STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING -- B. WING	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF FORT WAYNE	7519 WINCHESTER RD FORT WAYNE, IN 46819

(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: 11/16/18 Facility Number: 000250 Provider Number: 155359 AIM Number: 100289980 At this Emergency Preparedness survey, Majestic Care of Fort Wayne was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 66 and had a census of 51 at the time of this survey. Quality Review completed on 11/20/18 - DA	E 0000		
E 0006 SS=F Bldg. --	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance	E 0006	What corrective action(s) will be done for residents found to have been effected by the deficient practice(s). Executive Director completed a facility based and community based risk assessment utilizing an all-hazard approach. How Facility will identify other residents having potential to be affected by practice and what	11/21/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155359	A. BUILDING -- B. WING	11/16/2018

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	Director and Administrator on 11/16/18 at 10:00 a.m., the facility did not conduct a facility-based and community-based risk assessment, utilizing an all-hazards approach to ensure the Emergency Preparedness plan address all possible hazards. Based on interview at the time of records review, the Administrator stated a risk assessment, utilizing an all-hazards approach was not conducted.		corrective action will be taken. All residents have the potential to be effective by this practice. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur. Facility based and community based risk assessment utilizing an all-hazard approach will be added to emergency preparedness plan. How the corrective action(s) will be monitored to ensure the deficient practices will not recur, i.e. what quality assurance program will be put in place. Facility based and community based risk assessment utilizing an all-hazard approach will be reviewed during monthly QAPI. Results will be submitted monthly for review to ensure improved compliance and may require additional and/or adjusting if improvements are not met. The QAA Committee will recommend a schedule of on-going review.	

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E 0024 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director and Administrator on 11/16/18 at 10:20 a.m., the facility's Emergency Preparedness plan provided did not address the use of volunteers in an emergency. Based on interview at the time of records review, the Administrator stated the facility would not use volunteers and the plan did not address the use or non-use of volunteers in an emergency.	E 0024	What corrective action(s) will be done for residents found to have been effected by the deficient practice(s). A volunteer plan was added to the emergency preparedness plan. How Facility will identify other residents having potential to be affected by practice and what corrective action will be taken. All residents have the potential to be effective by this practice. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur. A volunteer plan was added to the emergency preparedness plan. How the corrective action(s) will be monitored to ensure the deficient practices will not recur, i.e. what quality assurance program will be put in place.	11/21/2018

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			A volunteer plan was added to the emergency preparedness plan. Will review monthly and submit results to QAPI for review to ensure improved compliance and may require additional and/or adjusting if improvements are not met timely. The QAA Committee will recommend a schedule of review.	
E 0033 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (4) a method for sharing information and medical documentation for residents under the LTC facility's care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). (6) A means of providing information about the general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and Maintenance Director on 11/16/18 at 10:55 a.m., the facility's Emergency Preparedness communication plan provided did not address a method for sharing information with other LTC facilities in an evacuation or emergency. Based on an interview at the time of records review, the Administrator and Maintenance Director stated there was an electronic way to share information	E 0033	What corrective action(s) will be done for residents found to have been effected by the deficient practice(s). A communication plan was added to the emergency preparedness plan. How Facility will identify other residents having potential to be affected by practice and what corrective action will be taken. All residents have the potential to be effective by this practice. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur. A communication plan was added to the emergency preparedness plan. How the corrective action(s) will be monitored to ensure the deficient practices will not recur, i.e. what quality assurance program will be put in place. A communication plan was added	11/30/2018

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	with other facilities, but the plan did not address this method for sharing information.		to the emergency preparedness plan. Will review monthly and submit results to QAPI for review to ensure improved compliance and may require additional and/or adjusting if improvements are not met timely. The QAA Committee will recommend a schedule of review.	
E 0034 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.73(c)(7). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director and Administrator on 11/16/18 at 11:10 a.m., the facility's Emergency Preparedness communication plan provided did not address a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance. Based on interview at the time of records review, the Administrator agreed the plan did not address a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance.	E 0034	What corrective action(s) will be done for residents found to have been effected by the deficient practice(s). A communication plan was added to the emergency preparedness plan. How Facility will identify other residents having potential to be affected by practice and what corrective action will be taken. All residents have the potential to be effective by this practice. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur. A communication plan was added to the emergency preparedness plan. How the corrective action(s) will be monitored to ensure the deficient practices will not recur, i.e. what quality assurance program will be put in place. A communication plan was added to the emergency preparedness	11/30/2018

