

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2016
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NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN 47112
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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
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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: 08/29/16</p> <p>Facility Number: 000338 Provider Number: 155441 AIM Number: 100287590</p> <p>At this Life Safety Code survey, Corydon Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 38</p>	K 0000	<p>Preparation and /or execution of thisplan does not constitute admission or agreement by the provider of the truth ofthe facts alleged or conclusions set forth on the statement of deficiencies. Thisplan of correction is prepared and/or executed solely because required.</p> <p>We respectfully request a desk review.Any additional documentation can be provided upon request to support the deskreview.</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>and had a census of 17 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except two detached sheds used for facility storage.</p> <p>Quality Review completed on 09/02/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 Based on observation and interview, the facility failed to ensure 1 of 8 hazardous area room doors, such as a room over 50 square feet containing combustible material, was equipped with a self closing device on the door. This deficient practice could affect up to 11 residents, as well as staff and visitors while in the rear smoke compartment.</p>	K 0029	<p>K-029 SelfClosing Device on Door</p> <p>(a) What corrective action(s) will be accomplished for thoseresidents found to have been affected by the practice?</p> <p>A self-closing device has been installed todoor of Room 10</p>	09/17/2016

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K 0038 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observation on 08/29/16 at 1:40 p.m. during a tour of the facility with the Maintenance Director, the corridor door to room 10 was not provided with a self closing device. Room 10 was over fifty square feet and was being used as a storage room and was full of cardboard boxes full of medical records and other items. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are</p>		<p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Any resident, staff, venter or visitor had the potential to be affected but none were identified.. A facility-wide audit was completed and no other areas were out of compliance.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Maintenance has been in-serviced as to the proper components to this tag.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. What quality assurance program will be put into place: The monitoring of this tag will be the joint effort between the administrator/designee.</p>		

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	<p>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 exit egress for 2 of 3 exits were arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires that means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires that walking surfaces in the means of egress shall comply with 7.1.6.2 through 7.1.6.4. LSC Section 7.1.6.2 requires abrupt changes in elevation shall not exceed 1/4 inch. LSC Section 7.1.6.3 requires walking surfaces to be nominally level. This deficient practice could affect all residents, as well as staff and visitor in the facility.</p> <p>Findings include:</p> <p>Based on observations on 08/29/16 between 1:15 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the following was noted:</p> <p>a. The sidewalk outside the rear exit had a crack at the first joint seam and a one half inch to one inch grade change, furthermore, there was a green garden hose which ran over the rear sidewalk to drain the cooling tower.</p> <p>b. The concrete stoop outside the side exit had a one half inch to one inch drop</p>	K 0038	<p>K-038 OutsideSidewalk Repair</p> <p>(a)What corrective action(s) will be accomplished for those residents found to havebeen affected by the practice?</p> <p>1) The crack in sidewalkand grade change will be repaired. 2) The garden hose hasbeen removed from the side walk. 3) The concrete stoop andramped area outside of side entrance will be repaired.</p> <p>(b) Howyou will identify other residents having potential to be affected by the samepractice and what corrective action will be taken: Any resident, staff, vender or visitorhad the potential to be affected, but none were identified.</p> <p>(c)What measures will be put into place or what systematic changes you will maketo ensure that the practice does not recur: Maintenance has been in-serviced as tothe proper components to this tag.</p>	10/31/2016
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K 0046 SS=F Bldg. 01	<p>from the door threshold, furthermore, the small ramped area at the end of the concrete stoop was cracked and uneven and had a one half inch to one inch grade change.</p> <p>The grade changes at both of these exits could create tripping hazards. This was acknowledged by the Maintenance Director at the time of each observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1.</p> <p>Based on record review, interview, and observation; the facility failed to ensure 5 of 5 battery powered light sets were tested monthly for 30 seconds. LSC 101, Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2</p>	K 0046	<p>(d) Howthe corrective action(s) will be monitored to ensure the practice will notrecur, i.e. What quality assuranceprogram will be put into place: The monitoring of this tag will be thejoint effort between the administrator/designee.</p> <p>(e)Date of compliance: 9/17/16-10/31/16 Note: Estimates of repair are beingobtained and will proceed to complete as soon as possible. Completion isdelayed due to Contractor prior schedules and work load.</p> <p>K-046 EmergencyLights Testing and Documentation</p> <p>(a) What corrective action(s) will be accomplished for thoseresidents found to have been affected by the practice? All battery powered back up lights weretested in August 2016</p>	09/17/2016

