

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989
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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: 07/26/16</p> <p>Facility Number: 000107 Provider Number: 155200 AIM Number: 100290330</p> <p>At this Life Safety Code survey, University Nursing 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 V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 75 and had a census of 71 at the time of this survey.</p>	K 0000	Dear Ms. Rhoades, Attached is University Nursing Center's Plan of Correction for the annual Life Safety Code inspection completed on 7/26/16. Please accept the plan of correction as written. Sincerely, Stephanie Allen, HFA, MHA University Nursing Center	
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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 0025 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. The facility had a storage shed of maintenance supplies that was not sprinklered.</p> <p>Quality Review completed on 07/27/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 4 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a</p>	K 0025	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The ceiling tile penetrations of the 100 smoke barrier wall, attic penetrations of the 200 smoke barrier wall, attic of the 100 smoke barrier wall penetrations were all fixed by the maintenance director. The ceiling penetrations of the housekeeping room on the service hall, and the ceiling of the dining room hall attic hatch hole were all fixed by the maintenance director. How other residents having the potential to be affected</p>	08/25/2016			

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	<p>material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect up to 46 residents on the 100 and 200 halls.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Executive Director on 07/26/16 from 12:30 p.m. to 01:30 p.m., the following smoke barrier walls had unsealed penetrations:</p> <p>a) Above the ceiling tiles of the 100 smoke barrier wall there were two unsealed half inch penetrations around wires.</p> <p>b) In the attic of the 200 smoke barrier wall there was an unsealed two inch penetration around wires where the fire caulk had pulled away.</p> <p>c) In the attic of the 100 smoke barrier wall there were two unsealed half inch penetrations around wires</p> <p>Based on interview at the time of observations, the Executive Director acknowledged the penetrations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers were maintained to</p>		<p>by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. The maintenance director will complete a house audit by 8/25/16 to ensure no other penetrations exist in the smoke barrier walls or ceiling smoke barriers. Any issues noted will be immediately addressed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director or designee will conduct a daily round on days worked to ensure no holes exist in the smoke barrier walls or ceiling smoke barriers. Any issues found will be immediately addressed. How the corrective action will be monitored to ensure the deficient practice does not recur? The maintenance director or designee will conduct a daily round to ensure no holes exist in the smoke barrier walls or ceiling smoke barriers for one month, then weekly for two months, and then monthly for 3 months with results to QAPI meeting each month. The Executive Director or designee will meet with the Maintenance director weekly to ensure compliance. If a 95% threshold is not maintained on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date the systemic changes will be completed:</p>				

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K 0029 SS=E Bldg. 01	<p>provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 26 residents in service/dining room corridor.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Executive Director on 07/26/16 from 12:10 p.m. to 01:15 p.m., the following areas had unsealed penetrations:</p> <ol style="list-style-type: none"> 1. In the ceiling of housekeeping room on the service hall there were two unsealed fourth of an inch penetrations around conduits. 2. In the ceiling of dining room hall the attic hatch was left open leaving a two foot by two foot hole. <p>Based on interview at the time of observations, the Executive Director acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic</p>		8/25/16		

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	<p>fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 kitchen doors automatically close and latched into the door frame. This deficient practice could affect 25 residents in the dining room.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Executive Director on 07/26/16 at 11:07a.m., the double doors form the dining room to the kitchen did not automatically latch into the door frame due to the latch sticking. Based on interview, this was acknowledged by the Executive Director at the time of observation.</p> <p>3.1-19(b)</p>	K 0029	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The kitchen double doors to the dining room/kitchen were fixed by the maintenance director to ensure they latched into the door frame automatically.</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? All residents have the potential to be affected. The maintenance director will complete a house audit by 8/25/16 to ensure all other doors latch into the door frames automatically. Any issues noted will be immediately addressed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director or designee will conduct a daily round on days worked to ensure all doors automatically latch into the door frame. Any issues found will be immediately addressed. How the corrective action will be</p>	08/25/2016

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K 0038 SS=E Bldg. 01	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 1. Based on observation and interview, the facility failed to ensure 1 of 3 kitchen exit doors was provided with door knobs readily operated under all lighting conditions. LSC 7.2.1.5.4 requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two-step release, such as a knob and independent dead	K 0038	monitored to ensure the deficient practice does not recur? The maintenance director or designee will conduct a daily round to ensure all doors automatically latch into the door frame for one month, then weekly for two months, and then monthly for 3 months with results to QAPI meeting each month. The Executive Director or designee will meet with the Maintenance director weekly to ensure compliance. If a 95% threshold is not maintained on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date the systemic changes will be completed: 8/25/16 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The double doors from the kitchen to the dining room had the locks fixed so that a single action unlatched the door and the service hall door had a sign posted "push until alarm sounds door can be opened in 15 seconds." These were both completed by the maintenance director. How other residents having the potential to be affected by the same deficient practice will be identified and	08/25/2016

