

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15C0001114	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2015
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NAME OF PROVIDER OR SUPPLIER SOUTH CENTRAL SURGERY CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5002 E SR 44 FRANKLIN, IN 46131
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 416.44(b).</p> <p>Survey Date: 04/28/15</p> <p>Facility Number: 003073 Provider Number: 15C0001114 AIM Number: 200377120A</p> <p>At this Life Safety Code survey, South Central Surgery Center LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies.</p> <p>This facility located in a one story building was determined to be of Type V (111) construction and was fully sprinklered except for two exterior combustible canopies. The facility has a fire alarm system with smoke detection at corridor smoke barrier door sets and in ventilation ducts.</p>	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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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K 0029 Bldg. 01	<p>416.44(b)(1) LIFE SAFETY CODE STANDARD Hazardous areas separated from other parts of the building by fire barriers have at least one hour fire resistance rating or such areas are enclosed with partitions and doors and the area is provided with an automatic sprinkler system. High hazard areas are provided with both fire barriers and sprinkler systems 38.3.2, 39.3.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 4 hazardous areas self closing corridor doors were not secured in the open position. LSC 38.3.2.1 states hazardous areas such as general storage areas shall be protected in accordance with Section 8.4. Section 8.4.1.2 states the area shall be enclosed with smoke resistant partitions in accordance with 8.2.4. 8.2.4.3.5 states doors shall be self-closing or automatic closing in accordance with 7.2.1.8. 7.2.1.8 states a door normally required to be kept closed shall not be secured in the open position. This deficient practice could affect four patients and staff.</p> <p>Findings include:</p> <p>Based on observations with the DON during a tour of the facility from 11:10 a.m. to 12:30 p.m. on 04/28/15, the soiled utility room by the clean utility room has two corridor doors and each corridor door's latching mechanism failed to latch</p>	K 0029	Both doors now meet this code and latch securely into the door frame. Both these doors will be checked monthly by the Director of Nursing and Quarterly by the Medical Director. Any problems will be reported immediately to the Director of Nursing and Medical Director. Repairs will take place when needed. A QA will be maintained by the Director of Nursing transported quarterly to the QA committee.	05/12/2015

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K 0046 Bldg. 01	<p>into the door frame. Based on interview at the time of the observations, the DON acknowledged the corridor doors to the aforementioned hazardous area failed to latch into the door frame.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Emergency illumination is provided in accordance with section 7.9. 20.2.9.1, 21.2.9.1</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 3 of 3 battery powered lights during the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr 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 patients, staff and visitors.</p> <p>Findings include: Based on record review with the Director</p>	K 0046	<p>A log for functional testing on the battery powered emergency lights will be started. The first will be a test every 30 days for 30 seconds to make sure the lights turn on and stay on for 30 seconds. Their appearance will also be checked and when the battery was changed will be noted. This test will be done by the Director of Nursing or Maintenance and reported to the Director of Nursing. The second will be a log for annual testing to see if the lights remain on for 90 minutes. Any problems will be reported to the Director of Nursing and repairs will be made. This test will also be done by the Director of Nursing or the Maintenance department. A Quality Assessment will be maintained on this log by the Director of Nursing and the DON will report the findings quarterly to the QA committee.</p>	06/02/2015

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K 0048 Bldg. 01	<p>of Nursing (DON) from 9:30 a.m. to 11:10 a.m. on 04/28/15, documentation of functional testing conducted at 30 day intervals and annual 90 minute testing for battery powered emergency lights in the facility for the most recent twelve month period was not available for review. Based on observations with the DON during a tour of the facility from 11:10 a.m. to 12:30 p.m. on 04/28/15, Operating Room 1 (OR1), OR2 and OR3 are each provided with battery operated emergency lighting to provide continuous illumination in three of four operating rooms at the facility. None of the three operating room battery operated emergency lighting systems functioned when their respective test button was pushed five separate times. Based on interview at the time of the observations, the DON acknowledged documentation of functional testing conducted at 30 day intervals and annual 90 minute testing for battery powered emergency lights in the facility for the most recent twelve month period was not available for review.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 20.7.1.1, 21.7.1.1 Based on record review and interview, the facility failed to provide a complete written plan containing procedures to be</p>	K 0048	A new Fire Watch Policy has been written. It is waiting on approval from the Governing Board. It will be inserviced to the	06/02/2015

