

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/08/2015
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NAME OF PROVIDER OR SUPPLIER  UNIVERSITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/8/15</p> <p>Facility Number: 000107 Provider Number: 155200 AIM Number: 100290330</p> <p>At this Life Safety Code survey, University Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 75 and had a census of 67 at the time of this survey.</p>	K 0000	<p>Dear Ms. Rhoades, Attached is University Nursing Center's Plan of Correction for the annual Life Safety Code inspection completed on June 8, 2015. Please accept the plan of correction as written. Sincerely, Stephanie Allen, HFA, MHA University Nursing Center</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0017 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview the facility failed to ensure the corridor wall for 1 of 1 sprinkler riser rooms was capable of resisting the passage of smoke as required in a sprinklered building. This deficient practice could affect 26 residents in the 100 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with Maintenance Supervisor on 06/08/15 at 11:13 a.m., there was a two inch by two inch hole cut into the corridor wall in the sprinkler riser room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided the measurements of the hole.</p>	K 0017	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The two inch by two inch hole in the corridor wall in the sprinkler riser room was fixed by the Maintenance Director. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. The Maintenance Director will complete a house audit by 7/8/15 to ensure no other holes exist in the corridor walls. Any issues found will be immediately addressed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance</p>	07/08/2015			

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K 0025 SS=E Bldg. 01	3.1-19(b)  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 1. Based on observation and interview,	K 0025	director or designee will conduct a daily round on days worked to ensure no holes exist in the corridor walls. Any issues found will be immediately addressed. How the corrective action will be monitored to ensure the deficient practice will not recur? The maintenance director or designee will conduct a daily round to ensure no holes exist in the corridor walls for one month, then a weekly round for two months, and then a monthly round for three months with results brought to the CQI meeting. The Executive Director or designee will meet with the Maintenance Director weekly to ensure compliance. If a 95% threshold is not maintained on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date systemic changes will be completed: 7.8.15  What corrective action will be	07/08/2015	

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	<p>the facility failed to ensure the penetrations through 2 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice affects 50 residents in 4 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observations during the tour of the facility with the Maintenance Supervisor on 06/08/15 between 12:23 p.m. and 1:00 p.m., the following unsealed smoke barrier penetrations were noted:</p> <p>a. measuring one fourth of an inch around a wire located in attic of the 300 hall smoke wall.</p> <p>d. measuring four inches by four inches on the top half of a water line located above the ceiling tile in the 200 hall smoke wall.</p>		<p>accomplished for those residents found to have been affected by the deficient practice? The penetrations in the smoke barrier walls were all fixed by the Maintenance Director. The penetrations around the sprinkler heads were also fixed by the Maintenance Director. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. The maintenance director or designee will complete a house audit by 7/8/15 to ensure no other penetrations exist in the smoke barrier walls or around sprinkler heads. Any issues will be immediately addressed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance director or designee will complete a daily round to ensure no penetrations exist in the smoke walls or around the sprinkler heads. Any issues will be immediately addressed. Any new installation of new wiring or cable will be inspected by maintenance director to ensure no penetrations in the smoke barrier walls. How the corrective actions will be monitored to ensure the deficient practice does not recur? The maintenance director or designee will conduct a daily round for one</p>	

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	<p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one 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 affects 26 residents in 2 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Maintenance Supervisor on 06/08/15 between 10:00 a.m. and 1:00 p.m., the following penetrations were noted measuring a half of an inch to one fourth of an inch around sprinkler heads:</p> <ul style="list-style-type: none"> <li>a. one in room 207</li> <li>b. one in service hall storage</li> <li>c. one in staff lounge closet</li> <li>d. two in the kitchen</li> </ul> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided the measurements of the penetrations.</p>		<p>month, then a weekly round for two months, then a monthly round for three months to ensure no penetrations exist in the smoke barrier walls and around sprinkler heads with results to the CQI meeting. The Executive Director or designee will monitor the Maintenance Director or designee's compliance weekly. If a 95% threshold is not met on any of the above indicators, an internal plan of correction will be made to ensure compliance. By what date systemic changes will be completed? 7.8.15</p>	

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K 0029 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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>Based on observation and interview, the facility failed to ensure 1 of 4 rooms with a fuel-fired hot water heater, a hazardous area, was smoke resistive. This deficient practice could affect 19 residents in the 200 hall.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Maintenance Supervisor on 06/08/15 at 12:28 p.m., there was a two inch hole in the wall of the 200 hall mechanical room, which contained a gas-fired hot water heater. Based on interview at the time of observation, the Maintenance Supervisor</p>	K 0029	<p>What corrective action will be accomplished for those residents found to have been affected? The two inch hole in the wall of the 200 hall mechanical room was fixed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the ability to be affected. The Maintenance Director or designee will conduct a house audit by 7/8/15 to ensure no other holes exist in mechanical rooms with gas-fired hot water heaters. Any issues found will be immediately fixed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The</p>	07/08/2015			

