

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A014	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2012
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NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
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K0000	<p>A Life Safety Code Recertification, State Licensure and a Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/16/12</p> <p>Facility Number: 000274 Provider Number: 15A014 AIM Number: 100271660</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Vernon Manor Children's Home 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) and 410 IAC 16.2. The original section of the building consisting of Daliha Lane, Rose Harbor, Babbling Brook, Hanson Blvd., Dotties Dream and the Service hall was surveyed with</p>	K0000	<p>This plan of correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this plan of correct is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by the state and Federal law. Vernon Manor Children's Home desires this Plan of Correctio to be considered the facility's allegation of compliance.</p> <p>Compliance is effective on 8/03/2012</p>	

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>Chapter 19, Existing Health Care Occupancies</p> <p>This original section of this one story facility was determined to be of Type II (111) construction and was sprinklered. A service hall and the 300 hall was of Type V (111) construction and was sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors. Hard wired smoke detectors were provided in the resident rooms. The facility has a capacity of 119 and had a census of 89 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to smoke detector and sprinkler coverage.</p> <p>All areas where residents have customary access were sprinklered.</p> <p>A detached storage building used for the storage of nursing supplies was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/20/12.</p>				

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	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0025 SS=E	<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 could affect any number of staff in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Supervisor on 07/16/12 at 12:18 p.m., as viewed from the attic, there is a one foot by one foot section of drywall missing near the ventilation pipe for the water heater located in the water heater</p>	K0025	<p>It is the policy of this facility to maintain ceiling smoke barriers to provide a one half hour fire resistance rating.</p> <p>1. <u>What corrective action will be done by the facility for those residents found to have been affected by this practice?</u> No residents were affected by this practice.</p> <p>2. <u>How will the facility identify other residents who could have been affected by the practice.</u> This was located in a non-resident area. No residents had the potential to be affected.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> Maintenance Supervisor was re-educated on regulation K025 on 7/23/12. The ceiling was repaired.</p> <p>4. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Excutive</p>	08/03/2012			

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	room in the Service hall. This was acknowledged by the Environmental Supervisor at the time of observation. 3.1-19(b)		Director/Designee will observe ceiling in water heater room during rounding weekly xs 4 weeks, monthly x 2 months, than randomly thereafter. Results of the monitoring will be taken to Safety Committee monthly x 6 months.. Safety Committee minutes will be reviewed at QA. Further need for monitoring will be determined by Safety Committee and approved by QA. Date of compliance: 8/03/ 2012		

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K0044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 3 of 5 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect any number of residents.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 07/16/12 from 11:57 a.m. to 2:32 p.m., the following fire door sets did not latch into the frame: near the medication room on Babbling Brook, Hanson Blvd. near resident</p>	K0044	<p>It is the policy of the facility to maintain fire door sets that latch into the frame.</p> <p>1. <u>What corrective action will be done by the facility for those residents found to have been affected by this practice?</u> No residents were affected by this practice.</p> <p>2. <u>How will the facility identify other residents who could have been affected by the practice.</u> This practice could affect residents living on Hanson Blvd. and those resident who eat in the Persimmon Dining Room. No residents are living on Babbling Brook.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> Maintenance Supervisor was re-educated on regulation K044 on 7/23/12. The fire doors were re-adjusted to latch into the frame.</p> <p>4. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Maintenance Supervisor /Designee will observe closing of fire doors during rounding weekly xs 4 weeks,with monthly fire drills on going and Random inspections will be completed throughout the month on going.. Results of the monitoring will be taken to Safety committee monthly</p>	08/03/2012

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	room 204, and at Persimmon dining room on Babbling Brook. Based on an interview with the Environmental Supervisor at the time of observation, these doors were confirmed to be fire doors. 3.1-19(b)		x 6 months. Safety Committee minutes will be reviewed at QA. Further need for monitoring will be determined by Safety Committee and approved by QA. <u>Date of compliance:</u> 8/03/ 2012		

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K0056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 4 of 10 sprinkler heads in the activity room in Rose Harbor 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 any resident in the Rose Harbor activity room in the event of a fire emergency.</p> <p>Findings include:</p> <p>Based on observations with the Environmental Supervisor on 07/16/12 at 12:50 p.m., two sprinkler heads near the closet on</p>	K0056	<p>It is the policy of this facility for the automatic sprinkler systems to be installed in accordance with NFPA 13</p> <p>1. <u>What corrective action will be done by the facility for those residents found to have been affected by this practice?</u> No residents were affected by this practice.</p> <p>2. <u>How will the facility identify other residents who could have been affected by the practice.</u> In the event of a fire emergency this practice could have affect any resident in the Rose Harbor activity Room.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> Maintenance Supervisor was re-educated on regulation K056 on 7/23/12. VFP Fire Systems was schedulded to relocate the necessary sprinkler heads on 8/2/12 An audit was conducted of all</p>	08/03/2012	