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K 0050 Bldg. 01	<p>followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 which requires the authority having jurisdiction be notified and the building evacuated or an approved fire watch provided until the fire alarm system has been returned to service. This deficient practice could affect all patients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Director of Nursing (DON) from 9:30 a.m. to 11:10 a.m. on 04/28/15, a written policy in the event the fire alarm system is out of service for four hours or more in a twenty four hour period was not available for review. Based on interview at the time of record review, the DON acknowledged a written policy in the event the fire alarm system is out of service for four hours or more in a twenty four hour period was not available for review.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. 20.7.1.2, 21.7.1.2</p>		<p>staff once this is completed. It then will be included in the annual inservice training for all staff members. It will also be included in the orientation training of all new employees. A QA of this activity will be maintained by the Director of Nursing and results will be reported by the DON to the QA Committee.</p>	

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	<p>1. Based on record review and interview, the facility failed to document activation of the fire alarm system and transmission of the fire alarm signal for 4 of 4 first shift quarterly fire drills. LSC 21.7.1.2 requires fire drills in ambulatory health care facilities to include the transmission of the fire alarm signal. When drills are conducted between 9:00 p.m. and 6:00 a.m., a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include</p> <p>Based on review of "Fire Drill Record" and "Safety Committee" documentation with the Director of Nursing (DON) during record review from 9:30 a.m. to 11:10 a.m. on 04/28/15, documentation for first shift (7:00 a.m. to 3:00 p.m.) fire drills conducted on 05/27/14, 09/02/14, 11/11/14 and 02/20/15 did not include the transmission of the fire alarm signal and the time of day each fire drill was conducted. Documentation for each of the aforementioned fire drills stated "General Alarm stated they received the signal" but with no time of day listed for</p>	K 0050	A new fire drill record has been made. The new one includes Date and time of drill. The fire department received the alarm during the drill. The general alarm company received the alarm during the drill. The staff signatures. A Quality Assessment will be maintained that these new requirements are met. The Director of Nursing will maintain this and report the findings to the QA committee.	06/02/2015			

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	<p>each fire drill activation of the fire alarm system and transmission of the fire alarm signal could not be verified for each fire drill. Based on interview at the time of record review, the DON stated the facility operates one shift per day and acknowledged documentation for the aforementioned fire drills did not include the transmission of the fire alarm signal and the time of day each fire drill was conducted.</p> <p>2. Based on record review and interview, the facility failed to document staff participation in 4 of 4 quarterly fire drills conducted during the most recent twelve month period. LSC 21.7.2.3 states all personnel shall be instructed in the use of and response to fire alarms. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Record" and "Safety Committee" documentation with the Director of Nursing (DON) during record review from 9:30 a.m. to 11:10 a.m. on 04/28/15, documentation for first shift (7:00 a.m. to 3:00 p.m.) fire drills conducted on 05/27/14, 09/02/14, 11/11/14 and 02/20/15 did not include personnel who participated in the fire drill. Based on interview at the time of</p>						

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K 0051 Bldg. 01	<p>record review, the DON stated the facility operates one shift per day and acknowledged documentation for the aforementioned fire drills did not list personnel who participated in the fire drill.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD A manual fire alarm system, not a pre-signal type, is provided to automatically warn the building occupants. Fire alarm system has initiation notification and control function. The fire alarm system is arranged to automatically transmit an alarm to summon the fire department. 20.3.4.1, 21.3.4.1 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. LSC 21.3.4.1 refers to LSC 9.6.1.7 which refers to NFPA 72, the National Fire Alarm Code. NFPA 72, 7-3.2 requires testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply. Table 7-3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p>	K 0051	AADCO came on 4/29/2015 and completed their annual inspection of the alarm system. A Quality assessment will be maintained by the Director of Nursing that this is completed annually on time. Results will be reported to the QA committee by the Director of Nursing.	04/29/2015

