STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155430	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 04/22/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER		STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN 46975	

(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
K010000	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). Survey Date: 04/22/14 Facility Number: 000326 Provider Number: 155430 AIM Number: 100290770 Surveyor: Phillip Komsiski, Life Safety Code Specialist At this Life Safety Code survey, Hickory Creek at Rochester 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. This one story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has a	K010000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	capacity of 36 and had a census of 35 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had three detached sheds used for facility storage which were not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/29/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010018 SS=E	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 Roller latches are prohibited by CMS regulations in all health care facilities.			

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	Based on observation and interview, the facility failed to ensure 2 of 2 sets of double leaf corridor doors could latch independently into their door frames. This deficient practice could affect 6 residents observed in the Therapy room and 7 residents observed in the Dining room as well as visitors and staff. Findings include: Based on observations on 04/22/14 during the tour from 1:00 p.m. to 1:15 p.m. with the Maintenance Supervisor, the set of double leaf corridor doors leading into Therapy next to the Kitchen and the set of double leaf corridor doors leading into the Dining room required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. Based on interview on 04/22/14 concurrent with the observations, it was acknowledged by the Maintenance Supervisor, the aforementioned sets of corridor doors would not latch independently into their door frame. 3.1-19(b)	K010018	This Plan of Correctionconstitutes the written allegation of compliance for the deficiencies cited.However, submission of this Plan of Correction is not an admission that adeficiency exists or that one was cited correctly. This Plan of Correction is submittedto meet requirements established by state and federal law. Hickory Creek atRochester desires this Plan ofCorrection to be considered the facility's Allegation of Compliance. Compliance is effective on 05/22/2014 K018. It is the policy of thisfacility to comply with NFPA 101 Life Safety Code Standard Chapter 19requirements regarding doors accessing hallway passage. <u>What corrective action will bedone by the facility?</u> On 04/30/2014 the Maintenance staff	05/22/2014

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			installeddoor latching devices to both sets of doorways which would allow both doors ineach set to latch independently to the doorway frame. How will all facilityresidents be protected in future by this doorway latch requirement? All residents who use theserooms in the future well benefit from the double doors which are now able to beindependently latched to doorway frame as per NFPA101 section 19.3.63. Therewere no residents found to be affected by this condition. What measures will be put intoplace to ensure that this latching system will be maintained? The facility will post signagenext to the double doors to communicate that these doorways have a requireddoorway frame latch so that future changes do not occur. How will corrective action	

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			bemonitored? The Environmental Supervisor will confirmdoorway function rounds for the next quarter and report to the QualityAssurance committee that door latches to both doorways are operative and inplace. After the 1st quarter if the committee is satisfied that thelatches are functioning properly, this reporting sequence may be discontinuedunless the QA members become concerned of further difficulties in the future. Date of compliance: 05/22/2014	
K010046 SS=E	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 record review and interview, the facility failed to provide documentation of functional tests on all emergency lighting for 1 of 1 battery operated lights at the generator. NFPA 110, 5-3-1 requires lighting at the emergency generator. LSC Section 7.9.3 requires a functional test be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test for not less than 1 1/2 hours. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient	K010046	K046. It is the policy of this facility to maintainthe emergency generator testing consistent with NFPA 110, 5.3.1. Records ofthis testing will be maintained to reflect duration of this testing to showthat this requirement has been met. What corrective action will bedone by the facility? The maintenance staff has initiated use of anew testing records form which confirms testing duration of functional	05/22/2014

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	practice could affect all occupants in the facility including staff, visitors and residents if the generator was impaired and there was no functional emergency battery powered light available. Findings include: Based on Fire Safety Record review on 04/22/14 at 4:13 p.m. with the Maintenance Supervisor, the facility tested the battery back up emergency light by the generator monthly, but did not document any length of time. In addition, a 90 minute annual test was not available for review. Based on interview on 04/22/14 at 4:15 p.m. with the Maintenance Supervisor, it was acknowledged the battery back up emergency light at the generator was checked monthly, but no documentation for the duration of the monthly test, or annual test, was available for review. 3.1-19(b)		tests onall emergency battery lighting at the generator. <u>Could facility identify amethod for preventing facility occupants from being affected?</u> Although there was noresidents found to be affected the new test from was immediately implemented toavoid future concerns. <u>What system will be used andmonitored by facility to make sure this documentation occurs?</u> - The new facility form will beused at the time that each emergency generator test occurs. This form will bekept and used for confirming compliance with each area of L.S.C. Standard19.7.2.2. This record will be monitored by reporting the results of theemergency battery test to each monthly QA meeting for the next quarter and ifthe QA committee is satisfied that the form is functioning properly, thisreporting sequence may be	

