| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155684 | A. BUILDING -- B. WING | 12/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SOUTHFIELD VILLAGE | 6450 MIAMI CIR SOUTH BEND, IN 46614 |

| (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<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 12/02/24<br><br>Facility Number: 002662<br>Provider Number: 155684<br>AIM Number: 200315930<br><br>At this Emergency Preparedness survey, Southfield Village was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 60 certified beds. At the time of the survey, the census was 50.<br><br>Quality Review completed on 12/04/24 | E 0000 | This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction 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 state and federal law. | |
| E 0018<br>SS=F<br>Bldg. -- | 403.748(b)(2), 416.54(b)(1), 418.113(b)(<br>Procedures for Tracking of Staff and Patients<br><br>Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures included a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all residents and staff.<br><br>Findings include: | E 0018 | A policy and procedure has been developed for tracking residents and staff, to support the already existing work sheets, to be used during an emergency event.<br><br>No other emergency preparedness policies and procedures were found to be missing.<br><br>All staff will be in-serviced on the new staff and resident tracking procedure by the Director of Maintenance or his designee. | 12/31/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Joseph M. Doran | Administrator | 12/19/2024 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155684 | A. BUILDING -- B. WING | 12/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SOUTHFIELD VILLAGE | 6450 MIAMI CIR SOUTH BEND, IN 46614 |

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| | Based on record review and interview with the Administrator and Lead Maintenance from 9:55 a.m. to 12:45 p.m. on 12/02/24, no policies or procedures that included a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency was available for review. Based on interview at the time of record review, the Administrator located a form to be used for tracking residents and on-duty staff but stated no policy or procedure was available.<br><br>This finding was reviewed with the Administrator and Lead Maintenance at the exit conference. | | With the next scheduled fire drill, licensed nurses will be asked to complete the existing forms in their designated work areas in conjunction with the new policy. The facility Quality Assessment and Process Improvement Committee (QAPI) will assure the plan of correction is completed. | |
| K 0000<br><br>Bldg. 01 | A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 12/02/24<br><br>Facility Number: 002662<br>Provider Number: 155684<br>AIM Number: 200315930<br><br>At this Life Safety Code survey, Southfield Village, 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. The 2020 Therapy addition was evaluated under Life Safety Code (LSC), Chapter 18, New Health Care Occupancies. | K 0000 | This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction 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 state and federal law. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155684 | A. BUILDING 01<br>B. WING | 12/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SOUTHFIELD VILLAGE | 6450 MIAMI CIR<br>SOUTH BEND, IN 46614 |

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| | This one-story facility was determined to be of Type V (111) construction, with a 2020 Therapy addition with Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The hard-wired smoke detection in the resident sleeping rooms is not supervised by the fire alarm system. The facility is connected to a three story Assisted Living facility, from which it is separated by a Fire Wall with a 2-Hour Fire Resistive Rating. The original facility and the 2020 addition are separated by a Fire Wall with a 1-hour Fire Resistive Rating. The Healthcare facility is fully protected by a diesel powered 200 kW generator. The facility has 60 certified beds. At the time of the survey, the census was 50.<br><br>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.<br><br>Quality Review completed on 12/04/24 | | | |
| K 0324 SS=E Bldg. 01 | NFPA 101<br>Cooking Facilities<br><br>1.) Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer | K 0324 | The floor under the hood has been labeled to designate where each piece of equipment should be located. The Ansul system pull station has been lowered to the appropriate height.<br><br>There are no other range hoods in the building that can be affected by this requirement for either the labeling or pull station height. | 12/31/2024 |

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| | 155684 | A. BUILDING 01<br>B. WING | 12/02/2024 |

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| | or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff only.<br><br>Findings include:<br><br>Based on observation and interview with the Lead Maintenance from 12:50 p.m. to 3:05 p.m. on 12/02/24, cooking appliances including a gas burner stove with an oven and a flat-top grill located under the hood in the kitchen, was not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and/or cleaning. Based on interview at the time of observation with the Lead Maintenance, the facility was not aware of a method provided to ensure that the appliances were returned to an approved design location after maintenance or cleaning.<br><br>2.) Based on observation and interview, the facility failed to maintain 1 of 1 kitchen extinguishing system in accordance with NFPA 96, Standard for Ventilation and Fire Protection of Commercial Cooking Operations, Section 10.5.1 states A readily accessible means for manual | | The Culinary Manager or his designee will in-service the staff regarding the labeling and necessary location of all equipment under the range hood. Additionally, the Culinary Manager or his designee will inspect the location of the equipment each time a piece of equipment must be moved, to assure the proper location. The Ansul pull station is an immovable device and it does not require any additional follow up since it has been lowered. The facility's Quality Assurance and Process Improvement (QAPI) Committee will assure the plan of correction is completed. | |

