STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155157	A. BUILDING -- B. WING	08/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-RICHMOND	1042 OAK DR RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/04/20 Facility Number: 000077 Provider Number: 155157 AIM Number: 100266490 At this Emergency Preparedness survey, Golden Living Center-Richmond was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 122 certified beds. At the time of the survey, the census was 57. Quality Review completed on 08/12/20	E 0000		
K 0000 Bldg. 01	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). Survey Date: 08/04/20 Facility Number: 000077 Provider Number: 155157 AIM Number: 100266490 At this Life Safety Code survey, Golden Living Center-Richmond was found not in compliance	K 0000	Preparation, submission and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all federal and state requirements. Golden Living Centers- Golden Living Richmond respectfully	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	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. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 122 and had a census of 57 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has two detached wooden storage sheds which were not sprinkled. Quality Review completed on 08/12/20		requests a paper compliance desk review for the completion and compliance of the Plan of Correction. Thank you, Rachel Armstrong HFA	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 1 of 7 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be	K 0232	1.No residents were affected by this alleged deficient practice. 2.The alleged deficient practice could potentially affect all residents who reside on the	09/01/2020

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	permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 19 residents, visitor and staff on TCU. Findings include: Based on observation on 08/04/20 during the tour between 12:29 p.m. to 3:00 p.m. with the Maintenance Supervisor (MS) the exit corridor next to laundry which measured eight feet wide, had three large tables, a desk and a set of lockers limiting the corridor width to 4 1/2 feet. Based on interview at the time of the observation and		Transitional Care Unit and any staff or visitors who may be present on the unit as well. 3.The tables, lockers and desk that were noted to be limiting the clearance of the corridor have been removed. 4.The maintenance Director or his designee will monitor all corridors to ensure that the clearance of all corridors are maintained and any fixture that is in a corridor is fixed in place without limiting the clearance to less than 6 feet 5 times a week for 4 weeks; weekly for 2 months; and 2 times a month for 3 months. (See Attachment K-232) All audits will be presented in the monthly QAPI meeting for review and further recommendations as warranted until compliance is maintained for 6 consecutive months.	

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	measurement with the MS and with the Administrator, it was acknowledged the items stored in the corridor limited corridor access to less than six feet. This finding was reviewed with the Administrator at the exit conference 3.1-19(b)			
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 emergency battery backup lights was tested monthly for 30 seconds and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) 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 at least 5 staff. Findings include: Based on observation on 08/04/20 at 2:11 p.m. with the Maintenance Supervisor (MS), a Battery Operated Emergency Light located outside the	K 0291	1.No residents or staff were affected by this alleged deficient practice. 2.The alleged deficient practice could have potentially affected 5 staff members. 3.The battery operated emergency light located outside of the service entrance has been removed. This entrance was already equipped with an emergency light that was hardwired to the generator at the time of the inspection therefore the battery operated light was no longer required. All other exit doors are equipped with emergency backup lighting that is hardwired directly to the generator. 4.The Maintenance Director or his designee will conduct monthly inspections to ensure that all battery powered emergency lighting devices are inspected and	09/01/2020

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	Service entrance failed to function when tested. Based on an interview at the time of observation the MS indicated he was unaware the emergency battery powered light did not work. This finding was reviewed with the Administrator at the exit conference 3.1-19(b)		tested for at least 30 seconds every month and at least annually for 90 minutes and will verify documentation of said tests is in place monthly for 6 months. (See Attachment K 291) All audits will be presented in the monthly QAPI meeting for review and further recommendations as warranted until compliance is maintained for 6 consecutive months.	
K 0293 SS=E Bldg. 01	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 install exit signage in 1 of 7 corridors 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. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect 25 residents, visitors and staff. Findings include:	K 0293	1.No residents or staff were affected by this alleged deficient practice. 2.The alleged deficient practice could have potentially affected all residents and staff within the building. 3.The facility will place exit signs on both sides of the fire doors on the Extended Care Unit and the Transitional Care Unit. All other fire doors in the facility have been observed and are noted to have the proper exit signage visible on both sides of the doors.	09/01/2020

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	Based on observation with the Maintenance Supervisor (MS) on 08/04/20 at 1:28 p.m. the horizontal exit smoke doors on ECU and TCU halls were not provided with an exit sign on both sides of the smokewalls to indicate pathway to an exit. Based on interview at the time of observation, the MS acknowledged there were no directional exit signs on both sides of the smokewalls to indicate path of travel to an exit. This finding was reviewed with the Administrator at the exit conference 3.1-19(b)		**4.** The Maintenance Director or his designee will conduct walking rounds to ensure the appropriate exit signage is located on both sides of all fire doors throughout the facility. (See Attachment K 293) All audits will be presented in the monthly QAPI meeting for review and further recommendations as warranted until compliance is maintained for 6 consecutive months.	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			

