

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155322	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/22/2014
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NAME OF PROVIDER OR SUPPLIER RENAISSANCE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6050 S CR 800 E 92 FORT WAYNE, IN 46814
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K010000	<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: 01/22/14</p> <p>Facility Number: 000215 Provider Number: 155322 AIM Number: 100267600</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Renaissance Village was found in not compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridor and hard wired smoke detectors</p>	K010000		

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>in resident rooms 310 to 317. The remaining resident rooms have battery operated smoke detectors. The facility has a capacity of 96 and had a census of 61 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered with the exception of a detached garage used to store maintenance supplies and equipment.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/28/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010025 SS=D	<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 1 of 1 ceiling smoke barriers 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 was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Lead Maintenance and Maintenance Technician # 1 on 01/22/14 at 2:50 p.m., there was a three quarter inch unsealed ceiling penetration around a gas line in the furnace closet located in the main dining room. Measurements were provided by the Lead Maintenance at the time of observation.</p> <p>3.1-19(b)</p>	K010025	<p>CORRECTIVE ACTION FOR AFFECTED RESIDENTS</p> <p>Identified</p> <p>ceiling penetration was sealed with fire caulk for compliance (See photo # 1).</p> <p>IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS</p>	02/09/2014			

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			<p>All facility areas checked for other ceiling penetration.</p> <p>None found.</p> <p>MEASURES FOR PREVENTION</p> <p>Maintenance staff will continue to check quarterly, and seal any future identified ceiling penetrations throughout the facility (See Attachment # 7).</p>	

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			<p>QA FOR PREVENTION</p> <p>Environmental</p> <p>Services Manager to review maintenance logs quarterly for completion and report findings to QA committee monthly.</p> <p>EFFECTIVE DATE</p> <p>The changes are completed and effective by February 9, 2014.</p>	

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 3 of 3 kitchen exit doors were provided with door knobs readily operated under all lighting conditions. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of</p>	K010038	CORRECTIVE ACTION FOR AFFECTED RESIDENTS	02/09/2014

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	<p>operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice was not in a resident area area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observations with the Lead Maintenance and Maintenance Technician # 1 on 01/22/14 at 2:55 p.m., both doors entering the kitchen from the main dining room and the door entering the kitchen from the service hall were equipped with an independent dead bolt. At the time of observation, the Lead Maintenance stated he was not aware the kitchen doors could not have independent dead bolts.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 exit access corridors was readily accessible and unobstructed at all times. This deficient practice could affect any of the 17 residents on the 200 hall.</p>		<p>All three (3) deadbolt locked were replaced with compliant locks (See Photo # 2, #3, #4).</p> <p>Scales were relocated to 300 hall shower room to allow for proper clearance of at least 48 inches in the corridor (see Photo # 5).</p> <p>IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS</p> <p>All facility doors were checked for presence of any other deadbolt locks. None were found. All halls were checked for proper clearance</p>	

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	<p>Findings include:</p> <p>Based on an observation with the Lead Maintenance on 01/22/14 from 2:25 p.m. to 3:50 p.m., a portable scale was stored unattended in the 200 hall across from the activity room. This was acknowledged by the Lead Maintenance at 3:50 p.m.</p> <p>3.1-19(b)</p>		<p>and items/equipment were relocated to only one side of the hall to allow for at least 48 inches of clearance</p> <p>MEASURES FOR PREVENTION</p> <p>Maintenance staff will ensure compliant locks will be used for any future necessary replacements. Employees were in-serviced regarding proper corridor clearance. Environmental staff will monitor and log hallways daily for proper clearance (See Attachment # 6 & # 8).</p>	

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			<p>QA FOR PREVENTION</p> <p>Environmental</p> <p>Services Manager to review maintenance logs quarterly for lock replacement compliance, and review environmental logs monthly for completion and report findings to QA committee monthly.</p> <p>EFFECTIVE DATE</p> <p>The changes are completed and effective by February 9, 2014.</p>	

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K010048 SS=C	<p>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 provide 1 of 1 written fire plans which included the evacuation of a smoke compartment within the evacuation instructions. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p>	K010048	<p>CORRECTIVE ACTION FOR AFFECTED RESIDENTS</p> <p>Fire evacuation policy and floor plan was modified to clarify, identify and define smoke compartments and their evacuation procedure (See Attachment # 4 & 4a).</p>	02/09/2014

