

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E187	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/29/2016
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NAME OF PROVIDER OR SUPPLIER SIMMONS LOVING CARE HEALTH FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 E 21ST AVE GARY, IN 46407
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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: 02/29/16</p> <p>Facility Number: 000368 Provider Number: 15E187 AIM Number: 1002752200</p> <p>At this Life Safety Code survey, Simmons Loving Care Health Facility was found not in compliance with Requirements for Participation in 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 with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. Twenty resident rooms were provided with battery operated smoke detectors. The facility has the capacity for 46 and</p>	K 0000		

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 0020 SS=F Bldg. 01	<p>had a census of 18 at the time of this survey.</p> <p>All areas accessible to residents and areas providing facility services were sprinklered.</p> <p>Quality Review completed on 03/04/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 Based on observation and interview, the facility failed to ensure 1 of 2 vertical openings was enclosed to prevent the passage of smoke. LSC 19.3.1.1 requires any vertical opening to be enclosed or protected in accordance with LSC 8.2.5. LSC 8.2.5.2 requires openings through floors, such as dumbwaiters, be enclosed with fire barrier walls. Openings shall be protected as appropriate for the fire resistance rating of the barrier. An exception at LSC 8.2.5.3 allows shafts to terminate in a room or space having a use related to the purpose of the shaft, provided that the room or space is separated from the remainder of the building by construction having a fire</p>	K 0020	<p>F020</p> <p>Findings include: Based on observation with the Administrative Assistant and Maintenance #1 on 2/29/16 during the tour from 11:12 a.m. to 1:18 p.m., there was a hand powered dumbwaiter that served the kitchen from the basement. The dumbwaiter car was at the bottom of the shaft in the basement with the door on the basement side open. The doors to the dumbwaiter did not self-close. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition. 1. Describe what the facility did to correct the deficient practice</p>	02/29/2016

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	<p>resistance rating and opening protectives in accordance with LSC 8.2.5.4 and LSC 8.2.3.2.3. LSC 8.2.3.2.3.1 states every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke. LSC 8.2.5.10 requires service openings for dumbwaiters, where required to be open on more than one story at the same time for purposes of operation, shall be provided with closing devices in accordance with LSC 7.2.1.8. This deficient practice could affect all occupants in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Administrative Assistant and Maintenance #1 on 2/29/16 during the tour from 11:12 a.m. to 1:18 p.m., there was a hand powered dumbwaiter that served the kitchen from the basement. The dumbwaiter car was at the bottom of the shaft in the basement with the door on the basement side open. The doors to the dumbwaiter did not self-close. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>for each client cited in the deficiency.</p> <p>The dumbwaiter is fully equipped with a fire sprinkler. The doors to the dumbwaiter were securely closed with screws until a vendor which can make the self-closing devices to modify the openings of the dumbwaiter.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. No one injured and no residents affected.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Dumbwaiter will not be used until devices of self-closures can be found.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Dumbwaiter will be checked weekly for secure closure by administrative staff for 1 month then quarterly for 2 months then monitoring will discontinue until</p>	

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K 0021 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</p> <p>(a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2</p> <p>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1</p> <p>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 3 Kitchen doors serving hazardous areas was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice could affect staff and up to 18 residents.</p> <p>Findings include:</p>	K 0021	<p>self-closing devices is found.</p> <p>F0021 Findings include: Based on observations with the Administrative Assistant and Maintenance #1 on 02/29/16 at 12:32 p.m., one kitchen door was held open by a device attached to the wall, 1 of 1 Laundry door serving hazardous areas was held open only by a device, the Laundry door was held open by a piece of wire attached to the wall. Based on interview confirmed that the Laundry door would not release</p>	03/30/2016	

