

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155307	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/07/2012
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NAME OF PROVIDER OR SUPPLIER TOWNE CENTRE HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 7250 ARTHUR BLVD MERRILLVILLE, IN 46410
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K0000	<p>A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/07/12</p> <p>Facility Number: 000204 Provider Number: 155307 AIM Number: 100284910</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Towne Centre Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, 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 two story facility was determined to be of Type II (111)</p>	K0000	Preparation and implementation of this plan of correction does not constitute admission or agreement by Towne Centre Health Care of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated 8-7-2012. Towne Centre Health Care specifically reserves the rights to move to strike or exclude this document as evidence in any civil, administrative, and criminal action not related directly to the licensing and/or certification of this facility or provider.	

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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	<p>construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors, spaces open to the corridors, and in first floor resident rooms. Second floor resident rooms were provided with battery powered smoke detectors. The facility has the capacity for 120 and had a census of 85 at the time of this survey.</p> <p>The facility was found in compliance with regard to smoke detector coverage. The facility was found in compliance with regard to sprinkler coverage with the exceptions cited at K-56 and K-62.</p> <p>Sprinklers were not provided in all areas residents have access to. Sprinklers were provided in all areas providing facility services.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/13/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the</p>			

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K0011 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire barrier walls separating health care from the assisted living occupancy provided the protection needed for a two hour fire barrier. This deficient practice could affect visitors, staff and 30 or more residents in the first floor D Hall smoke compartment which includes the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 08/07/12 at 2:30 p.m., the first floor D wing corridor fire wall providing separation between the health care facility and another occupancy had a two inch unsealed penetration above the suspended ceiling. The administrator said at the time of</p>	K0011	<p>K 011</p> <p>1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice; The unsealed penetration above the suspended ceiling has been properly sealed.</p> <p>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All corridor fire walls above the suspended ceiling at the door separations on all halls on both floors on Health Care will be evaluated for any unsealed penetrations.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Any contractor i.e. plumber, telephone or cable television repair worker will report to</p>	09/06/2012			

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	<p>observation, she was unaware the wall was not intact.</p> <p>3.1-19(b)</p>		<p>Maintenance department that work has been completed. Fire Walls will then be checked by facility Maintenance staff within 24-hours of any contractor work that would create penetration in fire wall to assure any new penetrations have been properly sealed, any penetrations discovered not sealed, will be sealed by the maintenance staff immediately upon discovery.</p> <p>4) How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place; All fire walls will be checked again monthly for 3 months, then at least quarterly by Maintenance supervisor/designee to ensure that the walls are properly sealed. Any unsealed areas will be sealed immediately. The report of the findings will be presented to the QA Committee monthly for 3 months, and as long as 100% compliance of sealed penetrations is reported the frequency of audits may be reduced to quarterly as the committee recommends.</p> <p>5) By what date the systemic changes will be completed: September 6, 2012</p>		

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K0018 SS=E	<p>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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 4 second floor smoke compartments were equipped with latches which latched into the door frame. This deficient practice affects staff, visitors and 20 or more residents in the second floor D Hall smoke compartment which includes the dining room and physical therapy.</p> <p>Findings include:</p> <p>Based on observation with administrator on 08/07/12 at 2:25 p.m., the double door set accessing the physical therapy</p>	K0018	<p>K 018 1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice; The Therapy room door manual latch will be replaced with the proper rolling latch.</p> <p>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All corridor doors in Health Care will be assessed for presence any other manual latches by the Maintenance staff. Any manual latched discovered will be replaced with proper latching device(s) immediately, or will be scheduled for replacement to</p>	09/06/2012			

