correction on behalf of Franklin Meadows does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of any regulation. This provider respectfully requests that the Plan of Correction be considered the Letter of Credible Allegation by October 25, 2015 and requests a Desk Certification Review. The community respectfully requests a desk review for paper compliance</p>	
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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 0029 SS=E Bldg. 01	<p>the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except three detached wooden sheds providing facility storage.</p> <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 corridor doors to 2 of 10 hazardous areas such as soiled linen rooms and trash collection rooms were provided with a self closing device. This deficient practice could affect 32 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:35 a.m. to 1:25 p.m. on 09/25/15, the corridor door to the soiled</p>	K 0029	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice</p> <p>2. 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 community realizes that the alleged deficient practice could affect residents, visitors, and staff</p> <p>3. What measures will be put in place or what systemic changes will be made to ensure the deficient practice does not recur?</p>	10/25/2015

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K 0038 SS=E Bldg. 01	<p>linen and trash storage room by Room 162 and by Room 105 were each not equipped with a self closing device. Each storage room contained two 32 gallon capacity trash bags each containing soiled linen or trash. Based on interview at the time of the observations, the Maintenance Director acknowledged the corridor door to the aforementioned soiled linen and trash collection rooms were each not equipped with a self closing device.</p> <p>3.1-19(b)</p> <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 the means of egress through 1 of 1 delayed egress locks in the facility was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7,</p>	K 0038	<p>The corridor to the soiled linen and trash storage room has been equipped with a self closing device. 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place? The Maintenance Director will conduct monthly audits to ensure all closure devices remain in proper working order with documentation of such forwarded to the quality assurance committee for the next six months for review and recommendations.</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents, staff, or visitors were affected by the alleged deficient practice. 2. 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 community realizes that the alleged deficient practice could have the potential to affect 18 residents, staff and visitors. 3. What measures will be put in place or what systemic changes will be made to ensure the</p>	10/25/2015

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	<p>and where permitted in Chapters 12 through 42, provided: (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS</p> <p>This deficient practice could affect 18 residents, staff and visitors if needing to exit the facility by the conference room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:35 a.m. to 1:25 p.m. on</p>		<p>deficient practice does not recur? The appropriate signage was placed on the exit door reading "Push until alarm sounds Door can be opened in 15 seconds". 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place? The Maintenance Director will monitor all delayed egress doors to ensure the appropriate signage remains intact monthly for the next six months and quarterly thereafter with documentation of such forwarded to the quality assurance committee for review and recommendations.</p>		

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K 0046 SS=D Bldg. 01	<p>09/25/15, the exit door by the conference room to the exterior of the building was marked as a facility exit and was equipped with a delayed egress lock but was not provided with the necessary signage stating the door could be opened in 15 seconds by pushing on the door release device. The aforementioned exit door released to open when the door was pushed for 15 seconds two separate times. Based on interview at the time of observation, the Maintenance Director stated the aforementioned exit is a facility exit, is equipped with a delayed egress lock and acknowledged the exit door was not provided with the necessary signage stating the door could be opened in 15 seconds by pushing on the door release device.</p> <p>3.1-19(b)</p> <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. Based on observation and interview, the facility failed to ensure 1 of 4 battery powered emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.4 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided</p>			K 0046	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents, staff or visitors were affected by the alleged deficient practice. 2. How other residents having the potential to be affected by the</p>		10/25/2015

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K 0048 SS=C Bldg. 01	<p>with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect five staff and visitors in the service hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:35 a.m. to 1:25 p.m. on 09/25/15, the battery operated emergency light located in the service hall failed to illuminate when its respective test button was pressed five times. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned battery operated emergency light failed to illuminate when its respective test button was pressed five times.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to document a complete written health care occupancy fire safety</p>	K 0048	<p>same deficient practice will be identified and what corrective action will be taken?</p> <p>The community realizes that 5 staff and visitors in the service hall have the potential to be affected by the alleged deficient practice. 3. What measures will be put in place or what systemic changes will be made to ensure the deficient practice does not recur?</p> <p>The batteries were changed in the battery powered emergency lights A quality assurance tool was developed as part of the preventative maintenance program. 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place?</p> <p>The Maintenance Director will utilize a quality assurance tool to check the batteries monthly All documented findings will be forwarded to the quality assurance committee for the next six months for review and recommendations The tool will be used on-going thereafter.</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p>	10/25/2015			

