

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/04/2018

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 03/20/2018
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-KNOX	STREET ADDRESS, CITY, STATE, ZIP CODE 300 E CULVER RD KNOX, IN 46534
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 03/20/18</p> <p>Facility Number: 000088 Provider Number: 155686 AIM Number: 100289260</p> <p>At this Emergency Preparedness survey, Golden Living Center - Knox was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 57 certified beds. At the time of the survey, the census was 39.</p> <p>Quality Review completed on 03/22/18 - DA</p>	E 0000		
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 483.90(a).</p> <p>Survey Date: 03/20/18</p> <p>Facility Number: 000088 Provider Number: 155686 AIM Number: 100289260</p> <p>At this Life Safety Code survey, Golden Living</p>	K 0000	This Plan of Correction is prepared and executed as a means to continually improve the quality of care and to comply with all applicable State and Federal regulatory requirements.	

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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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 0221 SS=D Bldg. 01	<p>Center-Knox was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 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 III (211) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms were provided with battery powered smoke detectors. The facility has the capacity for 57 and had a census of 39 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. One detached storage shed was unsprinklered.</p> <p>Quality Review completed on 03/22/18 - DA</p> <p>NFPA 101 Patient Sleeping Room Doors Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 Based on observation, the facility failed to ensure 1 of 1 locked doors could be readily unlocked in accordance with LSC 19.2.2.2.6 which allows doors that are located in the means of egress and are permitted to be locked under other provisions of 19.2.2.2.5 shall comply with the following. (1)</p>	K 0221	1.Room # 13 door handle was replaced with a non-locking passage door handle unit. Room # 13 keypad dead bolt was disabled so that dead bolt is permanently non-operational.	04/19/2018

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K 0222 SS=D Bldg. 01	<p>Provisions shall be made for the rapid removal of occupants by means of one of the following: (a) Remote control of locks (b) Keying of all locks to keys carried by staff at all times (c) Other such reliable means available to the staff at all times. This deficient practice could affect up to 2 residents.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Supervisor on 03/20/18 at 1:20 p.m., resident room 13 corridor door contained a door knob and a dead bolt lock. Based on interview at the time of observation, the Executive Director and the Maintenance Supervisor stated the resident room was previously used as an office. They also confirmed that no one had a key to unlock the lock.</p> <p>3.1-19(b)</p> <p>NFPA 101 Egress Doors Egress Doors</p> <p>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING</p> <p>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or</p>		<p>2.All resident door handle units were inspected during the 3-20-2018 survey process and there were no other identified door handle unit concerns.</p> <p>3.Executive Director will inspect all resident room passage door units 1 X monthly for 6 months. Resident passage door handle units, if determined replacement necessary, will be replaced with non-locking passage units as approved by Executive Director.</p> <p>4.Results of inspections will be tracked through QAPI committee monthly to ensure compliance. Upon any identified concerns, monitoring/audits will be completed based on QAPI recommendations.</p> <p>5.Completion date April 19, 2018</p>	

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	<p>other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p>SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p>DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4</p> <p>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</p>			

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	<p>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>Based on observation, record review, and interview, the facility failed to ensure 1 of 1 Service Hall exit had a code posted. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. LSC 19.2.2.2.5.2 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Supervisor on 03/20/18 at 1:15 p.m., the Service Hall exit door was held in the locked position with a magnetic hold down device. Furthermore, the exit door was equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. A code was not posted at the entrance/exit door. Based on an interview at the time of observation, the Executive Director and the Maintenance Supervisor was unaware the code was missing.</p> <p>3.1-19(b)</p>	K 0222	<p>1.Exit code for identified service door was replaced immediately on 3-20-2018.</p> <p>2. There are three additional electric entry door keypads which were inspected during the 3-20-2018 survey process with no identified concerns.</p> <p>3.Maintenance Director/Designee will inspect all 4 electric keypad entry/exits 1 X weekly for 8 weeks, then 1 X monthly thereafter.</p> <p>4.Results of inspections will be tracked through QAPI committee monthly to ensure compliance. Upon any identified concerns, monitoring/audits will be completed based on QAPI recommendations.</p> <p>5.Completion date April 19, 2018</p>	04/19/2018
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K 0293 SS=D Bldg. 01	<p>NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on record review and interview; the facility failed to provide 2 of 4 corridor means of egress that was obvious and clearly identifiable as an exit in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. This deficient practice could affect staff and at least 11 residents.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Supervisor on 03/20/18 at 1:10 p.m. then again at 1:37 p.m., the South Service Hall smoke barrier double doors contained an illuminated EXIT sign and a stop sign indicating occupants to not use the exit. Then again, the Kitchen smoke barrier double doors contained an illuminated EXIT sign and a stop sign indicating occupants to not use the exit. Based on interview at the time of observation, the Executive Director and the Maintenance Supervisor acknowledged the stop signs and exit signs contradicting each other.</p> <p>3.1-19(b)</p>	K 0293	<p>1. Stop signs on South service hall and Kitchen service hall smoke barrier doors were removed immediately on 3-20-2108. 2. There are no other Service hall smoke barriers doors in the facility. 3. Maintenance Director/Designee will inspect the South service hall and Kitchen service hall smoke barrier doors 1 X weekly for 8 weeks, then 1 X monthly for 4 months. 4. Results of inspections will be tracked through QAPI committee monthly to ensure compliance. Upon any identified concerns, monitoring/audits will be completed based on QAPI recommendations. 5. Completion date April 19, 2018</p>	04/19/2018	

