

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2015
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NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122
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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
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: 08/21/15</p> <p>Facility Number: 000057 Provider Number: 155132 AIM Number: 100266570</p> <p>At this Life Safety Code survey, Danville Regional Rehabilitation 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). Building 0102 built prior to March 1, 2003 was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0102 built prior to March 1, 2003 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</p>	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after.	

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 0062 SS=F Bldg. 01	<p>corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system for resident sleeping rooms in the Active Life Transition Unit and in Rooms 201 to 214. The facility has battery operated smoke detectors installed in all other resident sleeping rooms. The facility has a capacity of 110 and had a census of 61 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility has two detached building providing facility services which were not sprinklered.</p> <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, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was inspected every five years as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 10-2.2 states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has</p>	K 0062	<p>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice No residents were found to have beenaffected by the finding.</p> <p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken All residents have the potential to beaffected by the finding. On 9/4/15, Dalmation conducted the</p>	09/20/2015

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	<p>not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor from 9:20 a.m. to 11:40 a.m. on 08/21/15, documentation of an internal pipe inspection performed within the most recent five year period for the facility's automatic sprinkler system was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 12:20 p.m. to 3:00 p.m. on 08/21/15, "Internal Pipe Inspection 05/05/09" was written on the sprinkler system riser but no documentation of what the 05/05/09 inspection entailed or the results of the inspection were available for review. Based on interview at the time of record review and of the observation, the Maintenance Supervisor acknowledged it has been more than five years since the most recent documented internal pipe inspection for the facility's automatic sprinkler system.</p>		<p>internal pipeinspection on the sprinkler system.</p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; The internal pipe inspection has beenadded to the Preventive Maintenance schedule. The Maintenance Director willcontact the appropriate vendor to schedule the internal pipe inspection when itis due.</p> <p>·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; The Executive Director will review andsign the monthly Preventative Maintenance program to ensure all tasks arecompleted. The monthly Preventative Maintenance Performed This Month task listwill be presented during monthly CQI Meetings by the Maintenance Director toensure all tasks are completed.</p>				

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K 0064 SS=F Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 27 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:20 p.m. to 3:00 p.m. on 08/21/15, the inspection tag affixed to the portable fire extinguisher in the Automatic Transfer Switch room indicated February 2014 as the date the most recent annual maintenance was</p>	K 0064	<p>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice No residents were found to have beenaffected by the finding.</p> <p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken All residents have the potential to beaffected by the finding. The fireextinguisher located in the Automatic Transfer Switch room was replaced by Vanguardand is in full working. Monthly inspections on all fire extinguishers will bechecked by the Maintenance Director to ensure they are in working order. TheMaintenance Director will initial the tag on each fire extinguisher to indicateit has been inspected and is in working order, and initial the PreventativeMaintenance Performed This Month form in the Preventive Maintenance manual.</p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;</p>	09/20/2015	

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K 0072 SS=E Bldg. 01	<p>performed. Based on interview at the time of observation, the Maintenance Supervisor stated no other annual fire extinguisher maintenance documentation was available for review and acknowledged the aforementioned portable fire extinguisher did not have documented annual maintenance within the most recent twelve month period.</p> <p>3.1-19(b)</p> <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,</p>		<p>The fire extinguisher located in the Automatic Transfer Switch room was replaced by Vanguard and is in full working. Monthly inspections on all fire extinguishers will be checked by the Maintenance Director to ensure they are in working order. The Maintenance Director will initial the tag on each fire extinguisher to indicate it has been inspected and is in working order, and initial the Preventative Maintenance Performed This Month form in the Preventive Maintenance manual.</p> <p>·how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</p> <p>·The Executive Director will review and sign the monthly Preventative Maintenance program to ensure all tasks are completed. The monthly Preventative Maintenance Performed This Month task list will be presented during monthly CQI Meetings by the Maintenance Director to ensure all tasks are completed ongoing.</p>		