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| | 155684 | A. BUILDING 01<br>B. WING | 12/02/2024 |

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| | activation shall be located between 42 in. and 48 in. above the floor, be accessible in the event of a fire, be located in a path of egress, and clearly identify the hazard protected. This deficient practice could affect kitchen staff only.<br><br>Findings include:<br><br>Based on observation and interview with the Lead Maintenance from 12:50 p.m. to 3:05 p.m. on 12/02/24, the kitchen extinguishing system "Pull Station" was mounted 59 inches above the floor next to the door leading out of the kitchen. Based on interview at time of observation, the Lead Maintenance acknowledged the height of the pull station when measured with a tape measure and stated, "it should be 48 inches."<br><br>These findings were reviewed with the Administrator and Lead Maintenance at the exit conference.<br><br>3.1-19(b) | | | |
| K 0918 SS=F Bldg. 01 | NFPA 101<br>Electrical Systems - Essential Electric Syste<br><br>Based on record review, observation, and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 | K 0918 | The emergency generator has been tested under load for 4 hours.<br><br>There are no other generators that could be affected by this practice.<br><br>To prevent reoccurrence, the 4-hour test, to be conducted every 36 months, has been entered into the facility's preventative maintenance software by the Director of Maintenance. | 12/31/2024 |

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| | 155684 | A. BUILDING 01<br>B. WING | 12/02/2024 |

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| | states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Administrator and Lead Maintenance from 9:55 a.m. to 12:45 p.m. on 12/02/24, documentation was not available to show a 36-month period test for 4 continuous hours for the diesel emergency generator. Based on interview at the time of record review, the Administrator and Lead Maintenance stated they were not certain a 4-hour test of the generator had been completed in the last 36 months. They confirmed no documentation was available to show the test had been completed after the Administrator and Lead Maintenance each looked through documentation binders.<br><br>This finding was reviewed with the Administrator and Lead Maintenance at the exit conference.<br><br>3.1-19(b) | | Additionally, the Director of Maintenance or his designee will in-service Maintenance personnel on this requirement. The facility's Quality Assurance and Process Improvement (QAPI) Committee will assure the plan of correction is completed. | |
| K 0920 SS=E Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires | K 0920 | The power strip was removed from room #109 and the multi-plug adaptor from room #319. | 12/31/2024 |

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| | 155684 | A. BUILDING 01<br>B. WING | 12/02/2024 |

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| | electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects residents in 2 of 56 resident sleeping rooms.<br><br>Findings include:<br><br>Based on observation and interview with the Lead Maintenance from 12:50 p.m. to 3:05 p.m. on 12/02/24, 1) in resident room 109, a white extension cord, a clock and a lamp were supplied power by a power strip with an unknown UL listing that was plugged into a wall receptacle next to the resident bed, also in the same room approximately 3 feet from the foot of the bed was a television and lamp plugged into a multi-plug adapter that was plugged into a wall receptacle. 2) in resident room 314 a lamp, a radio and 2 table-top fans were supplied power by a multi-plug adapter that was plugged into a wall receptacle. Based on interview at time of observation the Lead Maintenance stated he was not able to determine a UL listing for the power strip in resident room 109. At the time of observation, the Maintenance Lead removed the power strip and extension cord from resident room 109 and plugged the lamp and clock directly into a wall receptacle.<br><br>This finding was reviewed with the Administrator and Lead Maintenance at the exit conference.<br><br>3.1-19(b) | | An inspection was conducted of all other rooms located in the skilled nursing unit, no other power cords, multi-plug adaptors or extension cords were found.<br><br>To prevent reoccurrence, the Administrator will send a letter to all responsible parties, asking them to not bring in any device that violates this standard. The Director of Maintenance or his designee will inspection each room located withing the skilled nursing unit, with each fire drill conducted over the next 60 days. This will continue to 100% compliance is achieved. The facility's Quality Assurance and Process Improvement (QAPI) Committee will assure the plan of correction is completed. | |
| K 0000<br><br>Bldg. 02 | | | | |

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|---|---|---|---|
| | 155684 | A. BUILDING 02<br>B. WING | 12/02/2024 |