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	<p>Findings include:</p> <p>Based on a record review with the Lead Maintenance, Maintenance Technician # 1 and the Environmental Manager on 01/22/14 at 1:30 p.m., the "Disaster Plan" included zone to zone evacuation. Based on an interview with the Lead Maintenance at the time of record review, the zone's are identified according to the fire alarm system. He stated the zones and the smoke compartments are not the same.</p> <p>3.1-19(b)</p>				<p>IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS</p> <p>Fire evacuation policy and floor plan was modified to clarify, identify and define smoke compartments and their evacuation procedure.</p> <p>MEASURES FOR PREVENTION</p> <p>Staff in-serviced on revised evacuation plan with clarification of smoke compartments</p>		

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			(See Attachment 4b) QA FOR PREVENTION Environmental Services Manager to quarterly check Indiana LSC website for relevant updates prior to policy/plan updates and report findings to QA committee quarterly. EFFECTIVE DATE The changes are		

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K010050	<p>completed and effective by February 9, 2014.</p> <p>CORRECTIVE ACTION FOR AFFECTED RESIDENTS</p>	02/09/2014	

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	<p>Based on record review of the "Fire Drill Report" with the Lead Maintenance, Maintenance Technician # 1 and the Environmental Manager on 01/22/14 at 12:15 p.m., there was no record of a second shift fire drill for the first quarter of 2013. Based on an interview with the Lead Maintenance at the time of record review, this drill was not conducted.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>Fire drills are conducted timely, once per shift, each quarter at varied times by maintenance staff.</p> <p>IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS</p> <p>Fire drills are conducted timely, once per shift, each quarter by maintenance staff.</p> <p>MEASURES FOR PREVENTION</p>		

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			<p>Environmental</p> <p>Services Manager will review fire drill schedule annually for compliance (see Attachment # 1).</p> <p>QA FOR PREVENTION</p> <p>Environmental</p> <p>Services Manager to review fire drill logs monthly for timely completion and report findings to QA committee monthly.</p> <p>EFFECTIVE DATE</p>		

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K010052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 41 of 41 smoke detectors were maintained in accordance with the applicable 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</p>	K010052	<p>CORRECTIVE ACTION FOR AFFECTED RESIDENTS</p> <p>Sensitivity</p>	02/09/2014

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	<p>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. 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 (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice</p>		<p>testing completed by fire protection vendor (see Attachment # 2)</p> <p>IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS</p> <p>Sensitivity</p> <p>testing completed by fire protection vendor.</p> <p>MEASURES FOR PREVENTION</p> <p>Maintenance</p>				

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	<p>could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Lead Maintenance, Maintenance Technician # 1 and the Environmental Manager on 01/22/14 at 12:55 p.m., the most recent sensitivity report was completed by Koorsen in September of 2011. Based on an interview with Lead Maintenance, Maintenance Technician # 1 and the Environmental Manager at the time of record review, no other documentation of a more recent sensitivity test was available for review.</p> <p>3.1-19(b)</p>		<p>staff to monitor and schedule timely bi-annual vendor visits for sensitivity testing. (See Attachment 2a)</p> <p>QA FOR PREVENTION</p> <p>Environmental</p> <p>Services Manager to review sensitivity testing schedule bi-annually for completion and report findings to QA committee monthly.</p> <p>EFFECTIVE DATE</p>		

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K010056 SS=D	<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 ensure 2 of 5 sprinkler</p>	K010056	<p>The changes are</p> <p>completed and effective by February 9, 2014.</p>	02/09/2014	

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	<p>heads in the laundry room were separated by at least six feet as required by NFPA 13. NFPA 13 Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect 1 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Lead Maintenance and Maintenance Technician # 1 on 01/22/14 at 3:05 p.m., the laundry room had two sprinkler heads located twenty eight inches apart. Based on an interview with the Lead Maintenance at the time of observation, the initial plan was to enclose the area behind the dryers and an additional sprinkler head was added but the plan changed leaving these sprinkler heads too close together.</p> <p>3.1-19(b)</p>		<p>CORRECTIVE ACTION FOR AFFECTED RESIDENTS</p> <p>Identified</p> <p>sprinkler head in laundry room was dismantled and plugged, rendering it non-functional thereby, meeting spacing requirements (See Attachment # 9 & Photo # 6).</p> <p>IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS</p> <p>One (1)</p> <p>Sprinkler head was eliminated or</p>				

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			<p>relocated for compliant installation.</p> <p>MEASURES FOR PREVENTION</p> <p>Sprinkler maintenance company to notify and obtain approval from maintenance staff and/or Environmental Services Manager, prior to any installation or relocation of sprinkler heads in the facility (See Attachment # 9a).</p> <p>QA FOR PREVENTION</p>		

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			<p>Environmental</p> <p>Services Manager to review maintenance logs monthly for any vendor sprinkler</p> <p>maintenance non-compliance issues and report findings to QA committee monthly.</p> <p>EFFECTIVE DATE</p> <p>The changes are completed and effective by February 9, 2014.</p>	