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K 0105 Bldg. 01	<p>Based on review of AADCO Alarms & Communication Systems "Initiating & Supervisory Device Tests & Inspections" documentation dated 06/07/13 with the Director of Nursing (DON) during record review from 9:30 a.m. to 11:10 a.m. on 04/28/15, it has been more than one year since the most recent documented fire alarm inspection was performed. Based on interview at the time of record review, the DON stated documentation of fire alarm system inspections performed within the most recent twelve month period was not available for review and acknowledged it has been more than one year since the most recent fire alarm system inspection was performed.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Where general anesthesia or life support equipment is used, an emergency power system is provided in accordance with NFPA 99. 20.2.9.2, 21.2.9.2</p> <p>Based on observation and interview, the facility failed to provide emergency lighting in 3 of 3 operating rooms where general anesthesia or life support equipment is used. LSC Section 21.2.9.2 requires ambulatory health care facilities to provide emergency lighting where general anesthesia or life support equipment is used to be in accordance with LSC Section 7.9. LSC Section</p>	K 0105	The replacement batteries for the emergency light system have been ordered and received. They are scheduled to be replaced on 5/26/2015. There is and inspection log made for testing these monthly. This will be maintained by the Director of Nursing. A Quality assessment will be maintained by the Director of Nursing and results will be reported to the QA committee.	05/26/2015

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	<p>7.9.2.2 states an emergency lighting system shall be arranged to provide the required illumination automatically in the event of any of the following:</p> <p>(1) Interruption of normal lighting such as any failure of a public utility or other outside electrical power supply</p> <p>(2) Opening of a circuit breaker or fuse</p> <p>(3) Manual act(s), including accidental opening of a switch controlling normal lighting facilities.</p> <p>LSC Section 7.9.2.5 requires the emergency lighting system to either be in continuous operation or be capable of repeated automatic operation without manual intervention. This deficient practice could affect three patients and staff in any of three operating rooms where general anesthesia is used.</p> <p>Findings include:</p> <p>Based on observations with the DON during a tour of the facility from 11:10 a.m. to 12:30 p.m. on 04/28/15, Operating Room 1 (OR1), OR2 and OR3 are each provided with battery operated emergency lighting to provide continuous illumination in three of four operating rooms at the facility. None of the three operating room battery operated emergency lighting systems functioned</p>			

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K 0115 Bldg. 01	<p>when their respective test button was pushed five separate times. Based on interview at the time of the observations, the DON stated patients in each of the three aforementioned operating rooms can be completely sedated and rendered immobile using general anesthesia. In addition, the DON stated OR4 is a procedure room and is not used for patients requiring general anesthesia. The DON also stated an emergency generator is utilized to provide emergency lighting in each of the three aforementioned operating rooms but acknowledged there is no functional battery operated back up emergency lighting system to provide continuous illumination in each of the three operating rooms.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Ambulatory health care facilities are divided into at least two smoke compartments with smoke barriers having at least 1 hour fire resistance rating. Doors in smoke barriers are equipped with positive latcher. Doors are constructed of not less than 1¾ inch thick solid bonded core wood or equivalent. Vision panels are provided and are of fixed wire glass limited to 1,296 sq. inch per panel. 20.3.7.1, 20.3.7.2, 20.3.7.3, 21.3.7.1, 21.3.7.2, 21.3.7.3</p>			

