STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155734	A. BUILDING -- B. WING	07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THORNTON TERRACE HEALTH CAMPUS	188 THORNTON RD HANOVER, IN 47243

(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 Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/17/23 Facility Number: 004075 Provider Number: 155734 AIM Number: 200491220 At this Emergency Preparedness survey, Thornton Terrace Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 55 certified beds. At the time of the survey, the census was 38. Quality Review completed on 07/20/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/17/23 Facility Number: 004075 Provider Number: 155734 AIM Number: 200491220 At this Life Safety Code survey, Thornton Terrace	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Miller	Executive Director	08/03/2023

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.

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	Health Campus 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. This one story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors, and resident rooms 221, 222, 223, 224, and 225, plus battery operated smoke alarms in all other resident rooms. The healthcare portion of the facility has a capacity of 55and had a census of 38 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 07/20/23			
K 0131 SS=F Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout			

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	by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure 2 of 2 sets of fire doors in the two, 2 hour fire separation walls between the Assisted Living section of the facility and the skilled health care section of the facility closed fully and latched when tested several times. LSC 8.3.3.1 states openings required to have a fire protection rating of 1 1/2 hour in a 2 hour fire wall or partition shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives. 8.3.3.2.2 states all products required shall bear an approved label. This deficient practice could affect all residents. Findings include: Based on observation on 07/17/23 between 12:15 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations from a sister facility, the two sets of 90 minute rated fire doors between the Assisted Living unit and the Skilled Care unit, which are part of the two separate, two hour fire walls that separate the Assisted Living section and the skilled health care section of the facility did not latch when tested several times. Based on interview at the time of each observation, this was acknowledged by the	K 0131	**The submission of this plan of correction does not indicate an admission by Thornton Terrace Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Thornton Terrace Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.** **Corrections to be completed by 8/1/23**	08/01/2023

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	Director of Plant Operations. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)		K131 Fire door not latching Skilled to Assisted Living No residents were affected by this alleged deficient practice. Skilled to Assisted Living door immediately fixed. Director of Plant Operations audited skilled nursing fire doors with no further findings Director of Plant Operations educated on tag K131 As a measure of ongoing compliance, skilled fire doors will be audited by Director of Plant Operations/Executive Director or Designee once a week for two months then twice monthly for four months. Findings and corrective action will be reviewed and updated as warranted by the QAPI committee. The results of these audits will be reviewed by QA committee overseen by the Executive Director if a threshold of 100% is not achieved an action plan will be developed. The facility through the QAPI program will review update and make changes to POC as needed for sustaining substantial compliance.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC			

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	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. 1. Based on observation and interview, the facility failed to replace battery operated smoke alarms installed in at least 15 of the 32 resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations on 07/17/23 between 12:15 p.m. and 2:30 p.m. while performing record review, the Director of Plant Operations from a sister facility brought in a several resident room battery operated smoke alarms. Most of the resident room battery operated smoke alarms had manufactured dates of 05/2000 or 12/2012. At least two resident room battery operated smoke alarms had manufactured dates of 04/2015. Based on interview at the time of observation of the smoke alarms, the Director of Plant Operations confirmed most smoke alarms had manufactured dates of 05/2000 and 12/2012 and agreed they were past due for replacement. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference.	K 0300	**The submission of this plan of correction does not indicate an admission by Thornton Terrace Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Thornton Terrace Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.** **Corrections to be completed by 8/1/23**	08/01/2023