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	<p>the west side of the Rose Harbor activity room were mounted forty eight inches apart, and two sprinkler heads near the exit door in the Rose Harbor activity room were mounted forty eight inches apart. Based on an interview with the Environmental Supervisor at the time of observations, a corridor wall had been removed to enlarge the activity room.</p> <p>3.1-19(b)</p>		<p>sprinkler heads in the facility and no others were found to be less that 6 ft. apart.</p> <p><u>4. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> . When walls are removed Maintenance Supervisor will measure the distance between sprinkler heads to ensure they are at least six feet apart. Measurements will be reported to the Excutive Director. When this occurs, results of the monitoring will be brought to Safety Committee. Safety Committee minutes will be reviewed at QA. Further need for monitoring will be determined by Safety Committee committee and approved by QA.</p> <p><u>Date of compliance:</u> 8/03/ 2012</p>		

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K0064 SS=E	<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 maintain 1 of 1 K-Class portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This</p>	K0064	<p>It is the policy of this facility to maintain proper signage identifying K class fire extinguishers as secondary to the automatic fire suppression systems.</p> <p>1. <u>What corrective action will be done by the facility for those residents found to have been affected by this practice?</u> No residents were affected by this practice.</p> <p>2. <u>How will the facility identify other residents who could have been affected by the practice.</u> This was located in a non-resident area. No residents had the potential to be affected.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> Maintenance Supervisor and Dietary Supervisor was re-educated on regulation K064 on 7/23/12. the placard identifying the K-Class fire extinguisher as secondary backup to the Kitchen automatic fire suppression system was palced by the K-Class extinguisher.</p> <p>4. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Dietary Supervisor/Designee will observe the placard weekly xs 4 weeks, monthly x 2 months than randomly</p>	08/03/2012			

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	<p>deficient practice could affect any residents evacuated through the corridor exit that runs along side the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 07/16/12 at 12:55 p.m., the kitchen K-Class fire extinguisher lacked a placard. Based on an interview with the Environmental Supervisor at the time of observation, the kitchen K-Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen automatic fire suppression system.</p> <p>3.1-19(b)</p>		<p>thereafter. Dietary Supervisor will report to Maintenance Supervisor if it has been removed for replacement. Results of the monitoring will be taken to Safety Committee Meeting monthly x 6 months. Safety Committee minutes will be reviewed at QA. Further need for monitoring will be determined by Safety Committee and approved by QA.</p> <p>Date of compliance: 8/03/ 2012</p>		

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K0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gas was secured in a rack or fastened securely to prevent accidental damage. NFPA 99, Health Care Facilities, 4-3.1.1.2(a)3, Storage Requirements for nonflammable gases requires provisions shall be made for racks or fastenings to protect cylinders from accidental damage or dislocation. This deficient practice could affect any resident near the maintenance office on Babbling Brook.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Supervisor on 07/16/12 at 1:15 p.m., there was an unsupported helium cylinder in the restroom of the maintenance office. This was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K0130	<p>It is the policy of this facility to ensure nonflammable gas cyhinders are secured.</p> <p>1. <u>What corrective action will be done by the facility for those residents found to have been affected by this practice?</u> No residents were affected by this practice.</p> <p>2. <u>How will the facility indentify other residents who could have been affected by the practice.</u> Any resident passing through Babbling Brook near the Maintenance office had the potential to be affected.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> Maintenance Supervisor was re-educated on regulation K130 on 7/23/12. The helium Cylinder was secured /fastened by chaining the cylinder to the wall.</p> <p>4. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> . Excutive Director/Designee will observe the helium cylinder during rounding weekly xs 4 weeks, monthly x 2 months, than randomly thereafter. Results of the monitoring will be taken to the Safety Committee monthly x 6 months.Safety Committee minutes will be reviewed at QA. Further need for monitoring will be determined by Safety</p>	08/03/2012	

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	<p>Occupancies</p> <p>This original section of this one story facility was determined to be of Type II (111) construction and was sprinklered. A service hall and the 300 hall was of Type V (111) construction and was sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors. Hard wired smoke detectors were provided in the resident rooms. The facility has a capacity of 119 and had a census of 89 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to smoke detector and sprinkler coverage.</p> <p>All areas where residents have customary access were sprinklered.</p> <p>A detached storage building used for the storage of nursing supplies was not sprinklered.</p> <p>The facility was found not in compliance with the</p>				

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	aforementioned regulatory requirements as evidenced by the following:				