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K 0300 SS=F Bldg. 01	<p>NFPA 101 Protection - Other Protection - Other</p> <p>List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in resident rooms in 4 of 4 smoke compartments was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Executive Director and the Maintenance Supervisor on 03/20/18 at 11:31 a.m., the battery operated smoke alarm maintenance documentation failed to indicate smoke alarm and/or battery replacement. Based on interview at the time of record review, the Maintenance Supervisor stated at least one smoke alarm had failed within the previous week and confirmed the smoke alarm and/or battery replacement was not documented.</p> <p>3.1-19(b)</p>	K 0300	<p>1.Maintenance Director replaced the smoke detector batteries, cleaned and tested the smoke detectors in 100% of resident rooms and documented all on the Battery-Operated Smoke Detector Maintenance Log.</p> <p>2.Maintenance Director/Designee will clean, test, and replace as identified, resident room smoke detectors monthly. Documentation of inspections will be recorded on the Battery-Operated Smoke Detector Maintenance Log and this will be on-going.</p> <p>3.Executive Director/Designee will review the Battery-Operated Smoke Detector Maintenance Log for monthly compliance of testing, cleaning and needed battery replacements for 6 months.</p> <p>4.Results of inspections will be tracked through QAPI committee monthly to ensure compliance. Upon any identified concerns, monitoring/audits will be completed based on QAPI recommendations.</p> <p>5.Completion date April 19,</p>	04/19/2018	

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K 0346 SS=C Bldg. 01	<p>NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.</p> <p>9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Executive Director and the Maintenance Supervisor on 03/20/18 between 12:53 p.m. and 2:24 p.m., the facility provided fire watch documentation but it was incorrect. The plan stated the fire watch would be started 10 hours in the 24 hour period. Based on an interview, the Executive Director and the Maintenance Supervisor acknowledged fire watch policy and later discovered an updated correct fire watch policy.</p> <p>3.1-19(b)</p>	K 0346	<p>2018</p> <p>1.Maintenance Director placed the current Fire Watch Policy in the West Nurse Station Emergency Preparedness binder on 3-20-2018.</p> <p>2. There are 4 additional facility Emergency Preparedness binders. All 4 were inspected and the current Fire Watch Policy was located in all 4 binders.</p> <p>3.All 5 of facility Emergency Preparedness binders will be inspected annually by the Maintenance Director to ensure current Fire Watch Policy is in place for all 5 binders.</p> <p>4.Results of inspections will be tracked through QAPI committee monthly to ensure compliance. Upon any identified concerns, monitoring/audits will be completed based on QAPI recommendations.</p> <p>5.Completion date April 19, 2018</p>	04/19/2018	

