

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155625	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2014
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NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/21/14</p> <p>Facility Number: 000305 Provider Number: 155625 AIM Number: 100287200</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Arbor Grove Village 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 fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 89 and had a census of 81 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except one wooden storage shed.</p>	K010000	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.	

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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K010018 SS=E	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/24/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 3 of 45 resident room corridor doors would latch and resist the passage of smoke. This deficient practice affects 6 residents who reside in resident room 212, resident room 106, and resident room 308.</p> <p>Findings include:</p> <p>Based on observations on 04/21/14 during a tour of the facility from 10:15 a.m. to 3:00 p.m. with the maintenance supervisor, resident room 212, 106 and 308 each had</p>	K010018	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The doors have been repaired by the maintenance director and now have no issues with gapping or latching. All doors were inspected and no other doors have been identified as having issues. 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</p>	05/02/2014
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K010025 SS=E	<p>between a three quarter inch and one inch gap along the top and latching sides of the doors with the doors closed. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the 3:00 p.m. exit conference on 04/21/14.</p> <p>3.1-19(b)</p> <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</p>		<p>affected by the alleged deficient practice. The doors have been repaired by the maintenance director and now have no issues with gapping or latching. All doors were inspected and no other doors have been identified as having issues. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: Maintenance director and/or designee, upon routine rounds will ensure that all doors appropriately close and latch without gapping. 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 plan: This will be monitored through the monthly fire drills and the environment CQI conducted monthly for six months to ensure that all doors properly close and latch without gapping. Any issues identified during the routine monitoring will be addressed timely by the Maintenance Director and/or designee. This will be reviewed by Quality Assurance Committee and action plans developed for any area lower than 90 % (ninety percent).</p>	

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	<p>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 100 room wall smoke barriers and 1 of 1 ceiling smoke barriers were 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 30 residents who use the main dining room, located adjacent to the kitchen and 18 residents who reside on the 200 Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 04/21/14 during a tour of the facility from 10:15 a.m. to 3:00 p.m., the kitchen storage room ceiling had a three inch gap around a square metal heating duct penetration with no fire stopping material. Furthermore, the 200 Hall mechanical room south wall had a six foot by three foot area of drywall missing with wooden studs exposed. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 04/21/14 at 3:00 p.m.</p> <p>3.1-19(b)</p>	K010025	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: All smoke barriers were corrected so that each area identified is now fire stopped by the maintenance supervisor. All smoke barriers inspected by maintenance supervisor, no other areas identified. 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 alleged deficient practice. All smoke barriers were corrected so that each area identified is now fire stopped by the maintenance supervisor. No other areas identified. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: Routine rounds will be conducted by the maintenance supervisor and/or designee to ensure that all smoke barriers are properly fire stopped. How the corrective actions will be monitored to ensure the deficient practice will not recur, ie: What quality assurance programs will</p>	05/02/2014

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K010027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 4 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice affects 43 residents who use the Therapy Hall and reside on the 400 Hall and 400 L Hall.</p>	K010027	<p>be put into place. This will be monitored through the environmental CQI on a monthly basis for six months. All areas identified on the environmental CQI will be addressed timely by the maintenance supervisor and/or designee. It will be reviewed by the Quality Assurance Committee and action plans will be developed for any area with a threshold lower than 90 % (ninety percent).</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: The actuator was repaired by the maintenance supervisor so that the smoke barrier doors close without gapping. The coordinator was repaired by the maintenance supervisor so that the smoke barrier doors close without gapping. All smoke barrier doors have been inspected and no other areas identified. How other residents having the potential to be affected by the same deficient</p>	05/02/2014	

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	<p>Findings include:</p> <p>Based on observations on 04/21/14 during a tour of the facility from 10:15 a.m. to 3:00 p.m. with the maintenance supervisor, the following smoke barrier doors failed to close and form a smoke tight barrier:</p> <p>a. The Kitchen Hall smoke barrier door had a one inch gap along the latching side of the door with the door in the closed position.</p> <p>b. The 400 L Hall set of smoke barrier doors had a three inch gap along the edge where the doors met.</p> <p>c. The Therapy Hall set of smoke barrier doors had a one foot opening where the north door was propped open by the floor and failed to close completely.</p> <p>d. The 400 Hall set of smoke barrier doors had a one foot opening where the west door was propped open by the floor and failed to close completely.</p> <p>This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 04/21/14 at 3:00 p.m.</p> <p>3.1-19(b)</p>		<p>practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the alleged deficient practice. The actuator was repaired by the maintenance supervisor so that the smoke barrier doors close without gapping. The coordinator was repaired by the maintenance supervisor so that the smoke barrier doors close without gapping. All smoke barriers have been inspected and no other areas identified. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: Smoke barrier doors will be inspected during monthly fire drills to ensure proper functioning without gapping by the maintenance supervisor and/or designee. 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 plan: This will be monitored through the monthly fire drills and the environment CQI monthly for six months. All issues identified through monitoring will be addressed timely by the maintenance supervisor and/or designee. This will be reviewed monthly by the Quality Assurance Committee and action plans will be developed for areas under 90 % (ninety percent).</p>				