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	<p>Based on observations with the Administrative Assistant and Maintenance #1 on 02/29/16 at 12:32 p.m., one kitchen door was held open by a device attached to the wall. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 confirmed that the kitchen door would not release with the fire alarm and acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Laundry door serving hazardous areas was held open only by a device arranged to automatically close the door or close the door upon activation of the fire alarm system. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Administrative Assistant and Maintenance #1 on 02/29/16 at 12:10 p.m., the Laundry door was held open by a piece of wire attached to the wall. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 confirmed that the Laundry door would not release with the</p>		<p>with the fire alarm and acknowledged the aforementioned condition.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. The kitchen door has had a door stopper at the bottom of the door for the past 46 years the reason the door stop was used was to allow easy access during meal serving from the kitchen to the residents. This has never been brought to our attention as a deficient finding. However the door stop was removed. The laundry door has also been left in the open position to allow easy access for laundry staff moving clothing in and out of laundry room. The door wire was removed.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what action the facility took to correct the deficient practice for any client the facility identified as being affected. No one affected no harm to residents or staff noted.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Door stops removed and staff in-serviced not to hold open the doors. Laundry room door</p>				

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K 0025 SS=E Bldg. 01	<p>fire alarm and acknowledged the aforementioned condition.</p> <p>3.1-19(b)</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>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barrier and 1 of 1 kitchen corridor was maintained to 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 all occupants.</p> <p>Findings include:</p>	K 0025	<p>framehas to be ordered and welder has to install once special frame is received.</p> <p>4.Describe how the corrective action(s) will be monitored toensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place. Administrativeassistant will monitor door openings for door opening devices for one week andthen monthly for one month. Monitoringwill then be at the decision of the Q.A. Committee.</p> <p>F0025 Based on observations with the Administrative Assistant andMaintenance #1 on 02/29/16 from 11:52 a.m. to 12:31 p.m., the following ceilingpenetration and corridor penetrations were discovered: a) one eighths inch ceiling penetration in the CustodianSupply room b) one inch corridor penetration in the Kitchen near thePatio exit door c) nine separate ceiling penetrations in the Dining Roomdrop ceiling</p> <p>1.Describe what the facility did</p>	03/30/2016	

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	<p>Based on observations with the Administrative Assistant and Maintenance #1 on 02/29/16 from 11:52 a.m. to 12:31 p.m., the following ceiling penetration and corridor penetrations were discovered:</p> <p>a) one eighths inch ceiling penetration in the Custodian Supply room</p> <p>b) one inch corridor penetration in the Kitchen near the Patio exit door</p> <p>c) nine separate ceiling penetrations in the Dining Room drop ceiling</p> <p>Based on interview at the time of each observation, the Administrative Assistant and Maintenance #1 acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p>		<p>to correct the deficient practice for each client cited in the deficiency.</p> <p>Areas caulked with fire barrier</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>No other areas noted the facility has been checked continuously for areas that need fire caulking by life safety surveyors since 2013. The areas noted in this deficiency were not determined to be deficient in the past.</p> <p>1. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>The fire caulking stays in the protected area when applied. The facility will monitor for openings that require fire caulking when repairs are done in the facility.</p> <p>1. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Maintenance will monitor for openings in walls and fire protected areas to prevent smoke penetrations monthly and caulk areas found.</p>		

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K 0029 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 West Wing Bathroom containing more than 32 gallons of hazardous soiled linen, a hazardous area, would positively latch into the frame. This deficient practice could affect staff and up to 18 residents.</p> <p>Findings include:</p> <p>Based on observation with the Administrative Assistant and Maintenance #1 on 02/29/16 at 1:05 p.m., the West Wing Bathroom contained two separate thirty gallon containers of soiled linen. The door contained a door stop device. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition.</p>	K 0029	<p>F 0029 Based on observation with the Administrative Assistant and Maintenance #1 on 02/29/16 at 1:05 p.m., the West Wing Bathroom contained two separate thirtygallon containers of soiled linen. The door contained a door stop device, corridor door to 1 of 1 Kitchen, a hazardous area, would self-close and positively attached into the frame. Based on observation with the Administrative Assistant and Maintenance #1 on 02/29/16 at 1:05 p.m., the Kitchen door contained a manual bolt latch and no self-closer. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. The kitchen door has had a door stopper at the bottom of the door</p>	03/30/2016
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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Kitchen, a hazardous area, would self-close and positively attached into the frame. This deficient practice could affect staff and up to 18 residents.</p> <p>Findings include:</p> <p>Based on observation with the Administrative Assistant and Maintenance #1 on 02/29/16 at 1:05 p.m., the Kitchen door contained a manual bolt latch and no self-closer. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>for the past 46years the reason the door stop was used was to allow easy access during mealserving from the kitchen to the residents. This has never been brought to our attention as a deficientfinding. However the door stop wasremoved. The laundry door has also beenleft in the open position to allow easy access for laundry staff movingclothing in and out of laundry room. Thedoor wire was removed.</p> <p>2.Describe how the facility reviewed all clients in the facilitythat could be affected by the same deficient practice, and state, what actionsthe facility took to correct the deficient practice for any client the facilityidentified as being affected. No one affected no harmto residents or staff noted.</p> <p>3.Describe the steps or systemic changes the facility has made orwill make to ensure that the deficient practice does not recur, including anyin-services, but this also should include any system changes you made. Door stops removed andstaff in-serviced not to hold open the doors. Laundry Room Door steelnew frame has to be ordered and installed by welder. Door Knobs will be installedon kitchen doors to ensure they latch when closing.</p> <p>4.Describe how the corrective</p>		