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K 0038 SS=E Bldg. 01	<p>acknowledged and provided the measurement of the penetration.</p> <p>3.1-19(b)</p> <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>Based on observation and interview, the facility failed to ensure 1 of 1 doors from the therapy room was provided with door latches readily operated under all lighting conditions. LSC 7.2.1.5.4 requires where a latch or other similar device is provided, the method of operation of its</p>	K 0038	<p>Maintenance Director or designee will conduct a daily round to ensure no holes exist in mechanical rooms with gas-fired hot water heaters. Any issues will be immediately fixed. How the corrective action will be monitored to ensure the deficient practice will not recur? The maintenance director or designee will conduct a daily round for one month, then a weekly round for two months, and then a monthly round for three months to ensure no holes exist in the mechanical rooms with gas-fired hot water heaters with results brought to the CQI meeting. The Executive Director or designee will monitor the maintenance director or designee weekly to ensure compliance. If a 95% threshold is not met on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date systemic changes will be completed: 7.8.15</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The therapy room door latch was fixed to one that releases and is obvious even in the dark and that also does not utilize a dead bolt with an independent key. How</p>	07/08/2015	

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	<p>releasing device must be obvious, even in the dark. The intention of this requirement is the method of release is 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 a single action unlatch the door. This deficient practice could affect 8 residents in the therapy room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 06/08/15 at 11:52 a.m., the therapy room corridor door was equipped with an independent key locking mechanism in addition to the door knob on the egress side of the door. The Maintenance Supervisor acknowledged the therapy room had an independent key locking mechanism at the time of observation.</p> <p>3.1-19(b)</p>		<p>other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. The Maintenance Director or designee will complete a house audit by 7/8/15 to ensure all latches have a releasing device that is obvious, even in the dark and that no dead bolts with independent keys are in use. Any issues found will be immediately addressed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director or designee will conduct a daily round to ensure all latches have a releasing device that is obvious, even in the dark and to ensure dead bolts with independent keys are not in use. Any issues will be immediately addressed. How the corrective action will be monitored to ensure the deficient practice will not recur? The Maintenance Director or designee will conduct a daily round for one month, then a weekly round for two months, and then a monthly round for three months to ensure latches in the facility are appropriate and per LSC guidelines with results to the CQI meeting. The Executive Director or designee will audit the Maintenance Director or designee weekly to ensure compliance. If a 95% threshold is not maintained</p>		

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K 0062 SS=E Bldg. 01	<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>1. Based on observation and interview, the facility failed to ensure 3 of over 300 sprinklers in the facility were properly maintained. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice can affect 29 residents in the 100 hall and 19 residents in the 200 hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 06/08/15 between 10:15 a.m. to 12:30 p.m., the following sprinkler heads were missing the escutcheons:</p> <p>a.) 1 of 7 in the 200 hall hallway b.) 1 of 1 in the closet of room 114 c.) 1 of 3 in the 100 hall spa</p>	K 0062	<p>on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date will the systemic changed be completed: 7.8.15</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The sprinkler heads missing escutcheons had escutcheons placed and the sprinkler head with paint on it had paint removed and replaced by the maintenance director. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. The Maintenance Director or designee will conduct a house audit by 7/8/15 to ensure all sprinkler heads have escutcheons on them and that no paint is on any sprinkler heads. Any issues will be immediately replaced. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The Maintenance Director or designee will conduct a daily round to ensure sprinkler heads</p>	07/08/2015	

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	<p>Based on interview at the time of observation, this was acknowledged by the Maintenance Supervisor.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of 3 sprinklers in the staff lounge which had been painted. 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 was not in a patient treatment area but could affect staff using the staff lounge.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Maintenance Supervisor on 06/08/15 at 11:59 a.m., one automatic sprinkler in the staff lounge had paint on the sprinkler head. Based on interview at the time of observation, the painted sprinkler head was acknowledged by the Maintenance Supervisor.</p>		<p>have escutcheons on them and that no paint is on sprinkler heads. Any issues noted will be immediately addressed. How the corrective action will be monitored to ensure the deficient practice will not recur? The maintenance director or designee will conduct a daily round for one month, then a weekly round for two months, then a monthly round for three months to ensure all sprinkler heads have escutcheons on them and no paint is on sprinkler heads with results brought to the CQI meeting. The Executive Director or designee will monitor the Maintenance Director or designee weekly to ensure compliance. If a 95% threshold is not maintained on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date the systemic changes will be completed? 7.8.15</p>		