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K010029 SS=E	<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 the corridor doors to 2 of 13 hazardous areas, such as storage rooms for combustibles over 50 square feet in size, were provided with a self closing device which would cause the doors to automatically close and latch into the door frame. This deficient practice affects 17 residents who reside on the Cottage Hall and 8 residents who use the Center Hall near the medical records storage room.</p> <p>Findings include:</p> <p>Based on observations on 04/21/14 during a tour of the facility from 10:15 a.m. to 3:00 p.m. with the maintenance supervisor, the Cottage Hall soiled linen room door had a two inch gap along the latching side of the door in the closed position and failed to latch into the door frame. Furthermore, the Center Hall medical records storage room, which measured one hundred twenty square feet and stored sixteen cardboard boxes of paper medical records, lacked a self closing device.</p>	K010029	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Self closing device was installed on the door to the affected area by the alleged deficient practice by the maintenance supervisor. All other areas were inspected and no others were identified as being affected. 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 alleged deficient practice. Self closing device was installed on the door to the affected area by the alleged deficient practice by the maintenance supervisor. All other areas were inspected and no others were identified as being affected. What measures will be put in place or what systematic changes will be made to ensure</p>	05/02/2014

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K010038 SS=E	<p>This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 04/21/14 at 3:00 p.m.</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 the sidewalk surface on 5 of 9 exit sidewalks was maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice could affect 3 residents who use the therapy room at a</p>	K010038	<p>that the deficient practice does not recur: Routine rounds will be conducted to ensure that all areas requiring self closing device will have these devices installed by the maintenance director and/or designee. 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 plan: This will be monitored through the environmental CQI monthly for six months. Any issued identified during the routine monitoring will be addressed timely by the Maintenance Director and/or designee. It will be reviewed by the Quality Assurance Committee and any areas below 90 % will have an action plan developed.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice:Corrective actions will be accomplished for those residents found to have been affected by the deficient practice regarding needed repairs of exterior sidewalks and paths. Contractor for the projects has been identified as Bane Masonry and Construction. Contract has been signed 5/1/2014, work to begin before 5/15/2014 and to be completed by 5/21/2014. All</p>	05/21/2014

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	<p>time, 30 residents who would use the front exit, 10 residents who would use the 100 Hall exit, and 30 residents who would use the main dining room exit.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 04/21/14 during a tour of the facility from 10:15 a.m. to 3:00 p.m., the following sidewalk surfaces were not maintained;</p> <p>a. The Therapy exit sidewalk had four, six foot sections of concrete sidewalk starting twenty five feet from the exit door which were pitted with one inch depressions, and broken and heaving with one inch elevation changes.</p> <p>b. The front entrance sidewalk had a two foot by six inch section of sidewalk located twenty feet from the parking lot which was broken and heaving with one inch elevation changes.</p> <p>Furthermore, the eight paving stones located on each side of the bridge were loose fitting and moving over an inch while walking over the sidewalk surface.</p> <p>c. The main dining room sidewalk had a four foot by one foot area of concrete broken and heaving over an inch through the gate.</p> <p>d. The employee breakroom exit sidewalk had a four foot by six foot section of concrete with over an inch in elevation change located ten feet from the exit door.</p> <p>e. The 100 Hall exit sidewalk had a twelve foot section of concrete located twenty feet from the exit door which was pitted with one inch depressions.</p> <p>The pitted, broken and heaving sidewalk surfaces were verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 04/21/14 at 3:00 p.m.</p>		<p>areas have been inspected and no other areas identified. 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 alleged deficient practice. Corrective actions will be accomplished for those residents found to have been affected by the deficient practice regarding needed repairs of exterior sidewalks and paths. Contractor for the projects has been identified as Bane Masonry and Construction. Contract has been signed 5/1/2014, work to begin before 5/15/2014 and to be completed by 5/21/2014. All areas have been inspected and no other areas identified. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: Rounds will be conducted by the Maintenance Director and/or designee to ensure compliance monthly for six months then routinely throughout the year. 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 plan: This will be monitored through the environmental CQI monthly for six months. Any issued identified through monitoring will be addressed timely by</p>	