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K 0046 SS=E Bldg. 01	<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 and interview; the facility failed to ensure 2 of 2 battery operated emergency lights in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 1/2 hour duration. 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. This deficient practice could affect staff and up to 20 residents.</p>	K 0046	<p>F0046 Based on record review with the Administrator Assistant and Maintenance #1 on 02/29/16 at 12:21 p.m. then again at 1:01 p.m., the exterior battery operated light outside the Chapel failed to illuminate when tested. Then again, the exterior battery operated light in the West Wing exit discharge failed to illuminate.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. The battery was tested outside the chapel and it illuminated. Battery was purchased for the emergency light on West Wing but it was not the battery and new lighting fixture replacement had to</p>	04/22/2016	

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K 0050 SS=C Bldg. 01	<p>Findings include:</p> <p>Based on record review with the Administrator Assistant and Maintenance #1 on 02/29/16 at 12:21 p.m. then again at 1:01 p.m., the exterior battery operated light outside the Chapel failed to illuminate when tested. Then again, the exterior battery operated light in the West Wing exit discharge failed to illuminate.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is</p>				<p>be ordered. Currently it is back ordered and will be installed as soon as it is received.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. No one was harmed.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. We already do our monthly checking of the emergency lighting system and Koorsens does the annual testing which was performed in February 2016.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. We will continue to use our following plan.</p>		

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	<p>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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of 4 quarters. This deficient practice affects all staff and residents.</p> <p>Findings include:</p> <p>Based on record review of the "Simmons Loving Care" form with the Administrator Assistant and Maintenance #1 on 02/29/16 at 10:35 a.m., four sequential third shift fire drills took place between 7:10 a.m. and 7:20 a.m. for four of the last four quarters. Based on interview at the time of record review, the Administrator Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 0050	<p>F 0050</p> <p>Based on record review of the "Simmons LovingCare" form with the Administrator Assistant and Maintenance #1 on 02/29/16at 10:35 a.m., four sequential third shift fire drills took place between 7:10a.m. and 7:20 a.m. for four of the last four quarters. Based on interview atthe time of record review, the Administrator Assistant and Maintenance #1acknowledged the aforementioned condition.</p> <p>1.Describewhat the facility did to correct the deficient practice for each client citedin the deficiency.</p> <p>Reviewof fire drill schedule was reviewed with administrative assistant.</p> <p>2.Describe how the facility reviewed all clients in the facilitythat could be affected by the same deficient practice, and state, what actionsthe facility took to correct the deficient practice for any client the facilityidentified as being affected. No one was harmed.</p> <p>3.Describe the steps or systemic changes the facility has</p>	03/30/2016

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K 0052 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, Based on record review and interview, the facility failed to ensure 1 of 1 smoke detector sensitivity report was in accordance with the applicable	K 0052	made orwill make to ensure that the deficient practice does not recur, including anyin-services, but this also should include any system changes you made. Scheduled fire drillsreports will be turned into the administrator for review to be compared withscheduled fire drill schedule to ensure drills are performed on individualshifts. 4. Describe how thecorrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e., what quality assurance program will be put into place. Administrator will review fire drills for 3 months and adviseQ.A. if further monitoring is needed. Scheduled fire drill schedule and fire drills will be reviewedby Q.A. in 3 months and determine if further monitoring is necessary.	03/30/2016	
			F0052 Based on record review with the Administrator Assistant andMaintenance #1 on 02/29/16 at 9:51 a.m., the most recent		