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	<p>bolt, is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect 25 residents in the dining room and staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Executive Director on 07/26/16 at 11:00 a.m., the double doors from the kitchen to the dining room was equipped with a pull chain latch that latched into the frame and a separate door knob that latched into the other door; causing the door to use two operations to open. Based on interview, this was acknowledged by the Executive Director at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 9 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(d) requires 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 not less than 1/8 inch in width on a contrasting background that reads as follows: "PUSH UNTIL ALARM</p>		<p>what corrective action will be taken? All residents have the potential to be affected. The maintenance director will complete a house audit by 8/25/16 to ensure all doors only require a single action to unlatch the doors and to ensure all exit doors have proper signage posted regarding opening in 15 seconds. Any issues noted will be immediately addressed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director or designee will conduct a daily round on days worked to ensure all doors only require a single action to unlatch the doors and to ensure all exit doors have proper signage posted regarding opening in 15 seconds. Any issues found will be immediately addressed. How the corrective action will be monitored to ensure the deficient practice does not recur? The maintenance director or designee will conduct a daily round to ensure all doors only require a single action to unlatch the doors and to ensure all exit doors have proper signage posted regarding opening in 15 seconds for one month, then weekly for two months, and then monthly for 3 months with results to QAPI meeting each month. The Executive Director or designee will meet with the Maintenance director weekly to ensure</p>		

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K 0044 SS=E Bldg. 01	<p>SOUNDS DOOR CAN BE OPENED IN 15 SECONDS." This deficient practice was not in a resident care area but could affect any staff in the service hall.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Executive Director on 07/26/16 at 11:05 a.m., the exit door on the service hall was equipped with electromagnetic locks that released after pushing the door for 15 seconds but lacked proper signage regarding pushing the door to open; no was a sing posted. Based on interview at the time of observation, the Executive Director acknowledged there was no signage regarding pushing the door to open.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 4 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to</p>	K 0044	<p>compliance. If a 95% threshold is not maintained on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date the systemic changes will be completed: 8/25/16</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The 300 hall fire door was fixed by the maintenance director so that it latched into the frame. How other residents having the</p>	08/25/2016

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K 0062	<p>be self-closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect 50 residents on the 300 and 100 halls.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Executive Director on 07/26/16 at 11:35 a.m., the fire door set to the 300 hall failed to latch into the frame. Based on interview at the time of observation, this was acknowledged and confirmed this was a set of fire doors by the Executive Director.</p> <p>3.1-19(b)</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. The maintenance director will complete a house audit by 8/25/16 to ensure all other fire doors latch into the frame. Any issues noted will be immediately addressed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director or designee will conduct a daily round on days worked to ensure all fire doors latch into the frame. Any issues found will be immediately addressed. How the corrective action will be monitored to ensure the deficient practice does not recur? The maintenance director or designee will conduct a daily round to ensure all fire doors latch into the frame for one month, then weekly for two months, and then monthly for 3 months with results to QAPI meeting each month The Executive Director or designee will meet with the Maintenance director weekly to ensure compliance. If a 95% threshold is not maintained on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date the systemic changes will be completed: 8/25/16</p>				

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SS=E Bldg. 01	<p>LIFE SAFETY CODE STANDARD 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 and interview, the facility failed to replace 1 of 1 sprinklers in the 300 spa and 1 of 3 sprinklers in laundry which were corroded. 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 24 residents in the 300 hall and staff in the service hall.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Executive Director on 07/26/16 between 10:21 a.m. and 11:10 a.m., the automatic sprinkler in the 300 spa had green substance on the sprinkler head and the automatic sprinkler in the laundry room above the washers had green substance on the sprinkler head. Based on interview at the time of observations, the corrosion on the</p>	K 0062	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The sprinkler head in the 300 spa and laundry room were replaced by PIPE due to green substance on them. The sprinkler behind the dryers in the laundry room was cleaned by the maintenance director. The sprinkler head in the closet of room 106 was moved by PIPE to ensure 4 inch gap from wall. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. The maintenance director will complete a house audit by 8/25/16 to ensure all corroded sprinkler heads are replaced by PIPE, all sprinkler heads are free of dust and lint, and to ensure all sprinkler heads in closets that do not have a 4 inch gap from the wall are replaced by PIPE. Any issues noted will be immediately addressed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director or designee will conduct</p>	08/25/2016			