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	<p>plan for 1 of 1 plans which incorporated all items listed in NFPA 101, Section 19.7.2.2.</p> <ol style="list-style-type: none"> 1. Use of alarms. 2. Transmission of alarms to 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 all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of "Disaster Preparedness Plan" documentation with the Maintenance Director during record review from 9:20 a.m. to 11:35 a.m. on 09/25/15, the facility did not document a complete written health care occupancy fire safety plan. The aforementioned written fire safety plan stated "each wing/section is expected to be evacuated beyond fire doors or to the nearest exit" in "Section E - Fire Essential Tasks". In the "Fire Procedure" section of the written fire safety plan it is stated to "Continue removing in sequence all people in the area until all are past the</p>		<p>No residents, staff or visitors were affected by the alleged deficient practice. 2. 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 community realizes that all residents, staff and visitors have the potential to be affected by the alleged deficient practice 3. What measures will be put in place or what systemic changes will be made to ensure the deficient practice does not recur? The community has developed a complete written health care occupancy fire safety plan to include the location of each fire door. 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place? The Maintenance Director will utilize a quality assurance tool to check that the written health care occupancy fire safety plan includes the location of each fire door.</p> <p>All documented findings will be forwarded to the quality assurance committee for the next six months for review and recommendations The tool will be used on-going thereafter.</p>				

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K 0050 SS=C Bldg. 01	<p>fire compartment doors". In the "Procedure for Staff Response to Battery Powered Smoke Detectors" section of the written fire safety plan, it is stated "continue past fire door with evacuated persons" and " Continue removing in sequence all persons in the area until all are past the fire doors". The floor plan of the written fire safety plan documents the location of red emergency outlet locations but does not state the location of fire doors in the facility. Based on interview at the time of record review, the Maintenance Director stated the location of fire doors in the facility is discussed in service training on staff response to fire emergency conditions but acknowledged the written fire safety plan for the facility does not provide the location of each fire door in the facility for evacuation purposes.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of</p>						

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K 0062 SS=F Bldg. 01	<p>audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second and third shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Director during record review from 9:20 a.m. to 11:35 a.m. on 09/25/15, second shift fire drills conducted on 09/30/14, 12/31/14, and 03/31/15 were conducted at, respectively, 4:41 p.m., 4:17 p.m. and 4:10 p.m. In addition, third shift fire drills conducted on 10/28/14, 01/17/15 and 07/29/15 were conducted at, respectively, 12:38 a.m., 12:40 a.m. and 1:38 a.m. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned second and third shift fire drills were not conducted at unexpected times under varying conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are</p>	K 0050	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents, staff and visitors were affected by the alleged deficient practice.</p> <p>2. 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 community realizes that all residents, staff and visitors have the potential to be affected by the alleged deficient practice.</p> <p>3. What measures will be put in place or what systemic changes will be made to ensure the deficient practice does not recur? The Executive Director and the Maintenance Director have developed a fire drill schedule that includes unexpected times under varying conditions to be implemented for the next six months with documentation of such.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place? Documentation of the fire drills will be forward to the quality assurance committee monthly for the next six months for review and recommendations.</p>	10/25/2015	

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	<p>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 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:20 a.m. to 11:35 a.m. on 09/25/15, documentation of facility fire hydrant inspections within the most recent twelve month period was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:35 a.m. to 1:25 p.m. on 09/25/15, one fire hydrant was noted in the northeast parking lot outside the exit by Room 161. Based on interview at the time of</p>	K 0062	<p>Fire Hydrant (1)</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents, staff and visitors were affected by the alleged deficient practice. 2. 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 community realizes that residents staff and visitors have the potential to be affected by the alleged deficient practice 3. What measures will be put in place or what systemic changes will be made to ensure the deficient practice does not recur? Vanguard has been contacted and will be inspecting the hydrant The fire hydrant will be inspected annually and after each operation. A quality assurance tool has been developed as part of the preventative maintenance program that will include annual inspections and inspections after operation thereafter of the fire hydrant The Director of Maintenance in responsible to monitor 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance</p>	10/25/2015			