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	<p>department required one door to be manually latched into the door frame before the second door would latch into the first door and secure them both tightly into the door frame. The administrator acknowledged at the time of observation, each door would not latch securely into the door frame.</p> <p>3.1-19(b)</p>		<p>occur.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Once an audit of all corridor doors has been completed and all corridor doors have been properly equipped with proper latching devices, any new doors or any existing door repairs will be reviewed by Maintenance Director to assure proper latching device(s) present prior to installation.</p> <p>4) How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place; Maintenance Director/designee will perform monthly audits of all doors to assure proper latching devices are present and functioning properly. Results of audit are expected to achieve 100% compliance for the first 3 months, than quarterly as QA committee recommends.</p> <p>5) By what date the systemic changes will be completed: September 6, 2012</p>	

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K0020 SS=E	<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 8.2.5.6. 19.3.1.1.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 4 stairway enclosures were enclosed with construction providing a fire resistance of at least one hour. This deficient practice could affect visitors, staff and and 30 or more residents in the first and second floor A and D hall smoke compartments which include the first floor dining room.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 08/07/12 between 2:15 p.m. and 3:10 p.m., the A hall stairway enclosure wall on the first floor had a two inch unsealed penetration and two penetrations sealed with expandable foam and the D hall stairway enclosure wall on the first floor had a two inch penetration which was unsealed. The administrator said at the time of the observations, she was unaware</p>	K0020	<p>K 020</p> <p>1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice; The penetrations identified on the A hall and D hall stairway enclosure walls have been re-sealed with the proper material and the penetrations with the expandable foam has been cleaned out and re-sealed with the proper material.</p> <p>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All stairway smoke barrier walls will be audited for presence of proper sealing materials and to assure all penetrations are sealed. Any expandable foam or other improper sealing materials discovered will be replaced and the penetrations will be sealed or re-sealed with the proper material by 8-6-12.</p> <p>3) What measures will be put</p>	09/06/2012			

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	the walls had not been properly sealed. 3.1-19(b)		<p>into place or what systemic changes will be made to ensure that the deficient practice does not recur; Only appropriately approved sealing materials will be used to seal penetrations in smoke/fire barrier walls. Any maintenance staff and/or contractors who create new penetrations in smoke/fire barrier walls will notify Maintenance Director/designee of intention to create any new penetrations. Maintenance Director/designee will instruct staff and/or contractor to use only appropriately approved sealing materials on the penetrations following any repair or new creation of penetrations in walls. Maintenance Director/designee will assure penetration has been properly sealed within 24-hours of notification.</p> <p>4) How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place; Maintenance Director/designee will audit all stairway barriers monthly for 3 months to assure no new penetrations have occurred without proper follow up sealing and that all sealing/re-sealing has been performed with use of appropriate materials. Results will be presented to QA Committee monthly and long as audit results</p>		

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			<p>achieve 100% compliance, then audits may be reduced to quarterly and if recommendation is approved by QA committee.</p> <p>5) By what date the systemic changes will be completed: September 6, 2012</p>	

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K0025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through corridor smoke barriers, and smoke barrier ceilings and walls on 2 of 2 floors were maintained to provide the 1/2 hour smoke resistance of the smoke barrier. LSC 8.2.4.1 requires smoke partitions such as walls and ceiling, shall limit the transfer of smoke. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, be protected so that the space between the penetrating item and the smoke barrier shall be filled with an approved 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 could</p>	K0025	<p>K 025</p> <p>1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>a. The identified penetrations have had the improper material cleaned out and have been re-sealed with proper materials and the identified holes have been properly sealed with the proper materials.</p> <p>b. Identified areas have been properly sealed.</p> <p>c. The identified ceiling tiles have been replaced with properly fitting ceiling tiles.</p> <p>d. The expandable foam has been removed and replaced with proper sealing materials.</p> <p>e. The penetrations identified in the Janitor's closet have been properly sealed.</p> <p>2) How other residents having the potential to be affected by the same deficient practice will</p>	09/06/2012