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	<p>sprinkler heads was acknowledged by the Executive Director.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to clean and maintain 1 of 3 sprinklers laundry room. 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. This deficient practice was not in a resident care area could affect all staff in the laundry room</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Executive Director on 07/26/16 at 11:11 a.m., the sprinkler behind the dryers in the laundry room was completely covered in dust and lint. Based on interview, this was acknowledged by the Executive Director at the time of observation.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinkler heads in the closet of room 106 was unobstructed.</p>		<p>a daily round on days worked to ensure no corroded sprinkler heads are in house, all sprinkler heads are free of dust and lint, and that all sprinkler heads in closets have a 4 inch gap from the wall. Any issues found will be immediately addressed. How the corrective action will be monitored to ensure the deficient practice does not recur? The maintenance director or designee will conduct a daily round to ensure no corroded sprinkler heads exist, all sprinkler heads are free of dust and lint, and that all sprinkler heads in closets have a 4 inch gap from the wall for one month, then weekly for two months, and then monthly for 3 months with results to QAPI meeting each month. The Executive Director or designee will meet with the Maintenance director weekly to ensure compliance. If a 95% threshold is not maintained on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date the systemic changes will be completed: 8/25/16</p>		

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K 0076 SS=B Bldg. 01	<p>LSC 9.7.5 requires all automatic sprinkler systems 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, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice could affect 2 residents in room 106.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Executive Director on 07/26/16 at 10:21 a.m., the spray pattern for the sprinkler head in the closet of room 106 was obstructed by the wall. The sprinkler head was less than an inch from the wall. Based on interview at the time of observation, the Executive Director acknowledged the sprinkler head was less than one inch from the wall.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2016
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989
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	<p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen cylinders in the Admissions Office was properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b) 27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice could affect any of the 26 residents on the 100 hall.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Executive Director on 07/26/16 at 10:10 a.m., there was an unsupported oxygen cylinder in the Admissions Office. Based on interview at the time of observation, the Executive Director acknowledged the unsupported cylinder and stated the cylinder was empty.</p> <p>3.1-19(b)</p>	K 0076	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The oxygen cylinder was removed by the maintenance man from the Director of Admission's Office. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. The maintenance director will complete a house audit by 8/25/16 to ensure no unsupported oxygen cylinders exist. Any issues noted will be immediately addressed. All staff to be inserviced by 8/25/16 regarding oxygen cylinders having to be supported by the Maintenance director or designee. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director or designee will conduct a daily round on days worked to ensure no unsupported oxygen cylinders exist. Any issues found will be immediately addressed. How the corrective action will be monitored to ensure the deficient practice does not</p>	08/25/2016

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K 0147 SS=B 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 1 of 1 flexible cords such as an extension cord was not used as a substitute for fixed wiring. 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 resident in room 305.</p> <p>Findings include:</p>	K 0147	<p>recur? The maintenance director or designee will conduct a daily round to ensure no unsupported oxygen cylinders exist for one month, then weekly for two months, and then monthly for 3 months with results to QAPI meeting each month. The Executive Director or designee will meet with the Maintenance director weekly to ensure compliance. If a 95% threshold is not maintained on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date the systemic changes will be completed: 8/25/16</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The extension cord in room 306 was removed by the Maintenance Director. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. The maintenance director will complete a house audit by 8/25/16 to ensure no other extension cord use exists. Any issues noted will be immediately</p>	08/25/2016	

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	<p>Based on an observation during a tour of the facility with the Executive Director on 07/26/16 at 11:40 a.m., In room 305, a regular light weight extension cord was plugged in and providing power for two phone chargers. Based on interview, this was acknowledged by the Executive Director at the time of observation.</p> <p>3.1-19(b)</p>		<p>addressed. All staff to be inserviced by the Maintenance Director or designee regarding no extension cord use in house by 8/25/16. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director or designee will conduct a daily round on days worked to ensure no extension cords are in use in facility. Any issues found will be immediately addressed. How the corrective action will be monitored to ensure the deficient practice does not recur? The maintenance director or designee will conduct a daily round to ensure no extension cord use in facility for one month, then weekly for two months, and then monthly for 3 months with results to QAPI meeting each month. The Executive Director or designee will meet with the Maintenance director weekly to ensure compliance. If a 95% threshold is not maintained on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date the systemic changes will be completed: 8/25/16</p>	