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	Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchens. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff. Findings include: Based on observation on 08/04/20 at 2:29 p.m. with the Maintenance Supervisor (MS), the Kitchen contained a UL 300 hood system above the gas stove. Based on interview, the Dietary staff was asked "what is the first and second thing to do if there was a grease fire on the gas stove underneath the UL 300 hood system". Dietary staff replied "turn burner off, put a lid on it and get an extinguisher". Staff did not know about first pulling the ring to activate the UL 300 hood system to extinguish the fire and subsequently the "K" cylinder if the UL 300 system did not put out the fire. This finding was reviewed with the Administrator at the exit conference 3.1-19(b)	K 0324	1.No residents or staff were affected by this alleged deficient practice. 2.The alleged deficient practice could have potentially affected all of the kitchen staff. 3.The kitchen staff have been re-educated on the steps that should occur if there were to be a grease fire on the gas stove under the UL 300 hood system. The kitchen staff voiced understanding and acknowledgement of the actions to be taken should a grease fire occur. 4.The Maintenance Director or his designee will conduct interviews with one kitchen employee to ensure they are aware of the proper actions that should occur if there is to be a grease fire on the gas stove under the UL 300 hood system 5 times a week for 4 weeks; weekly for 2 months; and 2 times a month for 3 months. (See Attachment K 324) All audits will be presented in the monthly QAPI meeting for review and further recommendations as warranted until compliance is maintained for 6 consecutive months.	09/01/2020
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined,			

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	recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed for the protection of 57 of 57 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 08/04/20 at 11:59 a.m. with the Maintenance Supervisor (MS), the facility provided Fire Watch Policy and Procedure documentation but it was incomplete. The Fire Watch Policy and Procedure plan failed to include contacting the Insurance carrier, Owner/Operator and Heads of staff. Furthermore, the facility failed to include calling back all entities once the sprinkler system had been restored to normal working condition. This was confirmed by the MS at the time of record review.	K 0354	1.No residents or staff were affected by this alleged deficient practice. 2.The alleged deficient practice could potentially affect all residents and staff within the facility. 3.The Fire Watch Policy was reviewed and has been updated to include direction to provide notification to the facility insurance carrier, owner/operator and heads of staff upon determination of a sprinkler impairment as well as notification to the aforementioned entities/individuals upon the restoration of the sprinkler system. (See Attachment K-354) 4.The Maintenance Director or his designee will ensure that notification to said entities and individuals occurs per the policy should the need arise. The New policy and procedure related to Fire Watch will be presented in the next scheduled monthly QAPI meeting for review and further recommendations as warranted.	09/01/2020

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	This finding was reviewed with the Administrator at the exit conference 3.1-19(b)			
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers was installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect staff only. Findings include: Based on observation on 08/04/20 at 1:54 p.m. with the Maintenance Supervisor (MS), the K portable fire extinguisher mounted on the wall in the Kitchen was measured to be sixty eight inches from the floor to the top of the extinguisher. Based on interview at the time of observation, the MS stated he was unaware of this requirement and would remount the fire extinguisher to within five feet from the floor. This finding was reviewed with the Administrator at the exit conference 3.1-19	K 0355	1.No residents or staff were affected by this alleged deficient practice. 2.The alleged deficient practice could potentially affect all staff within the facility. 3.The fire extinguisher located in the kitchen has been lowered to the correct height. All other portable fire extinguishers in the facility have been visually inspected to ensure they meet the appropriate height requirement. 4.During regular rounds the facility Maintenance Director will visually inspect and measure to ensure that all portable fire extinguishers are at the proper 5-foot height. (See Attachment K-355) The alleged deficient practice will be discussed during our next QAPI meeting and reviewed monthly until compliance is maintained for 6 consecutive months.	09/01/2020
K 0363 SS=E	NFPA 101 Corridor - Doors			

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Bldg. 01	Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing			