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	<p>requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range 		<p>documentation of as smoke detector sensitivity test was completed by Koorsen Fire and Security dated 2/9/16. Although the report indicated the smoke detector sensitivity was passing for all detectors, it was not clearly documented if the actual reading of each detector was within its listed and marked sensitivity range. Based on an interview at the time of record review, the Administrator Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Koorsen notified of error in report and another one was sent. Test was performed properly.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. No one was affected.</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Facility will continue with contract</p>				

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K 0062 SS=D Bldg. 01	<p>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all staff, resident, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Administrator Assistant and Maintenance #1 on 02/29/16 at 9:51 a.m., the most recent documentation of a smoke detector sensitivity test was completed by Koorsen Fire and Security dated 2/9/16. Although the report indicated the smoke detector sensitivity was passing for all detectors, it was not clearly documented if the actual reading of each detector was within its listed and marked sensitivity range. Based on an interview at the time of record review, the Administrator Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are</p>		<p>for sensitivity test and functions test as noted in regulation.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>No further action is needed the test was performed but it was the company's computer error.</p>		

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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 and interview, the facility failed to ensure 1 of 1 sprinkler system components was inspected quarterly for 3 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all staff, visitors, and residents.</p> <p>Findings include:</p> <p>Based on record review with the Administrator Assistant and Maintenance #1 on 02/29/16 at 9:28 a.m., there was no second, third, or fourth quarter of 2015 sprinkler system inspection reports available. Based on interview at the time of record review, the Administrator Assistant and Maintenance #1</p>	K 0062	<p>F0062</p> <p>Based on record review with the Administrator Assistant and Maintenance #1 on 02/29/16 at 9:28 a.m., there was no second, third, or fourth quarter of 2015 sprinkler system inspection reports available. 2. The East Wing Custodian Closet sprinkler head was corroded, West Wing Custodian Closetsprinkler head was corroded. 3. Custodian Supply room contained cardboard boxes stored against the sprinkler head.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>Facility contacted Koorsen who is contracted to do the quarterly fire sprinkler testing for the reports.</p> <p>Box removed from custodian closet and staff in-serviced not to put anything around sprinkler heads.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>No one affected.</p> <p>3. Describe the steps or</p>	03/30/2016			

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	<p>acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of 1 corroded sprinkler head in the East Wing Custodian Closet and 1 of 1 corroded sprinkler head in the West Wing Custodian Closet. 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 staff only.</p> <p>Findings include:</p> <p>Based on observation with the Administrator Assistant and Maintenance #1 on 2/29/16 at 11:45 a.m. then again at 1:04 p.m., The East Wing Custodian Closet sprinkler head was corroded. Then again, the West Wing Custodian Closet sprinkler head was corroded. Based on interview at the time of each observation, the Administrator Assistant and Maintenance #1 acknowledged the</p>		<p>systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Log sheet for quarterly fire inspections made and will be monitored by Administrator quarterly. Contract reviewed with Koorsen. Reminders signs placed in custodian closet "Keep Area Around Sprinkler Head Clear."</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Administrator will review quarterly testing ongoing. Q.A. will review quarterly testing and tour custodian closet in 3 months to ensure action has been corrected.</p>				

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	<p>condition of the sprinkler heads.</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 Custodian Supply room sprinklers in the facility was unobstructed. NFPA 25, 1998 Edition Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. NFPA 13, 1999 Edition Standard for the Installation of Sprinkler Systems, Section 5-8.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-8.5.2 and 5-8.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Administrator Assistant and Maintenance #1 on 02/29/16 at 11:51 a.m., the Custodian Supply room contained</p>			

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K 0066 SS=D Bldg. 01	<p>cardboard boxes stored against the sprinkler head. Based on interview at the time of observation, The Administrator Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents were maintained and the metal</p>	K 0066	F0066 Based on observations with the Administrative Assistant and Maintenance #1 on 02/29/16 at	03/30/2016			

