

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155103	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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NAME OF PROVIDER OR SUPPLIER TRAILPOINT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614
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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: 04/19/16</p> <p>Facility Number: 000042 Provider Number: 155103 AIM Number: 100291540</p> <p>At this Life Safety Code survey, Ironwood Health and Rehabilitation 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 (111) construction and was fully sprinklered with the exception of the rear entrance canopy. The facility has a fire alarm system with smoke detection the corridors, areas open to the corridors, and battery operated smoke detectors in the resident sleeping rooms. The facility</p>	K 0000	The creation and submission of this Plan of Correction doesnot constitute an admission by this provider of any conclusion set forth in thestatement of deficiencies or of any violation of regulation. This providerrespectfully requests that the 2567 Plan of Correction be considered the Letterof Credible Allegation and requests a Post Certification desk review in lieu ofa post survey revisit on or after May 3,2016.	

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>has a capacity of 183 with a census of 101 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered except for the rear entrance canopy. All areas providing facility services were sprinklered except for a detached laundry building, maintenance shed and a storage shed.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck 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 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, 19.3.6.4, 19.3.6.5 Based on observation, the facility failed to ensure 1 of 2 corridor walls at the Reception area was capable of resisting smoke for at least 1/2 hour. This deficient practice could affect staff, visitors, and up to 8 residents.</p> <p>Findings include:</p>	K 0017	<p>K017 What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: No residents were affected by the allegeddeficient practice.The phone jackwas reattached to the wall where the 3/4 inch hole was creating</p>	05/03/2016

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	<p>Based on observation with the Maintenance Supervisor, the Director of Maintenance, and the Health Facility Manager on 04/19/16 at 12:40 p.m., the corridor wall in the reception area was not smoke resistant due to a three quarter inch hole. Based on interview at the time of observation, the Maintenance Supervisor, the Director of Maintenance, and the Health Facility Manager acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>a smoke barrier capable of resisting smoke at least a ½ hour.</p> <p>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Staff, visitors, and up to 8 residents have the potential to be affected by the alleged deficient practice. The phone jack that had been pulled from the wall created a ¾ inch hole which has since been reattached. This has created a smoke barrier capable of resisting smoke at least ½ hour.</p> <p>What measure will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur:</p> <p>The Maintenance Director/designee will inspect corridors walls throughout facility weekly to ensure the smoke barriers have not been compromised with penetrations.</p> <p>How 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: The Maintenance Director/designee will complete Audit Tool "A" weekly x 4 weeks, monthly x 6, and quarterly thereafter for one year. The results of this audit will be reviewed by the QA committee overseen by the ED and DNS. If threshold of 95% or greater is not achieved an action plan will be developed.</p> <p>By what date the systematic change will be completed: May 3, 2016</p>	

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K 0018 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 Activity Storage room corridor door had a positive latching device. This deficient practice could affect staff and at least 18 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 04/19/16 at 11:44 a.m., the Maintenance Supervisor, the Director of Maintenance, and the Health Facility Manager acknowledged the corridor door to the</p>	K 0018	<p>K018</p> <p>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: No residents were affected by the allegeddeficient practice. The activity storage room corridor door was fixed with apositive latching device. The resident room corridor door 322 was fixed toensure it latches into the frame consistently.</p> <p>How other residentshave the potential to be affected by the same deficient practice will beidentified and what corrective</p>	05/03/2016

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K 0029	<p>Activities Storage room only had a manual slide bolt installed to latching into the frame.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 106 resident room corridor doors closed and latched into the door frame. This deficient practice could affect staff and at least 11 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 04/19/16 at 11:52 a.m., the Maintenance Supervisor, the Director of Maintenance, and the Health Facility Manager acknowledged the corridor door to resident room 322 failed to latch into the frame.</p> <p>3.1-19(b)</p>		<p>action(s) will be taken: Staff, visitors, and a total of 29 residents had the potential to be affected by the alleged deficient practice. The activity storage room corridor door has been fixed with a positive latching device. The resident room corridor door 322 was fixed to ensure it latches into the frame consistently.</p> <p>What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur: The Maintenance Director/designee will check all corridor doors requiring a positive latching device weekly to ensure they are operating properly. The Maintenance Director/designee will check all resident room corridor doors weekly to ensure they are latching into their frames.</p> <p>How 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: The Maintenance Director/designee will complete Audit Tool "A" weekly x 4 weeks, then monthly for 6 months, and then quarterly thereafter for one year. The results of this audit will be reviewed by the QA committee overseen by the ED and DNS. If a threshold of 95% is not achieved an action plan will be developed.</p> <p>By what date the systemic change will be completed: May 3, 2016</p>		

