STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155423	A. BUILDING 01 B. WING	06/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMOND-WHITING CARE CENTER	1000 114TH ST WHITING, IN 46394

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 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 483.70(a). Survey Date: 06/20/17 Facility Number: 000365 Provider Number: 155423 AIM Number: 100287460 At this Life Safety Code survey, Hammond-Whiting Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(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 was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and in common areas. The facility has a capacity of 80 and had a census of 71 at the time of this survey.	K 0000	Please reference the enclosed 2567 as “Plan of Correction” for the June 20, 2017 Life Safety Code Survey that was conducted at Hammond Whiting Care Center. I am respectfully requesting paper compliance for this survey and will upload supporting documentation electronically prior to date certain of July 20, 2017 via the ISDH Gateway Survey Reporting System. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our community. The Plan of Correction submitted on July 8, 2017serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	All areas where residents have customary access were sprinklered. The facility has one detached building providing storage. Quality Review completed on 06/27/17 - DA		Respectfully, Kimberly Ready Executive Director	
K 0232 SS=F 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 2 of 4 corridors clear width requirement exception per 19.2.3.4(5). LSC 19.2.3.4(5) requires where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture. 19.2.3.4(5)(a) the fixed furniture is securely attached to the floor or to the wall. This deficient practice could affect all occupants in the Main Dining room. Findings include: Based on observation with the Maintenance Director on 06/20/17 at 9:55 a.m. then again at 10:25 a.m., two	K 0232	**K232** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** The alleged deficient areas are located in facility common areas where residents, visitors, and facility personnel would have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes will be made to**	07/20/2017

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	separate chairs were located in the corridor outside of resident room 217. When tested, the chairs were able to be moved around the corridor. Then again, four separate chairs were located in the corridor outside of the Main Dining room. When tested, the chairs were able to be moved around the corridor. Based on interview at the time of each observation, the Maintenance Director acknowledged the aforementioned condition and confirmed the chairs were not secured. 3.1-19(b)		**ensure that the deficient practice does not recur:** The identified non-anchored chairs in corridor outside of resident room 217 and outside of the Main Dining room have been moved to a location with greater than 8-foot width. Facility staff will be educated on or prior to July 20,2017 by Executive Director and/or designee on correct placement of fixed furniture to ensure corridor width is at least 8-feet, projection into required width shall be permitted for fixed furniture that is securely attached to the floor or to the wall. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Executive Director and/or designee will conduct rounds a minimum of 10 times weekly on various shifts for 1 month and monthly times 3 months thereafter. Any issues identified will be immediately addressed. All audits results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that	

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			time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	
K 0291 SS=F 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 record review, observation and interview; the facility failed to ensure 8 of 8 exterior exit battery operated emergency lights in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 06/20/17 at	K 0291	**K291** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The battery operated emergency lights were tested and documented by Maintenance Director on 6/20/2017 with no issued identified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents had the potential to be affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance staff will be educated on or prior to July 20,2017 by Executive Director and/or designee on monthly and annual functional testing and proper documentation of	07/20/2017

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	9:15 a.m., the battery operated emergency light documentation was not available for review. Based on interview at the time of observation, the Maintenance Director confirmed that testing was performed but not documented. Based on observation, eight exterior exits contained a battery operated emergency light. 3.1-19(b)		emergency lighting equipment as per LSC 7.9, LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requirement. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Maintenance Director and/or designee will perform and document in the TELS system functional tests of emergency lightening equipment monthly (30 seconds at 30 day intervals) and annually (minimum of 1-1/2 hour duration on all battery powered emergency lighting systems). Any issues will be immediately addressed. All audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	
K 0321 SS=D Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating			

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	(with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)			
	Based on observation and interview, the facility failed to maintain protection of 1 of 1 Laundry in accordance of 19.3.2. LSC 19.3.2, Protection from Hazards, requires doors to be self-closing or automatic closing. This deficient practice could affect staff only. Findings include:	K 0321	**K321** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:**	07/20/2017

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	Based on observation with the Maintenance Director on 06/20/17 at 10:07 a.m., the Laundry contained fuel-fire equipment. The Laundry room contained double corridor doors. One of the doors had an astragal, but no coordinating device installed. Centers for Medicare & Medicaid Services (CMS) requires sets of doors which swing in the same direction and equipped with an astragal to have a coordinator to ensure the door which must close first always closes first. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)		No residents were immediately affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** On 6/29/2017 Preferred Window and Door installed a bar style door coordinator on the double corridor doors for the Laundry room to ensure the door which must close first always closes first. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Maintenance Director and/or designee will audit the doors on his weekly rounds for three months to ensure the door which must close first always closes first. Any issues identified will be immediately addressed. All audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	

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K 0353 SS=C 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 record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. This deficient practice could affect all occupants. Findings include:	K 0353	**K353** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No residents were identified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents had the potential to be affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	07/20/2017