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			discontinued unless the QA members become concernedof further difficulties in the future. Date of compliance: 05/22/2014	
K010048 SS=F	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 ensure its written fire safety plan incorporated all the items outlined in LSC 19.7.2.2. in order to protect 35 of 35 residents. LSC 19.7.1.1 requires every nursing home to have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire and for their evacuation to areas of refuge and for evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available. The provisions of LSC 19.7.1.2 to 19.7.2.3 inclusive shall apply. LSC 19.7.2.1 requires for health care occupancies, the proper protection of residents shall require the prompt and effective response of health care	K010048	K048. It is the intend of Hickory Creek at Rochesterto have a written plan for the protection for all residents and facilityoccupants in the event of evacuation during an emergency per L.S.C. 10119.7.1.1 <u>What corrective action will bedone by the facility?</u> To be more compliant with L.S.C. 101 19.7.1.1the facility will add a stipulation to our current evacuation policy that willinclude specifically that internal evacuation of residents and facilityoccupants to the alternate safe smoke compartment. This facility will ensureall residents and facility occupants will be safe as	05/22/2014

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	personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants, confinement of the effects of the fire by closing doors to isolate the fire area, and the execution of those evacuation duties as detailed in the facility's fire safety plan. LSC 19.7.2.2 states a written facility fire safety plan shall provide for: (a) Use of alarms, (b) Transmission of alarm to fire department, (c) Response to alarms, (d) Isolation of fire, (e) Evacuation of immediate area, (f) Evacuation of smoke compartment (g) Preparation of building for evacuation (h) Extinguishment of fire. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of the facility's fire and disaster plan provided by the Maintenance Supervisor on 04/22/14 at 4:00 p.m., the plan did not address all components of the LSC 19.7.2.2 such as evacuation of a smoke compartment. Based on interview at the time of record		stipulated by L.S.C. 10119.7.1.1. <u>What systemic changes will bemade to ensure that emergency plan addresses all components of L.S.C. 10119.7.2.2.</u> All staff members will be retrainedon components of the emergency evacuation policy on 05/08/2014 which willinclude specifically evacuation of an unsafe smoke compartment per L.S.C. 10119.7.2.2. <u>How will facility monitor theupdated evacuation policy L.S.C. 101.7.2.2.</u> On 05/08/2014 an all staffreview of the updated evacuation policy will be conducted emphasizingevacuation of smoke compartments during internal evacuations. This retrainingwill be reviewed during QA committee meeting and continually reviewed withstaff during future fire drills to confirm compliance with L.S.C. 101.7.2.2.	

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	review, it was acknowledged by the Maintenance Supervisor the facility's fire and disaster plan did not address evacuation of a smoke compartment. 3.1-19(b)		- Date of compliance: 05/22/2014	
K010056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 1. Based on observation and interview, the facility failed to ensure 1 of 1 steel armover sprinkler pipes observed on West hall was 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.	K010056	K056. It is the policy of Hickory Creek at Rochesterto comply with NFPA 13 Standard for the instillation of sprinkler systems forcomplete building coverage. <u>What corrective actions weretaking for affected residents of this condition?</u> Therehave been no residents found to be affected by this	05/22/2014

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	This deficient practice could affect all residents in the building if the sprinkler system required repair as well as staff or visitors. Findings include: Based on observation on 04/22/14 at 2:15 p.m. with the Maintenance Supervisor, a steel sprinkler pipe armover located in the Boiler room on West hall when measured, extended forty eight inches in length and was unsupported. Based on interview on 04/22/14 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned steel sprinkler pipe armover exceeded twenty four inches in length and was unsupported. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure sprinkler heads were spaced a minimum of 6 feet apart for 1 of 1 automatic sprinkler systems. NFPA 13, Section 5-6.3.4, "Minimum Distance between Sprinklers" states sprinklers shall be spaced not less than 6 feet on center. This deficient practice could affect 14 residents on West hall near the Boiler room as well as staff or visitors.		condition. What actions will be taken byfacility for residents having potential to be affected? The facility has scheduled asprinkler system review and correction in the building's boiler room on05/05/2014. These corrections will include addressing the length of theunsupported arm over to the sprinkler and to adjust or confirm that thedistance between sprinklers shall comply with NFPA 13 sections 5-6.3.4. What system will be put inplace by facility to ensure NFPA 13? The facility has scheduled asprinkler system review and correction in the building's boiler room on05/05/2014. These corrections will include addressing the length of theunsupported arm over to the sprinkler and to adjust or confirm that thedistance between sprinklers shall comply with NFPA 13	