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SS=E Bldg. 01	<p>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 fuel fired Mechanical room near resident room 317, a hazardous area, would latch into the frame. This deficient practice could affect 13 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor, the Director of Maintenance, and the Health Facility Manager on 04/19/16 at 11:53 a.m., the corridor door to the Mechanical room near resident room 317 self-closed when tested but failed to latch into the frame. Based on interview at the time of observation, the Maintenance Supervisor, the Director of Maintenance, and the Health Facility Manager acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0029	<p>K029</p> <p>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: No residents were affected by the allegeddeficient practice. The corridor door to 1 of 1 fuel firedMechanical room near resident room 317 has been repaired to consistently latchinto the frame. Storage room 509 has been emptied to no longer make it ahazardous area. Storage rooms 518 and519 were both outfitted with self-closers to ensure the doors would close andsecurely latch within the frames.</p> <p>How other residentshave the potential to be affected by the same deficient practice will beidentified and what corrective action(s) will be taken: 13 residents hadthe potential to be affected by the alleged deficient practice and staff hadthe potential to be affected as well.</p> <p>What measures will beput into</p>	05/03/2016
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K 0046 SS=C Bldg. 01	<p>2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Storage room 509 and 1 of 1 Storage room 518 greater than 50 square feet, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice was not in a resident care but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor, the Director of Maintenance, and the Health Facility Manager on 04/19/16 at 11:03 a.m. then again at 11:07 a.m., ten mattresses were stored in storage room 509 which did not have a self-closing device installed. Then again, four cabinets, sixteen large boxes of pantry items, and other miscellaneous furniture in storage room 518 which did not have a self-closing device installed. Based on interview at the time of each observation, the Maintenance Supervisor, the Director of Maintenance, and the Health Facility Manager acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in</p>		<p>place or what systematic changes will be made to ensure the deficient practice does not recur: The Maintenance Director/designee will check weekly to ensure all doors are latching into their frames consistently and that any rooms being used for storage that would be considered a hazardous area are fitted with self closer to ensure safety of the staff and/or residents. How 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: The Maintenance Director/designee will complete Audit Tool "A" weekly x 4 weeks, then monthly for 6 months, and then quarterly thereafter for one year. The results of this audit will be reviewed by the QA committee overseen by the ED and DNS. If a threshold of 95% is not achieved an action plan will be developed. By what date the systematic change will be completed: May 3, 2016</p>				

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	<p>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 battery operated emergency lights in 1 of 1 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 ½ 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 all residents, staff and visitors throughout the facility.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 04/19/16 at 9:55 a.m., the facility provided 30 second monthly testing, but failed to provide documentation for an annual 90 minute test. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition.</p>	K 0046	<p>K046</p> <p>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: No residents were affected by the allegeddeficient practice. A 90 minute test was conducted and recorded per regulation.</p> <p>How other residentshave the potential to be affected by the same deficient practice will beidentified and what corrective action(s) will be taken: The deficientpractice could affect staff, residents, and visitors throughout thefacility. A 90 minute test was conductedand successful.</p> <p>What measures will beput into place or what systematic changes will be made to ensure the deficientpractice does not recur: The Maintenance Director/designee will checkbattery operated emergency lighting following the preventative maintenancelogs. The 90 minute test of battery operated emergency lighting is on the PMlog annually (attachment 1).</p> <p>How correctiveaction(s) will be monitored to ensure the deficient practice will not recur; iewhat quality assurance program will be put into place: The MaintenanceDirector/designee will use Audit Tool "B" weekly x 4 weeks, then monthly for 6 months thenquarterly thereafter for one</p>	05/03/2016

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K 0070 SS=D Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8</p> <p>Based on observation, interview, and record review, the facility failed to enforce the policy for the use of 1 of 1 portable space heaters in accordance with NFPA 101, Section 19.7.8. This deficient practice is not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor, the Director of Maintenance, and the Health Facility Manager on 04/19/16 between 8:48 a.m. and 10:09 a.m., the space heater policy states the facility does not allow space heaters. Based on observation, a space</p>	K 0070	<p>year. The results of this audit will be reviewed by the QA committee overseen by the ED and DNS. If a threshold of 95% or greater is not achieved an action plan will be developed.</p> <p>By what date the systematic change will be completed: May 3, 2016</p> <p>K070</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by the alleged deficient practice. The space heater in question was immediately disposed of.</p> <p>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: Any number of staff have the potential to be affected by the alleged deficient practice. The space heater has been disposed of.</p> <p>What measures will be put into place or what systematic changes</p>	05/03/2016