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K010062 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 record review and interview, the facility failed to document and conduct weekly tests for 1 of 1 fire pumps in accordance with LSC Section 9.7.5 and 19.3.5.1 and NFPA 25. NFPA 25, Table 5-1.1 and then 5-2 through 5-3.2.4.4 requires the following weekly inspections: the pump house conditions-heat is at least 40 degrees F, heating ventilating louvers are free to operate, fire pump system conditions with valves fully open, piping free of leaks, suction line pressure gauge reading is normal, suction reservoir is full. Additionally, 5-3.2.1 requires a no flow, ten minute pump test shall be performed weekly. This deficient practice affects all occupants.</p> <p>Finding include:</p> <p>Based on record review with the Lead Maintenance, Maintenance Technician #</p>	K010062	<p>CORRECTIVE ACTION FOR AFFECTED RESIDENTS</p> <p>Fire pump tests are conducted weekly and log completed (see Attachment # 3).</p> <p>IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS</p>	02/09/2014

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	<p>1 and the Environmental Manager on 01/22/14 at 1:00 p.m., the facility was only able to provide documentation of a monthly inspection of the fire pump. Based on an interview with the Lead Maintenance at the time of observation, he was informed by his sprinkler inspection company that only a monthly inspection was required.</p> <p>3.1-19(b)</p>		<p>Fire pump tests are conducted weekly and log completed.</p> <p>MEASURES FOR PREVENTION</p> <p>Maintenance staff will consult current regulations prior to changing testing frequency.</p> <p>QA FOR PREVENTION</p>				

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			<p>Environmental Services Manager to review environmental logs</p> <p>monthly for completion and report findings to QA committee monthly.</p> <p>EFFECTIVE DATE</p> <p>The changes are completed and effective by February 9, 2014.</p>		

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K010072 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure 1 of 1 activity room exit doors was maintained free of all obstructions or impediments to full instant use. This deficient practice could affect at least 4 residents in the activity room.</p> <p>Findings include:</p> <p>Based on observation with the Lead Maintenance on 01/22/14 at 2:25 p.m., the activity room exit door was obstructed by portable decorative room dividers propped in front of the door. Based on an interview with the Lead Maintenance at the time of observation, the dividers are used to darken the room when a movie is being played to prevent glare on the TV screen but did agree there are other methods of preventing the glare that would not obstruct the exit door.</p>	K010072	<p>CORRECTIVE ACTION FOR AFFECTED RESIDENTS</p> <p>Portable partition removed from blocking Activity Room exterior exit door (see Photo #7).</p> <p>IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS</p>	02/09/2014
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	3.1-19(b)		<p>Portable partition removed from blocking Activity Room exterior exit door.</p> <p>MEASURES FOR PREVENTION</p> <p>Activity staff to maintain Activity Room, exterior door clearance.</p> <p>QA FOR PREVENTION</p>		

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			<p>Environmental</p> <p>staff to complete daily log for Activity Door clearance; (See Attachment # 6). Environmental Services Manager to review logs</p> <p>monthly for completion and report findings to QA committee monthly.</p> <p>EFFECTIVE DATE</p> <p>The changes are completed and effective by February 9, 2014.</p>	

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K010147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 flexible cords were not used as a substitute for fixed wiring to provide power for medical equipment or equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 to 3 residents in the Therapy room and facility staff.</p> <p>Findings include:</p> <p>Based on observation and interview with the Lead Maintenance and Maintenance Technician # 1 on 01/22/14 from 1:52 p.m. to 3:03 p.m., they acknowledged the following areas had high current draw equipment supplied electricity by an extension cord power strip:</p> <p>a. a microwave in the Therapy room b. a microwave in the supply closet of</p>	K010147	<p>CORRECTIVE ACTION FOR AFFECTED RESIDENTS All identified appliances plugged into power strips were disconnected and plugged directly into wall plugs or removed (see Photo #8, # 9, #10, #11). IDENTIFICATION/CORRECTIVE ACTION FOR POTENTIALLY AFFECTED RESIDENTS All areas (including resident rooms and office areas) of facility were checked for other non-compliant electrical connections. None were found. MEASURES FOR PREVENTION Environmental staff will continue to conduct weekly and quarterly checks (per policy) for non-compliant electrical connections, as a part of the preventative maintenance program (see Attachment # 5, # 5a, & 5b). QA FOR PREVENTION Environmental Services Manager to review maintenance logs quarterly for completion and report findings to QA committee monthly. EFFECTIVE DATE The</p>	02/09/2014

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	<p>the conference room</p> <p>c. a refrigerator in the DON's office</p> <p>d. a laminator in the laundry room</p> <p>3.1-19(b)</p>		<p>changes are completed and effective by February 9, 2014.</p>		