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	<p>observation, the Maintenance Director stated the aforementioned fire hydrant was owned by the facility and acknowledged documentation of facility fire hydrant inspection within the most recent twelve month period was not available for review.</p> <p>3.1-19(b)</p> <p>2. 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 32 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:35 a.m. to 1:25 p.m. on 09/25/15, the following was noted:</p> <p>a. two cables were affixed to a four foot length of sprinkler system pipe in the closet for Room 108.</p>		<p>program will be put into place? Documentation of the inspections the fire hydrant requirements (annually and after operation) will be forward to the quality assurance committee review and recommendations Sprinkler Pipes (2)</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents, staff and visitors were affected by the alleged deficient practice.</p> <p>2. 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 community realizes that residents staff and visitors have the potential to be affected by the alleged deficient practice All areas of the community have been monitored with no additional findings.</p> <p>3. What measures will be put in place or what systemic changes will be made to ensure the deficient practice does not recur? A quality assurance tool has been developed as part of the preventative maintenance program that will include monthly audits of all sprinkler pipes. The Director of Maintenance is responsible and will monitor.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place?</p>				

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	<p>b. one cable was affixed to a four foot length of sprinkler pipe in Room 134.</p> <p>c. two cables were affixed to an eight foot length of sprinkler pipe in the closet for Room 135.</p> <p>Based on interview at the time of the observations, the Maintenance Director acknowledged sprinkler system piping was being used to support nonsystem components at the aforementioned locations.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to replace 3 of over 100 sprinklers which had become corroded, had paint, lint or other foreign materials on them. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 26 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the</p>		<p>Documentation of the monthly audits of all sprinkler pipes will be forward to the quality assurance committee for the next six months for review and recommendations Sprinkler Heads (3)</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents, staff and visitors were affected by the alleged deficient practice.</p> <p>2. 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 community realizes that 5 staff and visitors in the service hall have the potential to be affected by the alleged deficient practice</p> <p>3. What measures will be put in place or what systemic changes will be made to ensure the deficient practice does not recur? A quality assurance tool has been developed as part of the preventative maintenance program that will include monthly audits of all sprinkler heads. The Maintenance Director is responsible and will monitor.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place? Documentation of the monthly audits of all sprinkler heads will be forward to the quality assurance committee for the next</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155171	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 09/25/2015
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K 0072 SS=E Bldg. 01	<p>Maintenance Director during a tour of the facility from 11:35 a.m. to 1:25 p.m. on 09/25/15, paint was on the pendant sprinkler in the closet in Room 144, Room 148 and Room 159. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned sprinklers had foreign materials on them.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect any resident, staff or visitor if needing to exit the facility by Room 118.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the</p>	K 0072	<p>six months for review and recommendations</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice</p> <p>2. 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 community realizes that 5 staff and visitors in the service hall have the potential to be affected by the alleged deficient practice.</p> <p>3. What measures will be put in</p>	10/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155171	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/25/2015
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	<p>facility from 11:35 a.m. to 1:25 p.m. on 09/25/15, the exit door by Room 118 which swings in the direction of egress to the outside of the facility only swings one foot wide before the bottom of the exit door becomes stuck on the concrete sidewalk serving as the exit discharge. A considerable amount of force was applied to the exit door by the Maintenance Director in order to force the door to swing to the fully open position. Based on interview at the time of observation, the Maintenance Director stated the exit door continues to keep settling, the sidewalk for the exit discharge has had to be ground down in the past to allow the door to swing fully open and acknowledged the exit door by Room 118 needed a considerable amount of force to push the door to the fully open position and would provide an obstruction or impediment to residents, staff and visitors in the case of fire or other emergency.</p> <p>3.1-19(b)</p>		<p>place or what systemic changes will be made to ensure the deficient practice does not recur? All exit doors were checked by the Maintenance Director to ensure all doors swing open freely without getting stuck to the concrete. The exit door concrete by room # 118 was ground down to ensure proper egress. A quality assurance tool was developed to monitor the exit doors monthly as part of the preventative maintenance program. 4. How the corrective action will be monitored to ensure the deficient practice does not recur i.e. what quality assurance program will be put into place? Documentation of the monthly exit door audits will be forward to the quality assurance committee monthly for the next six months for review and recommendations.</p>		