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	Findings include: Based on observation on 04/22/14 at 2:18 p.m. with the Maintenance Supervisor, the Boiler room on West hall had two sprinkler heads located above the boilers which were forty eight inches apart. Based on interview on 04/22/14 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned sprinkler heads were less than six feet apart. 3.1-19(b)		sections 5-6.3.4. All corrective adjustments tosprinkler system will be monitored by facilities maintenance plan to meetrequirements of NFPA13. How will corrective measuresby monitored by facility? The facility will provide for QAcommittee quarterly review updated preventative maintenance reports supportingcompliance with NFPA 13. After the quarter by QA committee review the QAcommittee upon being satisfied with continues preventative maintenanceoversight may discontinue QA reporting unless there is other concernsmaintaining NFPA 13 standards. Date of compliance 05/22/2014	
K010074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are			

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	in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 Based on observation and interview, the facility failed to ensure 17 of 18 resident rooms had cubicle curtains installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. The lack of cubicle curtain and sprinkler location coordination may obstruct the sprinkler spray onto the fire or may shield the heat from the sprinkler. This deficient practice could affect all residents in the facility as well as visitors and staff. Findings include: Based on observations on 04/22/14 during the tour from 12:17 p.m. to 3:30 p.m. with the Maintenance Supervisor, all resident rooms with the exception of resident room number 13 had three privacy curtains in each room which lacked a 1/2 inch diagonal mesh or 70	K010074	K074. It is the policy of Hickory Creek atRochester to provide facility furnishings (such as privacy curtains) inaccordance with provisions under 10.31 and NFPA 13 and NFPA 701 coveringinstallation. <u>What corrective actions weretaking for affected residents of this condition?</u> In response to correctiveactions for affected residents the facility respond that no residents wereidentified to be affected regarding this citing. <u>What has the facility</u>	05/22/2014

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	percent open weave top panel extending eighteen inches below the sprinkler deflector. Based on interview on 04/22/14 concurrent with observations made with the Maintenance Supervisor, it was acknowledged all resident rooms mentioned above had an open diagonal mesh which only extended ten inches below the sprinkler heads. 3.1-19(b)		actionbeen to address other residents with the potential to be affected? HickoryCreek at Rochester immediately reinstalled the privacy curtains to be withinaccordance of the NFPA 13 standard for the privacy curtain hanging distancefrom the sprinkler head deflection level. What system will facility useto confirm the NFPA 13 standard? - The facility system to be usedto confirm the NFPA 13 standard will be to record each privacy curtain distancefrom the height of the sprinkler deflector. This distance will be reported andreviewed by the QA committee monthly for one quarter. The preventativemaintenance program (PMP) will compare this distance whenever curtains areinspected for cleaning to monitor for correct NFPA 13 measure. After theQA review at the end of the quarter theQA committee may decide to	

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			discontinue the report if it is determined the PMAsystem is being maintained in accordance with NFPA 13 standards. <u>How will the corrective systembe maintained by facility?</u> The facility system to be usedto confirm the NFPA 13 standard will be to record each privacy curtain distancefrom the height of the sprinkler deflector. This distance will be reported andreviewed by the QA committee monthly for one quarter. The preventativemaintenance program (PMP) will compare this distance whenever curtains areinspected for cleaning to monitor for correct NFPA 13 measure. After theQA review at the end of the quarter theQA committee may decide to discontinue the report if it is determined the PMAsystem is being maintained in accordance with NFPA 13 standards. Date of compliance	