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	Based on record review with the Maintenance Supervisor on 06/20/17 at 10:30 a.m., no documentation was available for the monthly control valves, weekly dry system gauge and monthly wet system gauge inspection from the adoption of the 2012 Life Safety Code on 07/05/2016 to February 2017. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the lack of documentation. 3.1-19(b)		During February 2017, it was identified by the facility proper documentation was not complete for the monthly control values, weekly dry system gauge, and monthly wet system gauge inspection from the adoption of the 2012 Life Safety Code. The facility developed action plan through QA and implemented process for necessary documentation on February 21, 2017 and has been compliant with LSC 9.7.5 since that date as evidence of record review with Maintenance Director and Executive Director on June 20, 2017. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Maintenance Director and/or designee will continue weekly/monthly audits along with proper documentation as outlined by LSC 9.7.5 Any issues identified will be immediately addressed. All audits results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done	

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			to ensure the deficient practice does not reoccur and/or adapt audit schedules.	
K 0372 SS=E Bldg. 01	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. 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 2 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 staff and at least 25 residents. Findings include: Based on observations with the	K 0372	**K372** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No resident was identified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All facility residents and staff had the potential to be affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	07/20/2017

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	Maintenance Director on 06/20/17 between 9:25 a.m. and 10:59 a.m., a one inch by one inch piece of drywall was removed from the smoke barrier near resident room 108. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)		The one inch by one inch piece of drywall was replace and fixed on the smoke barrier wall. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Maintenance Director and/or designee will audit the facility smoke barrier walls during weekly rounds for three month to ensure the penetrations caused by the passage of wire and/or conduit through smoke barrier walls are protected to maintain the smoke resistance of each smoke barrier. Any issues identified will be immediately addressed. All audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	
K 0521 SS=D Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's			

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	specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered.	K 0521	**K521** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** No resident was identified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** All residents had the potential to be affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** SafeCare inspected facility fire damper in the corridor wall separating the Laundry room on 6/29/2017, which identified the fire damper was in proper working order and no maintenance work was necessary. Maintenance staff will be educated on or prior to July 20, 2017 by Executive Director and/or designee to ensure fire dampers in the facility are inspected and provided necessary maintenance along with proper documentation of inspection and maintenance at least every four years. **How the corrective action(s) will be monitored to ensure the**	07/20/2017

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	The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect staff only. Findings include: Based on record review with the Maintenance Director on 06/20/17 between 8:40 a.m. and 9:25 a.m., no damper documentation was available for review. Based on observation, there was a damper discovered in the corridor wall separating the Laundry room. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed no documentation was available for review. 3.1-19(b)		**deficient practice will not recur:** The Maintenance Director and/or designee will add the fire damper inspection and testing every four years to the TELS Preventive Maintenance System. All findings will be documented on the audit tool and report findings to the Executive Director ongoing. Any identified issues will be immediately addressed. All audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: * Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. * Decorations meet NFPA 701. * Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. * Decorations, such as photographs,			

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	155423	A. BUILDING 01 B. WING	06/20/2017

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	paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. * The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 1 Salon was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect staff and up to 46 residents. Findings include: Based on observation with the Maintenance Director on 06/20/17 at 9:50 a.m., the Salon contained a candle with a wick. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)	K 0753	**K753** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The candle was removed from the Salon and discarded on 6/20/2017. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Facility wide audit was performed on 6/20/2017 by the Executive Director to assure no other candles were within the facility. No issues were identified via this audit. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Facility staff will be educated by Executive Director and/or designee to ensure no candles are within the facility related to LSC 19.7.5.6 requirement. This education will take place on or prior to July 20, 2017. **How the corrective action(s) will be monitored to ensure the**	07/20/2017

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			deficient practice will not recur: The Maintenance Supervisor and/or designee will conduct 5 room audits each week to ensure no candles are within the facility. Any issues identified will be immediately addressed. All audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice does not reoccur and/or adapt audit schedules.	
K 0920 SS=E 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 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			

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	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 1 of 1 multiplug and 2 of 2 flexible cords were not used as a substitute for fixed wiring 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 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 staff and up to 46 residents. Findings include: Based on observation with the Maintenance Director on 06/20/17 at 9:50 a.m. then again at 10:20 a.m., a multiplug adapter was powering trimmers in the Salon. Then again, a surge protector was powering another surge	K 0920	**K920** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** On 6/20/2017, the multiplug adapter was removed from the Salon. On 7/7/2017 Foster Electric, Inc installed 3 receptacles in the Salon to eliminate the need for multiplug adapters, along with adding a quad receptacle in the Tel-com room to eliminate a surge protector powering another surge protector. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:** Facility wide audit will be performed by the Executive Director on 6/20/2017 to assure no other multiplug adapters were in use within the facility, along with no other surge protectors powering another surge	07/20/2017

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	protector in the Tel-com room. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b)		protector. No issues were identified via this audit. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Facility staff will be educated by Executive Director and/or designee to ensure flexible cords and cables are not used as a substitute for fixed wiring of a structure. This education will take place on or prior to July 20, 2017. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Maintenance Supervisor and/or designee will conduct 5 room audits each week to ensure no multiplug adapters are in use within the facility, along with no other surge protectors powering another surge protector. Any issues identified will be immediately addressed. All audit results and system components will be reviewed by the QA Committee on a monthly basis with subsequent plans of correction developed and implemented as deemed necessary. The criteria for determining that monitoring is no longer necessary will be 90% accuracy. If audits do not meet this criteria, audits shall continue at the same schedule for an additional three months. At that time, analysis of data will be done to ensure the deficient practice	

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			does not reoccur and/or adapt audit schedules.	