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K 0074 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 sets of curtains located in the conference room were flame retardant. This deficient practice could affect 9 residents near the conference room.</p> <p>Findings include:</p> <p>Based on observations during a tour of</p>	K 0074	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The curtains in the conference room changed to flame retardant curtains.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. The Maintenance Director or</p>	07/08/2015	

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	<p>the facility with the Maintenance Supervisor on 06/08/15 at 11 40 a.m., there were two sets of curtains covering two dry erase boards in the conference room. Upon inspection of the curtains, no flame retardant rating was found. Based on interview at the time of observation, the Maintenance Supervisor indicated there was no documentation regarding flame retardants for the curtains.</p> <p>3.1-19(b)</p>		<p>designee will conduct a house audit by 7/8/15 to ensure no other draperies, curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are present without flame retardant proof. Any issues will be immediately removed. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur? The Maintenance Director or designee will conduct a daily round to ensure non-flame retardant curtains, draperies, or other loosely hanging fabrics and films serving as furnishings or decorations are present. Any issues will be immediately fixed. Any new draperies hung will be inspected by the maintenance director to ensure draperies are flame retardant. How the corrective action will be monitored to ensure the deficient practice does not recur? The Maintenance Director or designee will conduct a daily round for one month, then a weekly round for two months, then a monthly round for three months to ensure no non-flame retardant curtains, draperies, or loosely hanging fabrics and films serving as furnishings or decorations are present with results to CQI meeting. The Executive Director or designee will monitor the Maintenance Director or designee weekly to ensure compliance. If a 95% threshold is not met on any</p>		

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K 0143 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was provided with continuous mechanical ventilation. This deficient practice was not in a patient treatment area but could affect any staff in the service hall.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 06/08/15 at 12:18 p.m., the mechanical ventilation system was not</p>	K 0143	<p>of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date will the systemic changes be completed? 7.8.15</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The mechanical ventilation system was fixed in the oxygen storage room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. The Maintenance Director or designee will conduct a house audit by 7/8/15 to ensure mechanical ventilation systems are functioning properly where</p>	07/08/2015	

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K 0147 SS=B Bldg. 01	working were transferring of oxygen took place in the oxygen storage room on the service hall. Base on an interview at the time of observation, the Maintenance Supervisor confirmed the oxygen room mechanical vent was not working.  3.1-19(b)  NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the	K 0147	oxygen transferring is taking place. Any issues will be immediately fixed.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director or designee will conduct a daily round to ensure mechanical ventilation systems are fully functioning where oxygen is being transferred. Any issues will be immediately fixed.How the corrective action will be monitored to ensure the deficient practice does not recur? The Maintenance Director or designee will conduct a daily round for one month, then a weekly round for two months, and then a monthly round for three months to ensure ventilation systems are fully functioning where oxygen is being transferred with results to the CQI meeting. The Executive Director or designee will audit the Maintenance Director or designee weekly to ensure compliance. If a 95% threshold is not maintained on any of the above indicators, an internal plan of correction will be formed to ensure compliance. By what date the systemic changes will be completed? 7.8.15  What corrective action will be	07/08/2015	

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	<p>facility failed to ensure 1 of 1 receptacles near a wet location was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, Article 517, Health Care Facilities, defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor or drenching of the work area, either of which condition is intimate to the patient or staff. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 8 residents in the therapy room.</p> <p>Findings include:</p> <p>Based on an observation during a tour of the facility with the Maintenance Supervisor on 06/08/15 at 11:50 a.m., there was an electrical GFCI receptacle on the wall less than three feet from a sink in the therapy room, but when tested with a GFCI testing device the receptacle failed to trip. Based on interview and testing, the Maintenance Supervisor acknowledged the power to the receptacle was not interrupted when tested with a GFCI testing device.</p>		<p>accomplished for those residents found to have been affected by the deficient practice? The electrical GFCI receptacle in the therapy room was fixed by the maintenance director so it trips properly when tested. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected. The Maintenance Director or designee will conduct a house audit by 7.8.15 to ensure all GFCI receptacles trip properly when tested. Any issues found will be fixed immediately. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director or designee will conduct a daily round to ensure GFCI receptacles trip properly when tested. Any issues will be immediately fixed. How the corrective action will be monitored to ensure the deficient practice will not recur? The Maintenance Director or designee will conduct a daily round for one month, then a weekly round for two months, then a monthly round for three months to ensure GFCI receptacles trip properly when tested with results brought to the CQI meeting. The Executive Director or designee will monitor the Maintenance Director or designee weekly to ensure</p>	

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	3.1-19(b)		compliance. If a 95% threshold is not met on any of the above indicators, then an internal plan of correction will be made to ensure compliance. By what date will the systemic changes be completed? 7.8.15		