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| | A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 12/02/24<br><br>Facility Number: 002662<br>Provider Number: 155684<br>AIM Number: 200315930<br><br>At this Life Safety Code survey, Southfield Village, 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. The 2020 Therapy addition was evaluated under Life Safety Code (LSC), Chapter 18, New Health Care Occupancies.<br><br>This one-story facility was determined to be of Type V (111) construction, with a 2020 Therapy addition with Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The hard-wired smoke detection in the resident sleeping rooms is not supervised by the fire alarm system. The facility is connected to a three story Assisted Living facility, from which it is separated by a Fire Wall with a 2-Hour Fire Resistive Rating. The original facility and the 2020 addition are separated by a Fire Wall with a 1-hour Fire Resistive Rating. The Healthcare facility is fully protected by a diesel powered 200 kW generator. The facility has 60 certified beds. At the time of the survey, the census was 50. | K 0000 | This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction 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 state and federal law. | |

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| | 155684 | A. BUILDING 02<br>B. WING | 12/02/2024 |

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| | All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.<br><br>Quality Review completed on 12/04/24 | | | |
| K 0918 SS=F Bldg. 02 | NFPA 101<br>Electrical Systems - Essential Electric Syste<br><br>Based on record review, observation, and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Administrator and Lead Maintenance from 9:55 a.m. to 12:45 p.m. on 12/02/24, documentation was not available to show a 36-month period test for 4 | K 0918 | The emergency generator has been tested under load for 4 hours.<br><br>There are no other generators that could be affected by this practice.<br><br>To prevent reoccurrence, the 4-hour test, to be conducted every 36 months, has been entered into the facility's preventative maintenance software by the Director of Maintenance. Additionally, the Director of Maintenance or his designee will in-service Maintenance personnel on this requirement. The facility's Quality Assurance and Process Improvement (QAPI) Committee will assure the plan of correction is completed. | 12/31/2024 |

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| | continuous hours for the diesel emergency generator. Based on interview at the time of record review, the Administrator and Lead Maintenance stated they were not certain a 4-hour test of the generator had been completed in the last 36 months. They confirmed no documentation was available to show the test had been completed after the Administrator and Lead Maintenance each looked through documentation binders.<br><br>This finding was reviewed with the Administrator and Lead Maintenance at the exit conference.<br><br>3.1-19(b) | | | |
| K 0000<br><br>Bldg. 03 | A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).<br><br>Survey Date: 12/02/24<br><br>Facility Number: 002662<br>Provider Number: 155684<br>AIM Number: 200315930<br><br>At this Life Safety Code survey, Southfield Village, 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. The 2020 Therapy addition was evaluated under Life Safety Code (LSC), Chapter 18, New Health Care Occupancies. | K 0000 | This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction 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 state and federal law. | |

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| | 155684 | A. BUILDING 03<br>B. WING | 12/02/2024 |

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| SOUTHFIELD VILLAGE | 6450 MIAMI CIR<br>SOUTH BEND, IN 46614 |

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|---|---|---|---|---|
| | This one-story facility was determined to be of Type V (111) construction, with a 2020 Therapy addition with Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The hard-wired smoke detection in the resident sleeping rooms is not supervised by the fire alarm system. The facility is connected to a three story Assisted Living facility, from which it is separated by a Fire Wall with a 2-Hour Fire Resistive Rating. The original facility and the 2020 addition are separated by a Fire Wall with a 1-hour Fire Resistive Rating. The Healthcare facility is fully protected by a diesel powered 200 kW generator. The facility has 60 certified beds. At the time of the survey, the census was 50.<br><br>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered.<br><br>Quality Review completed on 12/04/24 | | | |
| K 0918 SS=F Bldg. 03 | NFPA 101<br>Electrical Systems - Essential Electric Syste<br><br>Based on record review, observation, and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least | K 0918 | The emergency generator has been tested under load for 4 hours.<br><br>There are no other generators that could be affected by this practice.<br><br>To prevent reoccurrence, the 4-hour test, to be conducted every 36 months, has been entered into the facility's preventative maintenance software by the | 12/31/2024 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155684 | A. BUILDING 03<br>B. WING | 12/02/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SOUTHFIELD VILLAGE | 6450 MIAMI CIR<br>SOUTH BEND, IN 46614 |

| (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 |
|---|---|---|---|---|
| | once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Administrator and Lead Maintenance from 9:55 a.m. to 12:45 p.m. on 12/02/24, documentation was not available to show a 36-month period test for 4 continuous hours for the diesel emergency generator. Based on interview at the time of record review, the Administrator and Lead Maintenance stated they were not certain a 4-hour test of the generator had been completed in the last 36 months. They confirmed no documentation was available to show the test had been completed after the Administrator and Lead Maintenance each looked through documentation binders.<br><br>This finding was reviewed with the Administrator and Lead Maintenance at the exit conference.<br><br>3.1-19(b) | | Director of Maintenance. Additionally, the Director of Maintenance or his designee will in-service Maintenance personnel on this requirement. The facility's Quality Assurance and Process Improvement (QAPI) Committee will assure the plan of correction is completed. | |