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	<p>hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review on 08/29/16 at 11:00 a.m. with the Maintenance Director present, there was no documentation to show the five battery powered back up light sets were tested monthly during eleven of the past twelve months (except July 2016). This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3-1.19(b)</p>		<p>to ensure proper functioning for not less than 30seconds. All were tested in September 2016 to ensure proper functioning for notless than 90 minutes. MaintenanceDirector has been educated on required testing and documentation. . MaintenanceDirector will test and complete written documentation audits of all batterypowered back up lights 1 x per month to ensure proper functioning for not less than 30 seconds, and 1 x per year to ensure proper functioning for not less than 90 minutes.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Any resident, staff, vender or visitor had the potential to be affected, but none were identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Maintenance Director has been in-serviced as to the requirements of this tag. Maintenance Director will submit copies of written records of monthly emergency lights testing</p>				

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K 0056 SS=F Bldg. 01	<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 facility failed to ensure steel armover sprinkler pipes in 4 of over 40 rooms</p>	K 0056	<p>to Administrator during monthly QA meetings.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. What quality assurance program will be put into place: The monitoring of this tag will be a joint effort between NHA and Maintenance Director as they review their findings at the monthly Risk Management/QA meeting. This will be an ongoing solution and will be checked by the Director of Plant Operations on quarterly rounds at the facility, to ensure that the facility remains in compliance.</p> <p>K-056 Automatic Sprinkler Supports</p>	09/17/2016	

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	<p>were installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 08/29/16 between 1:15 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the following was noted:</p> <p>a. A steel sprinkler pipe armover against the outside wall of the Dining Room was five feet long and was unsupported.</p> <p>b. A steel sprinkler pipe armover in the Pantry was four feet long and was unsupported.</p> <p>c. A steel sprinkler pipe armover in room #2 was five feet long and was unsupported.</p> <p>d. A steel sprinkler pipe armover in room #4 (office) was three feet long and was unsupported.</p> <p>This was acknowledged by the Maintenance Director at the time of each observation.</p>		<p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice?</p> <p>The steel sprinkler pipe armover outside the dining room wall, inside the pantry, in room 2 and room 4 have had proper supports added within the last two feet of pipe to ensure compliance.</p> <p>(a) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>Any resident, staff, vender or visitor had the potential to be affected, but none were identified.</p> <p>(b) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>An audit of the building was completed to identify other unsupported armovers of more than two feet, and all have been corrected.</p> <p>(c) How the corrective action(s) will be monitored to</p>				

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K 0069 SS=B Bldg. 01	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen range hood's fire extinguishing equipment was inspected and approved every 6 months by properly trained and qualified persons, furthermore, the facility failed to ensure all components of the range hood fire extinguishing system were in proper operating condition. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, in 8-2 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made at least every 6 months by properly trained and qualified persons. NFPA 96, 8-2.1 requires all actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire actuated	K 0069	ensure the practice will not recur, i.e. What quality assurance program will be put into place: The monitoring of this tag will be the joint effort between the administrator/designee. K-069 Range Hood Inspection and Documentation (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice? A range hood inspection for proper functioning has been completed in September 2016. The provider of services was notified that the inspection must be completed every six months. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Any resident, staff, vendor or visitor had the potential to be	09/17/2016	

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K 0072 SS=E Bldg. 01	<p>dampers shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice could affect mostly kitchen staff.</p> <p>Findings include:</p> <p>Based on review of the range hood inspection reports in the Life Safety Book on 08/29/16 at 12:52 p.m. with the Maintenance Director present, the only range hood fire extinguishing equipment inspection report was dated 07/14/16 during the past twelve months. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be 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 shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 corridor means of egress was continuously maintained free of obstructions. This</p>	K 0072	<p>affected, but none were identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Maintenance has been in-serviced as to the proper components to this tag.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. What quality assurance program will be put into place: The monitoring of this tag will be the joint effort between the administrator/designee and Maintenance Director will audit the semi-annual inspections beginning early 2017.</p> <p>K-072 Means of Egress</p> <p>(a) What corrective action(s)</p>	09/17/2016			

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	<p>deficient practice affects up to 9 residents in the west corridor, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on an observation on 08/29/16 between 1:15 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, there was a couch in the west corridor placed against the wall and not bolted to the floor or wall. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>will be accomplished for those residents found to have been affected by the practice?</p> <p>The couch in the west corridor has been secured to the wall.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>Any resident, staff, venter or visitor had the potential to be affected, but none were identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>Maintenance has been in-serviced as to the proper components to this tag.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. What quality assurance program will be put into place:</p> <p>The monitoring of this tag will be the joint effort between the administrator/designee.</p>	