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K 0353 SS=F Bldg. 01	<p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 HVAC (Heating, Ventilation and Air Conditioning) rooms. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Supervisor on 03/20/18 between 12:53 p.m. and 2:24 p.m., the facility had at least thirteen grated ceiling tiles that were not smoke resistive. Based on interview at the time of observation, the Executive Director and the</p>	K 0353	<p>1. Ceiling grate adjacent to the sprinkler head is to be moved to a distance of more than 36 inches in the service hallway. The distance between the sprinkler heads and the ceiling is 5 inches. The facility is constructed in accordance with NFPA 13 2000 8.15.1.2.1.1. The ceiling contains a concealed space as defined by 8.15.1.2 which is used as an air plenum as defined in 8.15.1.2.2.1. This space is constructed of non combustibile and limited combustibile construction with limited combustibile loading. The 13 grates are a part of the air plenum assembly and original to</p>	04/19/2018
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K 0372 SS=F Bldg. 01	Maintenance Supervisor acknowledged the ceiling tiles that allow air to pass through. 3.1-19(b) NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.		the facility construction in accordance with 8.15.1.2.2.1. The system services only the corridors between smoke door assemblies and does not service or penetrate the resident rooms. 2. There were no additional ceiling grates identified other than those identified during the 3-20-2018 survey process. 3. Maintenance Director will review ceiling assembly annually to ensure no changes in construction have occurred and advise Executive Director of the annual inspection. 4. Results of inspections will be tracked through QAPI committee monthly to ensure compliance. Upon any identified concerns, monitoring/audits will be completed based on QAPI recommendations. 5. Completion date April 19, 2018		

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K 0781 SS=D Bldg. 01	<p>19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 3 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect all occupants open to the Main Dining room.</p> <p>Findings include:</p> <p>Based on observations with the Executive Director and the Maintenance Supervisor on 03/20/18 at 2:11 p.m., two separate one inch penetrations in the Dining room smoke barrier above the drop ceiling was noted. Based on interview at the time of observation, the Executive Director and the Maintenance Supervisor acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b) NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failed to ensure 1 of 1 space heater was in</p>	K 0372	<p>1.The 2 identified penetrations through the smoke barrier were filled with 4 hour intumescent caulk on 3-20-2018.</p> <p>2. There are 2 additional smoke barrier walls which were inspected at the time of the 3-20-2018 survey with no deficiency identified.</p> <p>3.Maintenance Director/Designee will Bi-Annually inspect the smoke barrier walls to ensure smoke barriers are intact per LCS Section 19.3.7.5.</p> <p>4.Results of inspections will be tracked through QAPI committee monthly to ensure compliance. Upon any identified concerns, monitoring/audits will be completed based on QAPI recommendations.</p> <p>5.Completion date April 19, 2018</p>	04/19/2018	
			K 0781	<p>1.The identified space heater was removed from the facility.</p>	04/19/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0920 SS=E Bldg. 01	<p>accordance with 19.7.8. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Supervisor on 03/20/18 at 1:41 p.m., a space heater was discovered in the Housekeeping office. Based on interview at the time of observation, the Executive Director and the Maintenance Supervisor was unaware the space heater was in the building and was unable to provide documentation that the heating element does not exceed 212 degrees.</p> <p>NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed</p>		<p>2.Executive Director completed 100% inspection of all service and social areas with no additional identified concerns.</p> <p>3.Maintenance Director/Designee will inspect all facility service and social areas 1 X monthly for any space heaters.</p> <p>4.Results of inspections will be tracked through QAPI committee monthly to ensure compliance. Upon any identified concerns, monitoring/audits will be completed based on QAPI recommendations.</p> <p>5.Completion date April 19, 2018</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155686	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/20/2018
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	<p>wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5</p> <p>Based on observation, record review, and interview, the facility failed to install 1 of 1 power strip according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 110.3(B) Installation and Use, states listed or labeled equipment shall be installed and used in accordance with any instructions included in the listing or labeling. This deficient practice affects staff and up to 14 residents.</p> <p>Findings include:</p> <p>Based on observation with the Executive Director and the Maintenance Supervisor on 03/20/18 at 2:02 p.m., a surge protector was powering resident electronics directly below the bed in resident room 32. Based on interview at the time of observation, the Executive Director and the Maintenance Supervisor confirmed the surge protector should not have been there.</p> <p>3.1-19(b)</p>	K 0920	<p>1.The identified power strip was removed from the resident room and replaced with fixed wiring to accommodate the resident's need.</p> <p>2.Executive Director inspected 100% resident rooms for power strips and no additional power strips were identified.</p> <p>3.Maintenance Director/Designee will inspect all resident rooms 1 X weekly for 8 weeks, then 1 X monthly for 4 months.</p> <p>4.Results of inspections will be tracked through QAPI committee monthly to ensure compliance. Upon any identified concerns, monitoring/audits will be completed based on QAPI recommendations.</p> <p>5.Completion date April 19, 2018</p>	04/19/2018	