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	<p>affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 08/07/12 between 12:00 p.m. and 3:30 p.m.:</p> <p>a. Five penetrations in the smoke barrier separating the second floor C and D Hall smoke compartments were found. Two were filled with an expandable foam and two one inch holes were unsealed;</p> <p>b. Two penetrations in the smoke barrier between the second floor D and A halls were unsealed leaving gaps of one to one and one half inches;</p> <p>c. One ceiling tile in the second floor medicine room was missing and two other ceiling tiles in this room were cut out leaving two inch gaps into the interstitial space above;</p> <p>d. Two or more penetrations in each of four first floor smoke barriers for all resident room wings were unsealed, partially sealed with expandable foam or completely sealed with expandable foam.</p>		<p>be identified and what corrective action(s) will be taken;</p> <p>All smoke barrier ceilings and walls will be audited for presence of any improper sealing materials in place and for any unsealed penetrations. Any expandable foam discovered will be removed and replaced with appropriate sealing material and any open penetrations discovered will be sealed with appropriate material by 8-6-2012. Any missing or improperly fitting ceiling tiles discovered will be replaced by 8-6-2012.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>Only appropriately approved sealing materials will be used to seal penetrations in smoke/fire barrier walls. Any maintenance staff and/or contractors who create new penetrations in smoke/fire barrier walls will notify Maintenance Director/designee of intention to create any new penetrations. Maintenance Director/designee will instruct staff and/or contractor to use only appropriately approved sealing materials in the penetrations following any repair or new creation of penetrations in walls. Any ceiling tiles removed or damaged will be replaced immediately. If cutting of ceiling</p>				

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	<p>e. Two one inch holes in the second floor janitor's closet ceiling were unsealed.</p> <p>The administrator acknowledged at the time of observations, the penetrations had not been properly sealed.</p> <p>3.1-19(b)</p>		<p>tiles is warranted, tiles will be cut appropriately to assure no gaps present in ceiling. Maintenance Director/designee will assure penetrations have been properly sealed and ceiling tiles have been replaced and are properly fitted within 24-hours of notification.</p> <p>4) How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place; Maintenance Director/designee will audit all smoke barrier walls and ceilings monthly to assure no open or improperly sealed penetrations or gaps exist. Results of the audits will be presented to the QA for 3 months and as long as 100% compliance is achieved and as the committee recommends, then audits will be reduced to quarterly.</p> <p>5) By what date the systemic changes will be completed: September 6, 2012</p>		

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K0045 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure the exterior exit discharge path for emergency exits for 2 of 2 floors was provided with emergency powered egress lighting with more than one bulb. LSC 7.9.1.1 requires emergency lighting be provided for means of egress, including walkways leading to a public way. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 08/07/12 between 1:45 p.m. and 3:00 p.m.:</p> <p>a. The exit discharge path from the first floor C wing was equipped with a single bulb fixture provided with emergency generator power. A second light was located around the corner of the building from another exit. The lighting could not supply</p>	K0045	<p>K 045</p> <p>1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>a. Additional bulb lighting will be installed to the exit discharge path from first floor C wing to assure 2 sources of illumination is present if one source fails and both will be on emergency generator power.</p> <p>b. Additional bulb lighting will be installed to the exit discharge path from first floor near 1121 to assure 2 sources of illumination is present if one source fails and both will be on emergency generator power.</p> <p>c. Additional bulb lighting will be installed to the exit discharge path from first floor near 1114 to assure 2 sources of illumination is present if one source fails and both will be on emergency generator power.</p> <p>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p>	09/06/2012			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>emergency lighting to both exit discharges if one failed;</p> <p>b. A single bulb exit discharge light was provided with emergency generator power for the exit near 1121;</p> <p>c. A single can light was provided for the exit discharge near 1114. No emergency power source could be determined for the fixture. The administrator acknowledged at the time of observation, the emergency lighting provided could not illuminate the exit discharges to the point of evacuation if any bulb should fail.</p> <p>3.1-19(b)</p>		<p>All exit lighting will be assessed to determine that 2 bulb lighting is present and to determine that all are on emergency generator power. Any lighting determined to be missing will be installed and any determined to lack generator power will be appropriately attached to the emergency generator power source.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Any exit lighting noted by any staff, residents or visitors to be lacking illumination will be reported immediately to the Maintenance staff. The Maintenance staff will replace bulbs immediately. All exit lighting will be checked at least monthly by Maintenance staff to assure all bulbs are working and all exit sources of illumination function on emergency generator power. Any bulbs identified as not working will be replaced immediately.</p> <p>4) How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place; Maintenance Director/designee will perform monthly audits of all exit lighting. Results of audit are expected to achieve 100%</p>		