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K 0130 SS=C Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, interview and observation; the facility failed to ensure the proper maintenance of 18 of 18 battery operated smoke alarms in resident rooms to ensure the smoke alarms are continually operable. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could all residents, as well as staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the Battery Check Smoke Detectors file on 08/29/16 at 11:10 a.m. with the Maintenance Director present, all 18 resident sleeping rooms have battery operated smoke alarms. There was no documentation available to show the battery operated smoke alarms were inspected/tested monthly during the months of September, October, and December of 2015, and January and February of 2016. This was confirmed by the Maintenance Director at the time of record review. Based on observation between 1:15 p.m. and 3:15 p.m. it was confirmed all resident rooms were provided with battery operated smoke alarms.</p>	K 0130	<p>K-130 BatteryOperated Smoke Detectors Testing and Documentation</p> <p>(a) What corrective action(s) will be accomplished for thoseresidents found to have been affected by the practice? Maintenance Director has been educated asto the required monthly testing and documentation of battery operated smokealarms. All battery operated smoke alarms have been properly tested,documented, and are in compliance.</p> <p>(b) How you will identify other residents having potential tobe affected by the same practice and what corrective action will be taken: Any resident, staff,vender or visitor had the potential to be affected, but none were identified.</p> <p>(c)What measures will be put into place or what systematic changes you will maketo</p>	09/17/2016			

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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
K 0144 SS=C Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on record review and interview, the facility failed to provide documentation that the transfer time for the generator was being recorded after each load test for 1 of 1 emergency generator. LSC 19.2.9.1 refers to LSC</p>	K 0144	<p>ensure that the practice does not recur Maintenance Director has been in-serviced as to the requirements of this tag. Maintenance Director will submit copies of documentation of monthly smoke detector tests to Administrator during monthly QA meetings.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. What quality assurance program will be put into place: The Quality Assurance Committee will review the audit tool for the next six months to ensure compliance and will continue until the Committee deems the audit is longer required.</p> <p>K-144 Generator Testing and Documentation</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have</p>	09/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2016
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN 47112		
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	<p>7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. 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 monthly generator load test file on 08/29/16 at 12:40 p.m. with the Maintenance Director present, the generator log form documented the generator was tested monthly for 30 minutes under load, however, there was no documentation that showed the generator transfer time being recorded following its load test. During an interview at the time of record review, the Maintenance Director acknowledged the monthly generator log did not include documentation of a generator transfer time being recorded.</p> <p>3.1-19(b)</p>		<p>been affected by the practice?</p> <p>Maintenance Director has been educated as to proper testing and documentation requirements of the facility's monthly generator load test and transfer time. A load test was completed in September on the generator and the transfer time was logged for record keeping.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>Any resident, staff, vendor or visitor had the potential to be affected, but none were identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>Maintenance Director has been in-serviced as to the requirements of this tag. Maintenance Director will submit copies of written records of monthly fire drills to Administrator during monthly QA meetings.</p>		

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K 0147 SS=E Bldg. 01	<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</p> <p>Based on observation and interview, the facility failed to ensure power strips were not used as a substitute for fixed wiring in 2 of over 40 rooms in the facility. 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 staff in the Pantry and staff and residents while in the Physical Therapy room.</p>	K 0147	<p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. What quality assurance program will be put into place: The Quality Assurance Committee will review the audit tool for the next six months to ensure compliance and will continue until the Committee deems the audit is longer required.</p> <p>K-147 Electrical Wiring and Equipment</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice? The power strips have been removed and additional hard-wired outlets have been added to compensate for the electrical needs</p> <p>(b) How you will identify other</p>	09/17/2016

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	<p>Findings include:</p> <p>Based on observations on 08/29/16 between 1:15 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the following was noted:</p> <p>a. The Physical Therapy room had a small air conditioning unit plugged into a power strip.</p> <p>b. The Pantry had two small refrigerators, a microwave, and a coffee maker plugged into a power strip. This was acknowledged by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p>		<p>residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>Any resident, staff, vendor or visitor had the potential to be affected, but none were identified.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>Maintenance has been serviced as to the proper components to this tag.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e. What quality assurance program will be put into place:</p> <p>The monitoring of this tag will be the joint effort between the administrator/designee.</p>	