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	<p>container with a self-closing cover was used for an ashtray. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations with the Administrative Assistant and Maintenance #1 on 02/29/16 at 12:46 p.m., there were at least 30 cigarette butts on the ground in the designated smoke area. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>12:46 p.m., there were at least 30 cigarettebutts on the ground in the designated smoke area. Based on interview at thetime of observation, the Administrative Assistant and Maintenance #1acknowledged the aforementioned condition.</p> <p>1.Describewhat the facility did to correct the deficient practice for each client citedin the deficiency.</p> <p>New ashtray ordered.</p> <p>2.Describe how the facility reviewed all clients in the facilitythat could be affected by the same deficient practice, and state, what actionsthe facility took to correct the deficient practice for any client the facilityidentified as being affected.</p> <p>No one affected.</p> <p>3.Describe the steps or systemic changes the facility has made orwill make to ensure that the deficient practice does not recur, including anyin-services, but this also should include any system changes you made.</p> <p>New ash tray ordered andash tray will be cleaned and monitored weekly by custodian staff. All employees that smoke were in-serviced tokeep area clean and not to burn up new ash tray when received.</p> <p>4.Describe how thecorrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e., what quality assurance program will be put</p>		

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K 0068 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for staff in the laundry room.</p> <p>Findings include:</p> <p>Based on an observation with the Administrative Assistant and Maintenance #1 on 02/29/16 at 12:10 p.m., the laundry room had fuel fired dryers with no fresh air intake. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0068	<p>into place. Administrative designee will monitor ash tray maintenance monthly.</p> <p>F0068 Based on an observation with the Administrative Assistant and Maintenance #1 on 02/29/16 at 12:10 p.m., the laundry room had fuel fired dryers with no fresh air intake. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition. 1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency. Fresh intake was placed 20 years ago a special vent was added by window to the basement which is vented out by the East Wing Planter Box. It is a silver box leading to the basement which brings in fresh outside air. 2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what action the facility took to correct the deficient practice for any client the facility identified</p>	02/29/2016

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K 0069 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review and interview; the facility failed to ensure 1 of 1 range hood's fire extinguishing equipment was inspected and approved every 6 months by properly trained and qualified persons. 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	K 0069	as being affected. No one affected. 3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Staff instructed if you are unaware of the practice to contact the Administrator and D.O.N. for clarification. Staff was in-serviced on fresh air intake area. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. No further action required.	03/30/2016	
			F0069 1. Based on record review with the Administrative Assistant and Maintenance #1 on 02/29/16 at 10:55 a.m., no hood fire extinguishing equipment documentation was available for review. Based on interview at the time of record review, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition. 2. 1 of 1 kitchen range hood fire suppression system nozzles were provided with		

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	<p>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 dampers shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on record review with the Administrative Assistant and Maintenance #1 on 02/29/16 at 10:55 a.m., no hood fire extinguishing equipment documentation was available for review. Based on interview at the time of record review, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen range hood fire suppression system nozzles were provided with blowoff caps or other suitable devices to prevent the entrance of grease vapors into the</p>		<p>blow off caps or other suitable devices to prevent the entrance of grease vapors into the nozzles.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>FireScience contacted for report and contract moved to Koorsen.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>No one affected</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>Koorsen contacted so that they will do future testing.</p> <p>Blow-off caps has never been mentioned in prior surveys.</p> <p>All inspection reports will be reviewed by Administrator.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Koorsen has been informed to do</p>				

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	<p>nozzles. LSC 9.2.3 requires commercial cooking equipment to be in compliance with NFPA 96, 1998 Edition, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 7-2.2.1 requires automatic fire extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable:</p> <ul style="list-style-type: none"> a. NFPA 12, Standard on Carbon Dioxide Extinguishing Systems b. NFPA 13, Standard for the Installation of Sprinkler Systems c. NFPA 17, Standard for Dry Chemical Extinguishing Systems d. NFPA 17A, Standard for Wet Chemical Extinguishing Systems <p>NFPA 17A, Standard for Wet Chemical Extinguishing Systems, 1998 Edition, 2-3.1.4 states all discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping. The protection device shall blow off, open, or blow out upon agent discharge. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the</p>		<p>the testing of the hood system and install the blow-off caps. Koorsen representative stated no one has requested this practice for years but they will install the required blow-off caps.</p> <p>Administrator will track inspection reports on-going and report to Q.A. Committee quarterly.</p>		