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			<p>compliance when presented to the QA committee. This audit will be ongoing.</p> <p>5) By what date the systemic changes will be completed: September 6, 2012</p>		

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>Based on observation and interview, the facility failed to provide complete sprinkler coverage for all areas in 2 of 8 smoke compartments. This deficient practice affects visitors, staff and 30 or more resident in the D hall smoke compartment on the first and second floors.</p> <p>Findings include:</p> <p>a. Based on observation with the administrator on 08/07/12 at 2:45 p.m., sprinkler protection was not provided for the four by four foot corridor access between the second floor corridor and dining room. The administrator acknowledged at the time of</p>	K0056	<p>K 056</p> <p>1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice; a and b. Bids are currently being obtained to provide coverage to the area identified between the 2 nd floor corridor and dining room area and to the areas identified in the shower stalls.</p> <p>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All areas in shower rooms and in corridor areas will be assessed to assure receive proper sprinkler coverage. Any additional areas identified will be referred for bids.</p>	09/06/2012
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	<p>observations, the exit corridor sprinklers provided no coverage for this area.</p> <p>b. Based on observation with the administrator on 08/07/12 between 2:10 p.m. and 3:15 p.m., sprinkler coverage was not provided in two shower stalls in the second floor shower room and one shower stall in the first floor shower room. The administrator agreed there was no sprinkler coverage provided for these stalls by other sprinklers in the rooms.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Areas requiring additional sprinkler coverage will be corrected by qualified professional once bids obtained and capital funding is processed by corporate. Upon completion of work, Maintenance Director will assure sprinkle area is in compliance.</p> <p>4) How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place; Maintenance Director/designee will monitor completion of work by qualified professional and report to QA committee once project is completed and 100% compliant. The committee will verify compliance and make any further recommendations.</p> <p>5) By what date the systemic changes will be completed: Bids to be obtained by September 6, 2012 with expected project completion date to occur within 90 days of 9-6-2012.</p>		

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K0062 SS=F	<p>NFPA 101 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>Based on observation and interview, the facility failed to ensure sprinkler heads providing protection for 1 of 2 floors were maintained. This deficient practice could affect all staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation with the administrator on 08/07/12 between 2:00 p.m. and 3:15 p.m., sprinkler head escutcheons were missing from sprinklers to leave annular gaps of 1/2 to 1 inch:</p> <ul style="list-style-type: none"> a. In the second floor B hall corridor near the stairway (1); b. In the second floor janitor's closet (1); c. At the second floor nurses station (1); d. On the north and south sides of the second floor A hall smoke barrier (2); e. In the corridors at the second floor A and D hall stairways (2). <p>The administrator acknowledged</p>	K0062	<p>K 062</p> <p>1) What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice; Escutcheons been replaced for all areas identified in a-e.</p> <p>2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The entire Health Care facility will be checked for any missing escutcheons. Any escutcheons discovered missing will be replaced by 9-6-2012.</p> <p>3) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance staff will perform routine checks of escutcheons at least monthly and replace within 24 hours of identification of missing escutcheon(s). Maintenance Director will perform ceiling inspections monthly to assure maintenance staff are</p>	09/06/2012			

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	at the time of observations, the escutcheons should have been in place. 3.1-19(b) 3.1-19(ff)		replacing any missing escutcheons as needed. 4) How the corrective action(s) will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put into place; The Maintenance Director/designee will perform a monthly audit of escutcheons and provide results to the QA committee. As long as 100% compliance is achieved for 3 months, the audit may be provided quarterly as long as the committee recommends less frequent audits. 5) By what date the systemic changes will be completed: September 6, 2012		