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K010046 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 5 battery backup lights was tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. 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 17 residents who reside on the Cottage Hall if the emergency generator battery backup light failed during a power outage.</p> <p>Findings include:</p> <p>Based on record review on 04/21/14 at 9:30 a.m. with the maintenance supervisor, the Emergency Lighting Log was reviewed and indicated four battery backup lights throughout the facility. Based on a tour of the</p>	K010046	<p>the Maintenance Supervisor and/or designee. It will be reviewed by the Quality Assurance Committee and any areas below 90% (ninety percent) will have an action plan developed.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Battery back up light mounted on outside wall of Auguste's Cottage nurse's station exit has now been added to the Emergency Lighting Log and has been tested for the annual 90 minutes by the maintenance supervisor. All Emergency Lighting has been inspected and no further issues identified. 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 alleged deficient practice. Battery back up light mounted on outside wall of Auguste's Cottage nurse's station exit has now been added to the Emergency Lighting Log and has been tested for the annual 90 minutes by the maintenance supervisor. All Emergency Lighting has been inspected and no further issues identified. What</p>	05/02/2014

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K010062 SS=F	<p>facility with the maintenance supervisor on 04/21/14 from 10:15 a.m. to 3:00 a.m., the Cottage Hall nurses' station exit had a battery backup light mounted on the outside wall. Furthermore, the Cottage Hall nurses' station exit battery backup light was not on the Emergency Lighting Log and was not tested monthly or annually for 90 minutes the past year. This was verified by the maintenance supervisor at the time of record review and observation, and acknowledged by the administrator at the exit conference on 04/21/14 at 3:00 p.m.</p> <p>3.1-19(b)</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 observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 requires supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall</p>	K010062	<p>measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: This will now be tested monthly and annually per Emergency Lighting Log procedures. 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 plan: This will be monitored through the environmental CQI monthly for six months. Any issues identified through monitoring will be addressed timely by the Maintenance Director and/or supervisor. It will be reviewed by the Quality Assurance Committee and any areas below 90% (ninety percent)will have an action plan developed.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Spare sprinklers have now been obtained with a minimum of two sprinklers of each type and temperature rating and are located in the 200 hall sprinkler riser room by the maintenance supervisor. We have inspected and we have verified we do have</p>	05/02/2014

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NAME OF PROVIDER OR SUPPLIER ARBOR GROVE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1021 E CENTRAL AVE GREENSBURG, IN 47240
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	<p>be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observations on 04/21/14 during the tour of the facility from 10:15 a.m. to 3:00 p.m. with the maintenance supervisor, red liquid filled quick response pendant sprinklers with a temperature rating of 160 degrees F were in all resident rooms and the main dining room.</p> <p>Based on observation of the spare sprinkler cabinet located in the 200 Hall sprinkler riser room on 04/21/14 at 1:10 p.m. with the maintenance supervisor, there were no red liquid filled quick response pendant sprinklers in the spare sprinkler cabinet. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 04/21/14 at 3:00 p.m.</p> <p>3.1-19(b)</p>		<p>a minimum of two sprinkler of each type and temperature rating in the 200 hall sprinkler riser room. 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 alleged deficient practice. Spare sprinklers have now been obtained with a minimum of two sprinklers of each type and temperature rating and are located in the 200 hall sprinkler riser room by the maintenance supervisor. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: In order to ensure inventory is met, Maintenance director will inspect the cabinet located in the 200 hall sprinkler riser room cabinet during routine rounds. 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 plan: This will be monitored through the monthly fire drills and the environment CQI monthly for six months. All issues identified through monitoring will be addressed timely by the maintenance supervisor and/or designee. This will be reviewed monthly by the Quality Assurance Committee and action plans will be developed for areas under 90 %</p>	

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K010211 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. 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>Based on observation and interview, the facility failed to ensure 2 of 21 alcohol based hand rub dispensers were not located over an ignition source. This deficient practice affects 30 residents who use the activity room at a time.</p> <p>Findings include:</p> <p>Based on observations on 04/21/14 at 2:10 p.m. with the maintenance supervisor, the activity room had a one liter alcohol based hand sanitizer dispenser mounted on the wall directly above electrical outlets outside of the activity director office, and inside of the activity director office. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 04/21/14 at 3:00 p.m.</p>	K010211	(ninety percent). What corrective action will be accomplished for those residents found to have been affected by the deficient practice: A one liter alcoholic based hand sanitizer dispenser mounted on the wall directly above the electric outlets both inside and outside the activity director office have been removed. They were remounted appropriately away from electrical outlet by the maintenance supervisor. All other areas have been inspected, and no others were identified as being affected. 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	05/02/2014	

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	3.1-19(b)		alleged deficient practice. A one liter alcoholic based hand sanitizer dispenser mounted on the wall directly above the electric outlets both inside and outside the activity director office have been removed. They were remounted appropriately away from electrical outlet by the maintenance supervisor. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice does not recur: Routine rounds will be conducted by the Maintenance supervisor and/or designee to ensure compliance. How the corrective actions will be monitored to ensure the deficient will no reoccur, ie: What quality assurance programs will be put into place: This will be monitored through the environmental CQI on a monthly basis for six months. All areas identified on the environmental CQI will be addressed timely by the maintenance supervisor. It will be reviewed by the Quality Assurance Committee and action plans will be developed for any area will a threshold lower than 90 % (ninety percent).	