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K 0144 SS=F Bldg. 01	<p>heater was discovered in the Medical Records office. Based on interview at the time of observation, the Maintenance Supervisor, the Director of Maintenance, and the Health Facility Manager acknowledged the space heater were a violation of the facility's policy.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) 1. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section</p>	K 0144	<p>will be made to ensure the deficient practice does not recur: All Department Heads were inserviced on facility's non use of space heaters. The Maintenance Director/designee will check rooms weekly to ensure no space heaters are being used in the facility. How corrective action(s) will be monitored to ensure the deficient practice will not recur; iewhat quality assurance program will be put into place: The Maintenance Director/designee will use Audit Tool "A" weekly x 4 weeks, then monthly for 6 months, then quarterly thereafter for one year. The results of this audit will be reviewed by the QA committee overseen by the ED and DNS. If a threshold of 95% or greater is not achieved an action plan will be developed. By what date the systematic change will be completed: May 3, 2016</p> <p>K144 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were affected by the</p>	05/03/2016

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	<p>3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. In addition, NFPA 101 at Section 4.6.12.1 requires that any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could affect all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor, the Director of Maintenance, and the Health Facility Manager on 04/19/16 at 12:29 p.m., the generator annunciator panel is in the 100 Hall Nurse's station which is closed down for renovation. Based on an interview at the time of observation, the Maintenance Supervisor, the Director of Maintenance, and the Health Facility Manager acknowledged the aforementioned condition.</p> <p>3-1.19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which</p>		<p>alleged deficient practice. An enunciator panel was added to unit 300 nurses station which is a location readily observed by operating personnel at a regular workstation. In addition, an area has been added to the facility's Emergency Generator monthly testing log to include cool down time.</p> <p>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The alleged deficient practice had the potential to affect all residents, staff, and visitors in the facility. An enunciator panel was added to unit 300 nurses station which is a location readily observed by operating personnel at a regular work station. In addition, an area has been added to the facility's Emergency Generator monthly testing log to include a cool down time.</p> <p>What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur: The Maintenance Director/designee will check the generator enunciator panel weekly to ensure proper function. The Emergency generator monthly testing log has been updated to include an area for the cool down time (attachment 2).</p> <p>How corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be</p>		

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	<p>refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log with the Maintenance Supervisor on 04/19/16 at 9:56 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition.</p>		<p>put into place: The Maintenance Director/designee will use Audit Tool "A" weekly x 4 weeks, then monthly for 6 months, and quarterly thereafter for one year. The results of this audit will be reviewed by the QA committee overseen by the ED and DNS. If a threshold of 95% or greater is not achieved an action plan will be developed.</p> <p>By what date the systematic change will be completed: May 3, 2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155103	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/19/2016
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NAME OF PROVIDER OR SUPPLIER TRAILPOINT VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614
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K 0147 SS=D Bldg. 01	<p>3.1-19(b)</p> <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 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 2 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor, the Director of Maintenance, and the Health Facility Manager on 04/19/16 at 10:40 a.m. then again at 11:35 a.m., a surge protector was powering an oxygen concentrator in resident room 426. Then again, a surge protector was powering a refrigerator in the Director of Nursing office. Based on interview at the time of each observation, the Maintenance Supervisor, the Director of Maintenance, and the Health Facility</p>	K 0147	<p>K147</p> <p>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice: No residents were affected by the allegeddeficient practice.The surgeprotectors were removed from the Director of Nursing office and from theresident room.</p> <p>How other residentshave the potential to be affected by the same deficient practice will beidentified and what corrective action(s) will be taken: The alleged deficient practice had thepotential to affect staff and up to 2 residents. The surge protectors in use have been removedfrom the Director of Nursing office and the resident room.</p> <p>What measures will beput into place or what systematic changes will be made to ensure the deficientpractice does not recur: TheMaintenance Director/designee will make weekly rounds to ensure no surgeprotectors are in use throughout the facility.</p> <p>How correctiveaction(s) will be monitored to ensure the deficient practice will not recur; iewhat</p>	05/03/2016

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NAME OF PROVIDER OR SUPPLIER TRAILPOINT VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1950 RIDGEDALE RD SOUTH BEND, IN 46614		
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	Manager acknowledged each aforementioned condition. 3.1-19(b)		quality assurance program will be put into place: The Maintenance Director/designee will use Audit Tool "A" weekly x 4 weeks, then monthly for 6 months, and then quarterly thereafter for one year. The results of this audit will be reviewed by the QA committee overseen by the ED and DNS. If a threshold of 95% or greater is not achieved an action plan will be developed. By what date the systematic change will be completed: May 3, 2016		