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K 0075 SS=E Bldg. 01	<p>Administrative Assistant and Maintenance #1 on 02/29/16 at 12:39 p.m., three of three kitchen range hood fire suppression system nozzles were not provided with a blowoff cap or other suitable devices to prevent the entrance of grease vapors into the nozzles. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 1 of 1 Dining Room. This deficient practice could affect staff and up to 18 residents.</p>	K 0075	<p>F 0075</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 1 of 1 Dining Room. This deficient practice could affect staff and up to 18 residents.</p>	03/30/2016

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	<p>Findings include:</p> <p>Based on observation with the Administrative Assistant and Maintenance #1 on 02/29/16 at 12:48 p.m., the Dining Room contained a 40 gallon barrel of trash. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>(PLEASE CLARIFY THIS ON REPORT: WE DO NOT STORE SOILED LINEN IN THE DINING ROOM, THIS SHOULD BE RESTATED SINCE THIS IS A PUBLIC REPORT.</p> <p>Based on observation with the Administrative Assistant and Maintenance #1 on 02/29/16 at 12:48 p.m., the Dining Room contained a 40 gallon barrel of trash. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>This has never been mentioned during prior surveys, however the 40 gallon garbage can was replaced with a smaller 32 gallon can.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>No one affected</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p>		

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K 0130 SS=F Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier wall was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific</p>	K 0130	<p>No further action necessary facility was unaware of the size of the trash can and it was never cited before.</p> <p>Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. No monitoring necessary 32 gallon can present.</p> <p>F 130 Based on an observation with the Administrative Assistant and Maintenance #1 on 02/29/16 at 1:10 p.m., four separate penetrations ranging from one inch to three inches on the East Wing section of the fire barrier above the drop ceiling. Then again two separate half inch penetrations on the Kitchen part of the same fire barrier. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged each aforementioned condition and provided the measurements. Same as 00025</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>Areas caulked with fire barrier</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by</p>	03/30/2016	

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	<p>purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect staff, visitors, and all 18 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Administrative Assistant and Maintenance #1 on 02/29/16 at 1:10 p.m., four separate penetrations ranging from one inch to three inches on the East Wing section of the fire barrier above the drop ceiling. Then again two separate half inch penetrations on the Kitchen part of the same fire barrier. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p>		<p>the same deficient practice, and state, what actionsthe facility took to correct the deficient practice for any client the facilityidentified as being affected.</p> <p>No other areas noted thefacility has been checked continuously for areas that need fire caulking bylife safety surveyors since 2013. Theareas noted in this deficiency were not determined to be deficient in the past.</p> <p>1.Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The fire caulking staysin the protected area when applied. Thefacility will monitor for openings that require fire caulking when repairs aredone in the facility.</p> <p>1.Describe how thecorrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e., what quality assurance program will be put into place.</p> <p>Maintenance will monitorfor openings in walls and fire protected areas to prevent smoke penetrationsmonthly and caulk areas found.</p>				

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K 0147 SS=D 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 electrical junction box in the Basement Mechanical Room observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities 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, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Administrative Assistant and Maintenance #1 on 02/29/16 at 11:45 a.m., there was exposed wiring in a junction box without a cover in the Basement Mechanical room. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0147	<p>F 147</p> <p>Based on observation with the Administrative Assistant and Maintenance #1 on 02/29/16 at 11:45 a.m., there was exposed wiring in a junction box without a cover in the Basement Mechanical room. Based on interview at the time of observation, the Administrative Assistant and Maintenance #1 acknowledged the aforementioned condition.</p> <p>1. Describe what the facility did to correct the deficient practice for each client cited in the deficiency.</p> <p>Administrators made aware of deficiency.</p> <p>2. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected.</p> <p>No one harmed</p> <p>3. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made.</p> <p>Administrator had to contact s</p>	03/30/2016			

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			<p>welder to make special boxes to cover junction boxes. They were made and installed.</p> <p>4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Inspection of junction boxes will be done semi-annually and if any problems are noted it will be discussed with Q.A. committee and further plans of actions will be discussed.</p>		