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			plan. Will review monthly and submit results to QAPI for review to ensure improved compliance and may require additional and/or adjusting if improvements are not met timely. The QAA Committee will recommend a schedule of review.	
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: 11/16/18 Facility Number: 000250 Provider Number: 155359 AIM Number: 100289980 At this Life Safety Code survey, Majestic Care of Fort Wayne 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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 66 and had a census of 51 at the time of this survey.	K 0000		

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	All areas where residents have customary access were sprinklered. All areas providing facilities services were sprinklered with the exception of a detached wood shed used for storage of maintenance supplies Quality Review completed on 11/20/18 - DA			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked			

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	space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 1 of 7 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.3 Doors within a required means of egress shall not be equipped	K 0222	What corrective action(s) will be done for residents found to have been effected by the deficient practice(s). The code to door on east hall exit was posted on code box.	11/16/2018

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	with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 20 residents in the east hall. Findings include: Based on an observation during a tour of the facility with the Maintenance Director and Administrator on 11/16/18 at 1:36 p.m., the southwest hall exit door had a key pad with no code posted. The Administrator and Maintenance Director entered a code to open the door but it did not open. The Maintenance Director and Administrator had to search for the code which took about 15 minutes to find the correct code to open the door. This condition would delay evacuation of the building of a person that did not know the code. Based on interview at the time of observation, the Maintenance Director and Administrator agreed the door code was not posted and stated the key pad was not accepting the code and had to use the override code to open the door. 3.1-19(b)		How Facility will identify other residents having potential to be affected by practice and what corrective action will be taken. All residents have the potential to be effective by this practice. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur. Maintenance Director will ensure code to exit the building is posted on each door once per week or if code changes. How the corrective action(s) will be monitored to ensure the deficient practices will not recur, i.e. what quality assurance program will be put in place. Maintenance Director or Designee to complete Code Posted Audit once weekly for three months. Results will be submitted monthly to QAPI for review to ensure improved compliance and may require additional and/or adjusting if improvements are not met timely. After three months, the QAA Committee will recommend a schedule of ongoing audits.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit			

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	discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 7 exit discharge had a level walking surface. This deficient practice could affect 20 residents in the west hall in the event of an evacuation. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 11/16/18 at 1:30 p.m., the 13 foot asphalt walkway discharge from the west exit to the parking lot was uneven, and deteriorating causing dips, holes, and loose gravel to form. Based on interview at the time of observation, the Maintenance Director provided the length of the walkway and stated the walkway was part of the emergency exit discharge, was deteriorating, and needed to be fixed. 3.1-19(b)	K 0271	What corrective action(s) will be done for residents found to have been effected by the deficient practice(s). The unlevel side walk had new concrete poured. How Facility will identify other residents having potential to be affected by practice and what corrective action will be taken. All residents have the potential to be effective by this practice. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur. The unlevel side walk had new concrete poured. Maintenance Director created TELS account to ensure routine maintenance is complete. How the corrective action(s) will be monitored to ensure the deficient practices will not recur, i.e. what quality assurance program will be put in place. Maintenance Director will complete monthly rounds to ensure all walking areas are level. Results will be submitted monthly to QAPI for review to ensure improved compliance and may require additional and/or adjusting if improvements are not met timely. After three months, the QAA Committee will recommend a schedule of ongoing audits.	11/29/2018

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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 observations and interview, the facility failed to ensure the penetrations caused by the passage of wire, pipes, and/or conduit through 1 of 5 smoke barrier walls were protected to maintain a 1/2-hour fire resistance rating. LSC 8.5.6.2 requires penetrations for cable, conduit, pipe, or wire of a smoke barrier assembly, shall be protected by a system or material capable of restricting the transfer of smoke. This deficient practice could affect staff and at least 35 residents in two smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 11/16/18 between 2:30 p.m. and 3:00 p.m., in the attic of the smoke barrier wall by the lobby contained an unsealed half inch gap around wires, and in the attic of the west hall smoke barrier wall there were four unsealed penetrations around	K 0372	What corrective action(s) will be done for residents found to have been effected by the deficient practice(s). Maintenance secured all fire penetration with fire rated caulk. How Facility will identify other residents having potential to be affected by practice and what corrective action will be taken. All residents have the potential to be effective by this practice. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur. Maintenance Director will inspect all spaces for fire penetration once per week and after any building maintenance. Maintenance Director created	11/16/2018