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K0044 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 fire door sets on the 300 wing was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice affects any number of the 44 residents on the 300 wing.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Supervisor on 07/16/12 at 2:32 p.m., the center fire door set near resident room 308 on Kalor Court did not latch into the frame upon activation of the fire alarm. this was</p>	K0044	<p>It is the policy of the facility to maintain fire door sets that latch into the frame.</p> <p>1. <u>What corrective action will be done by the facility for those residents found to have been affected by this practice?</u> No residents were affected by this practice.</p> <p>2. <u>How will the facility indentify other residents who could have been affected by the practice.</u> This practice could affect residents living on Hanson Blvd. and those resident who eat in the Persimmon Dining Room. No residents are living on Babbling Brook.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> Maintenance Supervisor was re-educated on regulation K044 on 7/23/12. The fire doors were re-adjusted to latch into the frame.</p> <p>4. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Maintenance Supervisor /Designee will observe closing of fire doors during rounding weekly xs 4 weeks,with monthly fire drills on going and Random inspections will be completed throughout the month on going.. Results of the monitoring will be taken to Safety committee monthly</p>	08/03/2012			

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	<p>acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>x 6 months. Safety Committee minutes will be reviewed at QA. Further need for monitoring will be determined by Safety Committee and approved by QA.</p> <p><u>Date of compliance:</u> 8/03/ 2012</p>		

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K0047 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed with continuous illumination also served by the emergency lighting system in accordance with section 7.10. 18.2.10.1.</p> <p>Based on observation and interview, the facility failed to ensure a continuously illuminated exit sign, where the exit or way to reach the exit was not apparent, was immediately visible for 1 of 4 ways to the exit from the 300 wing. LSC 7.10.1.4 requires access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not apparent to the occupants. This deficient practice could affect any residents evacuating through the Cherry Blossom dining room on the 300 wing in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Supervisor on 07/16/12 at 11:35 a.m., there was no illuminated exit sign above the door leading to the outside from the Cherry Blossom dining room. Based on an interview with</p>			K0047	<p>It is the policy of this facility to display illuminated exit signs when the way to an exit is not apparent.</p> <p>1. <u>What corrective action will be done by the facility for those residents found to have been affected by this practice?</u> No residents were affected by this practice.</p> <p>2. <u>How will the facility identify other residents who could have been affected by the practice.</u> No residents had the potential to be affected this door is not an not used as an emergency exit per disaster plan. An audit was completed of exits doors signage no other was found.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> Maintenance Supervisor was re-educated on regulation K047 and the disaster Plan on 7/23/12. A not an exit sign was placed on the door in the Cherry Blossom Dining room .</p> <p>4. <u>How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> Maintenance Supervisor/Designee will observe the signage weekly xs 4 weeks, monthly x 2 months than</p>		08/03/2012

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	<p>the Maintenance Supervisor at the time of interview, this door is using as an emergency exit.</p> <p>3.1-19(b)</p>		<p>randomly thereafter. Maintenance Supervisor will replace the signage if it has been removed. Results of the monitoring will be taken to Safety Committee Meeting monthly x 6 months. Safety Committee minutes will be reviewed at QA. Further need for monitoring will be determined by Safety Committee and approved by QA.</p> <p><u>Date of compliance:</u> 8/03/ 2012</p>		

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K0143 SS=E	<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 oxygen stored in 1 of 1 sprinklered oxygen storage/transfer locations was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction and where electrical fixtures were at least 5 feet above the floor. NFPA 99, 8-3.1.1.1.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed</p>	K0143	<p>It is the policy of this facility to store Oxygen according to NFPA 99 and the Compressed Gas Association.</p> <p>1. <u>What corrective action will be done by the facility for those residents found to have been affected by this practice?</u> No residents were affected by this practice.</p> <p>2. <u>How will the facility identify other residents who could have been affected by the practice.</u> No residents Live on Babbling Brook. Any resident near the oxygen transferring room could have been affected. This is the only location that oxygen is stored in the facility.</p> <p>3. <u>What measures will be put into place to ensure this practice does not recur?</u> Maintenance Supervisor was re-educated on regulation</p>	08/03/2012

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	<p>locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect any residents near the oxygen transferring room on the new section of Babbling Brook in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 07/16/12 at 11:55 a.m., the oxygen transferring room had one large liquid oxygen storage tank placed in the room with one electrical receptacle on the wall forty eight inches above the floor. This was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>K0143on 7/23/12. The electrical receptacle on the wall was re-installed in a fixed loction at 5 feet</p> <p><u>4. How will the corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>When installing electrical receptacle in an oxygen storage area the maintenance supppervisor will measure the location in the presents of the Excutive Director toensure the fixed location is at least 5 feet from the floor. Results of the monitoring will be taken toSafety Committee Meeting monthly x 6 months. Safety Committee minutes will be reviewed at QA. Further need for monitoring will be determined by Safety Committee and approved by QA.</p> <p><u>Date of compliance:</u> 8/03/ 2012</p>		