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	3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in 32 of 32 resident sleeping rooms 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 residents, staff and visitors. Findings include: Based on record review on 07/17/23 between 9:15 a.m. and 12:15 p.m. with the Director of Plant Operations from a sister facility present, the battery operated smoke alarm maintenance documentation failed to indicate battery replacement. Based on interview at the time of record review, the Director of Plant Operations said he was not sure if the batteries in the resident room smoke alarms had been replaced, but agreed it was not listed on the preventative maintenance documentation. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)		K300: Failed to replace battery power smoke alarms within 10years of manufacture date. Battery replacement needs documented annually No residents were affected by this alleged deficient practice Smoke alarms identified immediately changed Smoke alarms audited and further findings replaced Educated Director of Plant Operations on documentation showing battery replacement annually. Further Director of Plant Operations educated on changing smoke alarms every ten years from manufacture's date As a measure of ongoing compliance, skilled smoke alarms will be audited by Director of Plant Operations/Executive Director/Designee once a week for two months then twice monthly for four months. Findings and corrective action will be reviewed and updated as warranted by the QAPI committee. The results of these audits will be reviewed by QA committee overseen by the Executive Director if a threshold of 100% is not achieved an action plan will be developed. The facility through the QAPI program will review update and make changes to POC as needed for sustaining	

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			substantial compliance.	
K 0353 SS=E Bldg. 01	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. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ 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 ensure the ceiling in 2 of 5 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect at least 20 residents, staff, and visitors. Findings include: Based on observations on 07/17/23 between 12:15 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations from a sister facility, the sprinkler heads in the Housekeeping Office and storage room next to resident room 225 had escutcheon rings hanging down at least two inches which left a one half inch gap around the sprinkler pipe to the attic space at both locations.	K 0353	**The submission of this plan of correction does not indicate an admission by Thornton Terrace Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Thornton Terrace Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The**	08/01/2023

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	Based on interview at the time of each observation, the Director of Plant Operations acknowledged the escutcheon rings were hanging down to low and created a one half inch gap around the sprinkler pipe to the attic space at both locations. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)		**facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.** **Corrections to be completed by 8/1/23** No residents were affected by this alleged deficient practice Sprinkler head escutcheon ring in housekeeping office, storage room next to resident room 225 immediately fixed Director of Plant Operations audited sprinkler head escutcheon rings with no further findings Director of Plant Operations educated on sprinkler head escutcheon rings need to be affixed to the ceiling As a measure of ongoing compliance, escutcheon rings will be audited by Director of Plant Operations/Executive Director or Designee once a week for two months then twice monthly for four months. Findings and corrective action will be reviewed and updated as warranted by the QAPI	

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			committee. The results of these audits will be reviewed by QA committee overseen by the Executive Director if a threshold of 100% is not achieved an action plan will be developed. The facility through the QAPI program will review update and make changes to POC as needed for sustaining substantial compliance.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 2 set of smoke barrier doors which swing in the same direction and equipped with an astragal have a properly functioning coordinator to ensure the door which must close first always closes first. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include:	K 0374	**The submission of this plan of correction does not indicate an admission by Thornton Terrace Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Thornton Terrace Health**	08/01/2023

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	Based on observations on 07/17/23 between 12:15 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations from a sister facility, the set of smoke barrier doors between Living Room and the south service hall closed in the same direction with an astragal attached to one of the doors. There was a door coordinator attached to the door frame, however, when tested, the doors did not close completely and there was a six inch gap between the doors. Based on interview at the time of observation, the Director of Plant Operations agreed the smoke barrier doors did not close completely when tested. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)		**Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.** Corrections to be completed by 8/1/23 K374: Smoke door coordinator No residents were affected by this alleged deficient practice Door coordinator identified fixed Director of Plant Operations audited door coordinators with no further findings Director of Plan Operations educated on door coordinator As a measure of ongoing compliance, skilled smoke doors will be audited by Director of Plant Operations, Executive Director or Designee once a week for two months then twice monthly for four months. Findings and corrective action will be reviewed and updated as warranted by the QAPI	

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			committee. The results of these audits will be reviewed by QA committee overseen by the Executive Director if a threshold of 100% is not achieved an action plan will be developed. The facility through the QAPI program will review update and make changes to POC as needed for sustaining substantial compliance	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure at least 11 of over 30 wet locations, were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault	K 0511	**The submission of this plan of correction does not indicate an admission by Thornton Terrace Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Thornton Terrace Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in**	08/01/2023