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	wires and pipes. Based on interview at the time of observation, the Maintenance Director provided the measurements of the unsealed penetration. 3.1-19(b)		TELS account to ensure routine maintenance is complete. How the corrective action(s) will be monitored to ensure the deficient practices will not recur, i.e. what quality assurance program will be put in place. Maintenance Director will complete rounds once per week. Results will be submitted monthly to QAPI for review to ensure improved compliance and may require additional and/or adjusting if improvements are not met timely. After three months, the QAA Committee will recommend a schedule of ongoing audits.	
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause	K 0522	What corrective action(s) will be done for residents found to have been effected by the deficient practice(s). All items removed from intake cent area and vent cleaned.	11/16/2018

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	physical problems for all staff in the rear laundry room and affect 20 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 11/16/18 at 1:15 p.m., the laundry room had fuel-fired dryers with a fresh air intake that was covered with lint, a piece of cardboard, and trash bags full of clothes. This condition does not allow fresh air enter the room. Based on an interview at the time of observation, the Maintenance Director stated the intake was covered with lint and removed the cardboard and trash bags. 3.1-19(b)		How Facility will identify other residents having potential to be affected by practice and what corrective action will be taken. All residents have the potential to be effective by this practice. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur. All laundry staff will be educated on ensuring there are no items surrounding the fresh air intake. Housekeeping supervisor to complete audit once weekly to ensure vent is free from debris and cleaned. Vent to be scheduled for cleaning once per week or more frequently as needed. How the corrective action(s) will be monitored to ensure the deficient practices will not recur, i.e. what quality assurance program will be put in place. Housekeeping supervisor or designee to complete audit once weekly. Results will be submitted monthly to QAPI for review to ensure improved compliance and may require additional and/or adjusting if improvements are not met timely. After three months, the QAA Committee will recommend a schedule of ongoing audits.	
K 0741 SS=E	NFPA 101 Smoking Regulations			

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	155359	A. BUILDING 01 B. WING	11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF FORT WAYNE	7519 WINCHESTER RD FORT WAYNE, IN 46819

(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
Bldg. 01	Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview; the facility failed to ensure 1 of 2 smoking areas were maintained by disposing cigarette butts in the provided metal or noncombustible containers with self-closing cover devices. This deficient practice could affect staff and up to 25 residents that would use the smoking area. Findings include:	K 0741	What corrective action(s) will be done for residents found to have been effected by the deficient practice(s). Staff removed all cigarette trash and cigarette butts. How Facility will identify other residents having potential to be affected by practice and what corrective action will be taken.	11/19/2018

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	Based on observation during a tour of the facility with Maintenance Director on 11/16/18 at 12:55 p.m., in the resident smoking hut there were over 50 cigarette butts on the wood deck mixed with leaves. Also, the two smokers poles contained empty cigarette packs mixed with cigarette butts. Based on interview at the time of observation, the Maintenance Director agreed there were butts butt on the floor of the hut, provided the quantity of cigarette butts on the floor and confirmed there was trash mixed with cigarette butts. 3.1-19(b)		All residents have the potential to be effective by this practice. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur. All smoking residents were educated on smoking policy and safe smoking practices to include the disposal of cigarette butts. Maintenance Director will complete rounds 5x per week to ensure all cigarette butts are disposed of. How the corrective action(s) will be monitored to ensure the deficient practices will not recur, i.e. what quality assurance program will be put in place. Maintenance Director will complete rounds 5x per week to ensure all cigarette butts are disposed of.. Results will be submitted monthly to QAPI for review to ensure improved compliance and may require additional and/or adjusting if improvements are not met timely. After three months, the QAA Committee will recommend a schedule of ongoing audits.	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the			

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	monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 6.2.10 Time Delay on Engine Shutdown requires that a minimum time delay of 5	K 0918	What corrective action(s) will be done for residents found to have been effected by the deficient practice(s). Maintenance Director will allow a 5 minute cool down time after monthly generator check and record time. How Facility will identify other residents having potential to be	11/26/2018

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	minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on records review with the Maintenance Director on 11/16/18 at 11:07 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Maintenance Director stated according to the documentation a cool down for the generator was not recorded. 3.1-19(b)		affected by practice and what corrective action will be taken. All residents have the potential to be effective by this practice. What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur. Maintenance Director will complete monthly log and ensure the cool down time is recorded. How the corrective action(s) will be monitored to ensure the deficient practices will not recur, i.e. what quality assurance program will be put in place. Maintenance Director will complete logs monthly. Results will be submitted monthly to QAPI for review to ensure improved compliance and may require additional and/or adjusting if improvements are not met timely. After six months, the QAA Committee will recommend a schedule of ongoing audits.	