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	<p>decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use for 1 of 16 exit means of egress. This deficient practice could affect 22 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:20 p.m. to 3:00 p.m. on 08/21/15, a three foot high by two foot wide wooden chest of drawers used to store personal protective equipment and supplies for a resident's isolation equipment was stored in the corridor outside Room 138. The aforementioned three drawer chest of drawers was placed against the corridor wall and protruded eighteen inches into the corridor outside the room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged corridor storage in the means of egress was not continuously maintained free of all obstructions or impediments to full instant use at the aforementioned location.</p>	K 0072	<p>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice No resident was found to have a negativeoutcome as a result of the finding.</p> <p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken All residents have the potential to beaffected by the finding. The chest of drawers was removed from the hallway.</p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; The Housekeeping Supervisor/designee will observe each hallway daily to ensure egress is free of obstructions orimpediments and document findings on the Quality ControlInspection-Housekeeping form.</p> <p>·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; To ensure compliance, the HousekeepingSupervisor/designee is responsible for the completion of the Quality ControlInspection-Housekeeping</p>	09/20/2015			

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K 0147 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>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 facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.6 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 1999 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal</p>	K 0147	<p>form daily times 4 weeks, then twice weekly for 6 months until compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI Committee overseen by the E.D. If compliance is not achieved an action plan will be developed to ensure compliance.</p> <p>· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were found to have a negative outcome as a result of the finding.</p> <p>· 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 residents have the potential to be affected by the finding. The power strip was removed from the residents room and the resident was re-educated on not using power strips. The Housekeeping Supervisor/designee will observe 5 random rooms per day to ensure there are no power strips in use. The Housekeeping Supervisor/designee will record the findings of the room audits on the Quality Control</p>	09/20/2015	

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K 0211 SS=E Bldg. 01	<p>location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 24 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:20 p.m. to 3:00 p.m. on 08/21/15, a telephone charger and a radio were plugged into a power strip which was located under the resident bed nearest the corridor door in Room 119. Based on interview at the time of observation, the Maintenance Supervisor acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned location.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide</p>		<p>Inspection-Housekeeping form.</p> <ul style="list-style-type: none"> whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; The Housekeeping Supervisor/designee will observe 5 random rooms per day to ensure there are no power strips in use.The Housekeeping Supervisor/designee will record the findings of the roomaudits on the Quality Control Inspection-Housekeeping form. howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; To ensure compliance, the HousekeepingSupervisor/designee is responsible for the completion of the Quality ControlInspection-Housekeeping form for 5 random rooms daily times 4 weeks, then twice weekly for 6 months until compliance is maintained for 2 consecutive quarters.The results of these audits will be reviewed by the CQI Committee overseen bythe E.D. If compliance is not achieved an action plan will be developed toensure compliance. 		

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	<p>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</p> <p>o The dispensers have a minimum spacing of 4 ft from each other</p> <p>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.</p> <p>o Dispensers are not installed over or adjacent to an ignition source.</p> <p>o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623</p> <p>Based on observation and interview, the facility failed to ensure 5 of over 74 alcohol based hand sanitizers were not installed above an ignition source. NFPA 101, in 19.1.1.3 requires all health facilities to be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 50 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor during a tour of the facility from 12:20 p.m. to 3:00 p.m. on 08/21/15, an alcohol based hand sanitizer was observed installed directly above an ignition source in the following locations:</p> <p>a. above a light switch in Room 201 and Room 205.</p>	K 0211	<p>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice No residents were found to have anegative outcome as a result of the finding.</p> <p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken All residents have the potential to beaffected by the finding. The 5 alcohol dispensers were relocated to meet theguidelines.</p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; Any future alcohol dispensers will behung by the Maintenance Director/designee according to the required guidelines.</p> <p>·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur,</p>	09/20/2015

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K 0000 Bldg. 02	<p>b. above a light mounted in the wall in Room 123 and Room 405.</p> <p>c. above an electrical outlet in the restroom by the Moving Forward nurses' station.</p> <p>Each of the aforementioned hand sanitizer's contained ethyl alcohol as an ingredient as stated on its packaging. Based on interview at the time of the observations, the Maintenance Supervisor acknowledged the aforementioned hand sanitizer locations were alcohol based and were installed directly above an ignition source.</p> <p>3.1-19(b)</p> <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: 08/21/15</p> <p>Facility Number: 000057 Provider Number: 155132 AIM Number: 100266570</p> <p>At this Life Safety Code survey, Danville Regional Rehabilitation was found not in compliance with Requirements for</p>	K 0000	<p>i.e., what quality assurance program will be put into place; The placement of any future alcohol dispensers will be approved by the Maintenance Director to ensure placement according to current guidelines.</p> <p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after.</p>	