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	devices, etc. Based on observation and interview, the facility failed to ensure 1 of 2 Kitchen corridor doors would close completely and latch into the door frame. This deficient practice could affect at least 5 staff on Service hall. Findings include: Based on observation on 08/04/20 at 1:28 p.m. with the Maintenance Supervisor (MS) the door leading into the Kitchen from the employee service hall would close and clash against the door frame preventing the door from latching. Based on interview concurrent with the observation with the MS it was agreed the corridor door leading into the Kitchen needed to be adjusted so not to rub the door frame. This finding was reviewed with the Administrator at the exit conference 3.1-19(b)	K 0363	1.No residents or staff were affected by this alleged deficient practice. 2.The alleged deficient practice could potentially affect any employee who would happen to be located on the service hall. 3.The Maintenance Director inspected the doors and a new door has been ordered to replace the side that would not properly latch. The door will be installed upon its arrival. 4.The Maintenance Director or his designee will conduct inspections to all fire doors to ensure proper closure occurs when doors are shut weekly for 3 months then monthly for 3 months. (See Attachment K 363) All audits will be presented in the monthly QAPI meeting for further review and recommendations as warranted until compliance is maintained for 6 consecutive months.	09/01/2020
K 0920 SS=D Bldg. 01	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) assembles 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			

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	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 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 Based on observation and interview, the facility failed to ensure proper use of power strips and extension cords in 3 of 3 rooms observed. This deficient practice could affect at least 2 residents, visitors and staff. Findings include: Based on observations on 08/04/20 during the tour between 12:43 p.m. to 2:14 p.m. with the Maintenance Supervisor (MS), a power strip was misused to power a microwave and coffee pot maker in the Clean utility room by the ECU Nurse's station and a power strip was used between resident beds A and B in resident room 35 to power a light. Lastly, an extension cord was used in the Maintenance office to power electrical equipment. Based on interview concurrent with the observations with the MS, the misuse of the power strips and extension cord described was confirmed. This finding was reviewed with the Administrator at the exit conference	K 0920	1.No residents or staff were affected by this alleged deficient practice. 2.The alleged deficient practice could potentially affect 2 residents, visitors and staff. 3.The power strip located in the clean utility room was removed and the power strip located in room 35 was replaced with UL1363A power strips. The extension cord noted to be in the maintenance office was removed. 4.The maintenance Director has conducted additional facility rounds to ensure that all power cords being utilized are in accordance with NFPA 101 guidance. The maintenance Director or his designee will conduct rounds to ensure that if surge protectors are utilized they meet the requirements set forth by NFPA 101 weekly for 4 weeks;	09/01/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155157	A. BUILDING 01 B. WING	08/04/2020

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	3.1-19(b)		twice a month for 2 months and then monthly for 3 months. (See Attachment K 920) All audits will be presented in the monthly QAPI meeting for further review and recommendations as warranted until compliance is maintained for 6 consecutive months.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) 1. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfilling rooms had concrete or ceramic flooring. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated, is sprinklered, and have ceramic or concrete flooring. This deficient practice could affect 20 residents, visitors and staff on ECU hall. Findings include: Based on observation on 08/04/20 at 2:14 p.m. with the Maintenance Supervisor, the oxygen transfilling room on ECU hall had vinyl tile extended three inches into the oxygen room from	K 0927	1.No residents or staff were affected by this alleged deficient practice. 2.The alleged deficient practice could potentially affect any residents staff or visitors on the Extended Care Unit. 3.The 3 inches of vinyl floor noted to be extending into the room from the corridor was removed. The dry wall will be replaced with one-hour fire rated materials. The maintenance Director has inspected other areas within the facility to ensure that	09/01/2020

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	the corridor. Based on interview, this was verified by the Maintenance Supervisor at the time of observation. This finding was reviewed with the Administrator at the exit conference 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer location was provided with 1 hour fire-resistive construction and a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1 (1) states, a designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction and (3) states, the area is posted with signs indicating that transfilling is occurring and that smoking is the immediate area is not permitted. This deficient practice could affect residents, staff and visitors while in the same smoke compartment as the oxygen room which was located on ECU Hall. Findings include: Based on observation on 08/04/20 at 2:15 p.m. with the Maintenance Supervisor (MS), the liquid oxygen storage/transfer room had four liquid oxygen containers stored in the room. The wall switch had been removed and replaced with a plastic plate which was removed by the MS to reveal the wall was constructed of a single sheet of five eighths inch thick drywall, with a one half hour fire-resistive construction. This was verified by the MS at the time of observation. This finding was reviewed with the Administrator at the exit conference 3.1-19(b)		fire rated materials are utilized per the requirements. 4.The maintenance Director will continue to conduct monthly facility rounds to ensure that all areas requiring 1-hour fire protection continue to have the proper materials utilized to meet this requirement. (See Attachment 927) All audits will be presented in the monthly QAPI meeting for further review and recommendations as warranted until compliance is maintained for 6 consecutive months.	

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