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			05/22/2014	
K010076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, 8-3.1.11.2(c) requires oxidizing gases such as oxygen shall be separated from combustibles by a minimum distance of five feet if the required storage location is protected by an automatic sprinkler system. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation on 04/22/14 at 2:30 p.m. with the Maintenance Supervisor, the oxygen storage and transfilling room area located outside the back entrance within a chain link fence was also used to	K010076	K076. It is the policy of Hickory Creek atRochester to store oxygen according to NFPA99 standard for Healthcarefacilities. What corrective actions weretaking for affected residents of this condition? In response to correctiveactions for affected residents the facility respond that no residents wereidentified to be affected regarding this citing. What has the facility actionbeen to address other residents with the potential to	05/22/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155430	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 04/22/2014
NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT ROCHESTER		STREET ADDRESS, CITY, STATE, ZIP CODE 340 E 18TH ST ROCHESTER, IN 46975	

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	store a snow blowing machine filled with gasoline located within five feet of the oxygen containers. Based on interview on 04/22/14 concurrent with the observation, it was acknowledged by the Maintenance Supervisor a combustible liquid was stored within five feet of stationary liquid oxygen containers. 3.1-19(b)		be affected? HickoryCreek at Rochester immediately removed all items away from the stored oxygenper NFPA 99 standard in order to prevent other residents or facility occupantsfrom being affected. What facility system to be useto ensure future compliance with the NFPA 99 standard? The facility will re educateall co workers on 05/08/2014 not to store other materials in O2 storage area. Asign will be posted to remind others at all time to maintain this standard. APMA form will be added to the PMA record book to confirm compliance on amonthly basis as per NFPA 99. This monthly report will be reviewed at the nextQuarterly QA committee meeting for the next quarter to confirm NFPA 99 compliance. At this time the QA committee maydecide to discontinue this report sequence if the PMA reposting complies withNFPA 99 standards.	

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			How will the corrective systembe maintained and monitored ? The facility will re educateall co workers on 05/08/2014 not to store other materials in O2 storage area. Asign will be posted to remind others at all time to maintain this standard. APMA form will be added to the PMA record book to confirm compliance on amonthly basis as per NFPA 99. This monthly report will be reviewed at the nextQuarterly QA committee meeting for the next quarter to confirm NFPA 99 compliance. At this time the QA committee maydecide to discontinue this report sequence if the PMA reposting complies withNFPA 99 standards. - Date of compliance 05/22/2014	
K010147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 multiplug	K010147	K147. It is the policy of Hickory Creek atRochester be	05/22/2014

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	adapters were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, multiplug adapters, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 14 residents located by the back entrance as well as staff and visitors. Findings include: Based on observation on 04/22/14 at 1:33 p.m. with the Maintenance Supervisor, there was one, six prong multiplug adapter connected to a wall outlet which was used to power a bed in resident room number seven and a six prong multiplug adapter used to power a bed in resident room number fourteen. Based on interview on 04/22/14 concurrent with the observations with the Maintenance Supervisor, it was acknowledged it is the policy of the facility to not use multiplug adapters and to plug all medical equipment into the wall outlet, however, the aforementioned rooms did use six prong multiplugs as a substitute for fixed wiring. 3.1-19(b)		in accordance with NFPA 70, and National Electric code 9.192regarding use of electrical equipment. <u>What corrective actions weretaking for affected residents of this condition?</u> In response to correctiveactions for affected residents the facility respond that no residents wereidentified to be affected regarding this citing. <u>What has the facility actionbeen to address other residents with the potential to be affected regardingthis citing?</u> HickoryCreek at Rochester immediately removed both multi plug adapters in accordancewith our policy and NFPA 70. Although no residents were found affected thefacility began retraining co-workers to monitor for unauthorized use of thistype of electrical devise. A general staff retraining in-service is scheduledfor 05/08/2014 to	

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			emphasize this policy and compliance with NFPA 70. <u>What system will be used byfacility to ensure future compliance occurs?</u> The facility will re educateall co workers regarding multi plug adapters for medical equipment on05/08/2014. Our system will also use of a PMP form each week which will confirmthat compliance with NFPA 70 is occurring. <u>How will this system bemonitored to ensure compliance with policy and NFPA70 code?</u> This corrective action will bemonitored by repeating the PMP audits weekly and reporting each month to the QAcommittee that compliance has been monitored. This reporting sequence willoccur monthly for 3 month until the QA committee decides that quarterly auditswill once again be sufficient to sustain compliance with NFPA 70	

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