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	<p>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). Building 0202 built in 2010 was surveyed with Chapter 18, New Health Care Occupancies.</p> <p>This one story facility was surveyed as two separate buildings due to the construction dates of two sections of the building. Building 0202 consists of the walkway addition, was built after March 1, 2003, 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 corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system for resident sleeping rooms in the Active Life Transition Unit and in Rooms 201 to 214. The facility has battery operated smoke detectors installed in all other resident sleeping rooms. The facility has a capacity of 110 and had a census of 61 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility has two detached buildings providing facility services which were not sprinklered.</p>			

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K 0062 SS=F Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler systems was inspected every five years as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 10-2.2 states systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor during record review from 9:20 a.m. to 11:40 a.m. on 08/21/15, documentation of an internal pipe inspection performed within the most recent five year period for the</p>	K 0062	<p>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice No residents were found to have beenaffected by the finding.</p> <p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken All residents have the potential to beaffected by the finding. On 9/4/15, Dalmation conducted the internal pipeinspection on the sprinkler system.</p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; The internal pipe inspection has beenadded to the Preventive Maintenance schedule. The Maintenance Director willcontact the appropriate vendor to schedule the internal pipe inspection when itis due.</p> <p>·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; The Executive Director will review andsign the monthly Preventative</p>	09/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155132	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/21/2015
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NAME OF PROVIDER OR SUPPLIER DANVILLE REGIONAL REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 255 MEADOW DR DANVILLE, IN 46122
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K 0064 SS=E Bldg. 02	<p>facility's automatic sprinkler system was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 12:20 p.m. to 3:00 p.m. on 08/21/15, "Internal Pipe Inspection 05/05/09" was written on the sprinkler system riser but no documentation of what the 05/05/09 inspection entailed or the results of the inspection were available for review. Based on interview at the time of record review and of the observation, the Maintenance Supervisor acknowledged it has been more than five years since the most recent documented internal pipe inspection for the facility's automatic sprinkler system.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6 Based on observation and interview, the facility failed to ensure 1 of 27 portable fire extinguishers had pressure gauge readings in the acceptable range. LSC 4.5.6 requires any fire protection system, building service equipment, feature of protection or safe guard provided for life safety shall be designed, installed and approved in accordance with applicable NFPA standards. NFPA 10, the Standard</p>	K 0064	<p>Maintenance program to ensure all tasks are completed. The monthly Preventative Maintenance Performed This Month task list will be presented during monthly CQI Meetings by the Maintenance Director to ensure all tasks are completed.</p> <p>·what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice No residents were found to have been affected by the finding. ·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 residents have the potential to be affected by the finding. The</p>	09/20/2015

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	<p>for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect ten residents, staff and visitors in the Therapy Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:20 p.m. to 3:00 p.m. on 08/21/15, the pressure gauge on the portable fire extinguisher affixed to a hanger on the wall in the Therapy Room by the storage room showed the extinguisher was undercharged. The inspection tag on the portable fire extinguisher listed the most recent annual inspection was February 2015 and the most recent monthly inspection was August 2015. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned Therapy Room portable fire extinguisher pressure gauge indicated the fire extinguisher was undercharged.</p> <p>3.1-19(b)</p>		<p>fireextinguisher located in the Automatic Transfer Switch room was replaced by Vanguardand is in full working. Monthly inspections on all fire extinguishers will bechecked by the Maintenance Director to ensure they are in working order. TheMaintenance Director will initial the tag on each fire extinguisher to indicateit has been inspected and is in working order, and initial the PreventativeMaintenance Performed This Month form in the Preventive Maintenance manual.</p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; The fire extinguisher located in theAutomatic Transfer Switch room was replaced by Vanguard and is in full working.Monthly inspections on all fire extinguishers will be checked by theMaintenance Director to ensure they are in working order. The MaintenanceDirector will initial the tag on each fire extinguisher to indicate it has beeninspected and is in working order, and initial the Preventative MaintenancePerformed This Month form in the Preventive Maintenance manual.</p> <p>·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance</p>		

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			<p>program will be put into place;</p> <p>The Executive Director will review and sign the monthly Preventative Maintenance program to ensure all tasks are completed. The monthly Preventative Maintenance Performed This Month task list will be presented during monthly CQI Meetings by the Maintenance Director to ensure all tasks are completed ongoing.</p>		