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	circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all		**substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.** Corrections to be completed by 8/1/23 K511 No residents were affected by this alleged deficient practice Ground fault outlets identified removed and replaced with plate coverings. Beauty shop outlet rewired to function correctly Director of Plant Operations audited outlets within six feet of water source with no further findings Director of Plan Operations educated on outlets within six feet of water source need to have a ground fault. As a measure of ongoing compliance outlets near water sources will be audited by Director of Plant Operations, Executive Director, Designee once a week for two months then twice monthly for four months. Findings and corrective action will be reviewed and updated as warranted by the QAPI committee. The results of these audits will be reviewed by QA committee overseen by the Executive Director if a threshold of	

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	receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect one resident and staff in the Beauty Shop/Salon and over 10 residents in the Legacy Lane section of the facility. Findings include: Based on observations on 07/17/23 between 12:15 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations from a sister facility, the following was noted: a. The Beauty Shop/Salon had a GFCI receptacle within two feet of the hair washing sink. When tested with a GFCI tester it appeared the receptacle was wired correctly, however, when tested with the test button on the testing device the electrical circuit was not broken. Even when testing the test button on the receptacle, the electrical circuit was not broken. This was acknowledged by the Director of Plant Operations at the time of observation. b. 10 of 10 resident rooms in the Legacy Lane unit had electrical receptacles within four feet of each room sink. These receptacles were not provided with GFCI protection. This was confirmed when testing with a GFCI testing device. This was acknowledged by the Director of Plant Operations at the time of each observation. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)		100% is not achieved an action plan will be developed. The facility through the QAPI program will review update and make changes to POC as needed for sustaining substantial compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155734	A. BUILDING 01 B. WING	07/17/2023

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	2. Based on observation and interview, the facility failed to ensure 1 electrical receptacle in the Housekeeping Office was provided with a cover plate and was protected from damage. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect at least one staff while in the Housekeeping Office. Findings include: Based on observations on 07/17/23 between 12:15 p.m. and 2:30 p.m. during a tour of the facility with the Director of Plant Operations from a sister facility, the Housekeeping Office had one electrical receptacle on the wall not provided with a cover plate. A small refrigerator was plugged into this receptacle. Based on interview at the time of observation, the Director of Plant Operations acknowledged the lack of a cover plate on the electrical receptacle in the Housekeeping Office. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)			
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency.			

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	Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of 38 of 38 residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to:	K 0711	**The submission of this plan of correction does not indicate an admission by Thornton Terrace Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Thornton Terrace Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.** Corrections to be completed by 8/1/23	08/01/2023

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	i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's "Fire Emergency" plan on 07/17/23 between 9:15 a.m. and 12:15 p.m. with the Director of Plant Operations from a sister facility present, the plan did not address staff response to battery powered smoke alarms located in resident sleeping rooms. Based on interview at the time of record review, the Director of Plant Operations acknowledged and agreed that the Fire Emergency plan did not address staff response to battery powered smoke alarms located in resident sleeping rooms. This finding was reviewed with the Executive Director and Director of Plant Operations during the exit conference. 3.1-19(b)		K711: Plan does not address staff response to battery powered smoke alarms located in resident sleeping room. No residents were affected by this alleged deficient practice Battery power smoke alarm plan added to EOP Staff educated on response to battery power smoke alarm signal Director of plant operation/Executive Director or Designee audit three staff members on response to alarm of battery powered smoke alarms in resident rooms once a week for two months then twice monthly for four months. Findings and corrective action will be reviewed and updated as warranted by the QAPI committee. The results of these audits will be reviewed by QA committee overseen by the Executive Director if a threshold of 100% is not achieved an action plan will be developed. The facility through the QAPI program will review update and make changes to POC as needed for sustaining substantial compliance	