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	<p>Based on record review, observation and interview; the facility failed to ensure 2 of 3 smoke barriers was protected to maintain the one hour fire resistance rating of the smoke barrier. LSC 8.2.3.2.1 states door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with NFPA 80, Standard for Fire Doors and Fire Windows. NFPA 80, 1999 edition, section 2-3.1.7 states the clearance between the meeting edges of doors swinging in pairs on the pull side shall not exceed 1/8 inch for wood doors. This deficient practice could affect all patients and staff if smoke from a fire was to infiltrate the protective barrier.</p> <p>Findings include:</p> <p>Based on review of facility blueprint documentation with the Director of Nursing (DON) during record review from 9:30 a.m. to 11:10 a.m. on 04/28/15, the facility measures 13,125 square feet and South Central Surgery Center LLC occupies the entire building. A one hour fire rated smoke barrier wall separates the facility into at least two smoke compartments. Based on observations with the DON during a tour of the facility from 11:10 a.m. to 12:30</p>	K 0115	The double door that separates the patient recovery room and the operating room. The double door that separates the office corridor and the patient care area. The door next to the Pathology lab. Parts have been ordered to bring these doors up to code. The repair has been scheduled for 5/26/2015. An inspection will be done monthly by the Director of Nursing and quarterly by the Medical Director. A Quality Assessment will be maintained by the of Nursing and results will be reported to QA committee.	05/26/2015			

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	<p>p.m. on 04/28/15, the following was noted:</p> <p>A. the set of smoke barrier doors in the one hour fire rated smoke barrier wall separating the patient recovery area from the operating rooms smoke compartment was not equipped with a positive latching device. In addition, a three quarter inch gap was noted between the meeting edges of the wooden smoke barrier door set.</p> <p>B. the set of smoke barrier doors in the one hour fire rated smoke barrier wall separating the office area corridor from the patient recovery room was not equipped with a positive latching device.</p> <p>c. the smoke barrier door in the one hour fire rated smoke barrier wall next to the Pathology Lab was equipped with a self closing device and a positive latching device but failed to self close because carpet stopped the bottom of the door from swinging and failed to latch because the door was stopped from fully closing by hitting the frame on the latching side of the door.</p> <p>Based on interview at the time of the observations, the DON acknowledged 2 of 3 smoke barriers was not protected to maintain the one hour fire resistance rating of the smoke barrier at the aforementioned smoke barrier door locations.</p>			

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K 0130 Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review, observation and interview; the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. LSC 21.7.6, Maintenance and Testing, refers to 4.6.12. LSC 4.6.12.2 requires existing life safety features obvious to the public shall be maintained. LSC 9.7.1 states all automatic sprinkler systems shall be maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 5-1.1 states the requirements for spacing, location and position of sprinklers shall be based on the following principles or met an Exception:</p> <p>(1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>NFPA 13, 5-13.8 states sprinklers shall be installed under exterior roofs or canopies exceeding 4 feet in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is</p>	K 0130	<p>I have talked to the builder and he stated they used fire treated wood approved by the state in the canopies. He is sending me a letter to confirm this and for me to have on file. We also have smoke walls between the canopy and the building. The dry sprinkler system is also inside of the canopy. I will forward the letter to the state as soon as I receive it. By July 24,2015 we will have sprinklers under the 2 adjoining canopies of the building. These will be included in the quarterly check of the sprinkler system. The Director of Nursing will develop a QA along with the QA committee. The results of this QA will be reported by the Director of Nursing to the QA committee quarterly who will then report it quarterly to the Governing Board.</p>	06/10/2015			

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	<p>noncombustible or limited combustible construction.</p> <p>This deficient practice affects all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of facility blueprint documentation with the Director of Nursing (DON) during record review from 9:30 a.m. to 11:10 a.m. on 04/28/15, the exterior canopy at the main entrance and the exterior canopy at the patient discharge exit each extended at least 30 feet from the building and were of combustible construction. Based on observations with the DON during a tour of the facility from 11:10 a.m. to 12:30 p.m. on 04/28/15, the exterior canopy at the main entrance and the exterior canopy at the patient discharge exit each extended at least 30 feet from the building and were not provided with sprinklers. Based on interview at the time of the observations, the DON acknowledged the aforementioned exterior canopies were not provided with sprinklers.</p> <p>2. Based on record review and interview, the facility failed to provide a complete written plan containing procedures to be followed in the event the automatic sprinkler system has to be placed out of</p>			

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	<p>service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 which requires the authority having jurisdiction be notified and the building evacuated or an approved fire watch provided until the fire alarm system has been returned to service. In addition, sprinkler impairment procedures shall comply with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner or manager and other authorities having jurisdiction also be notified. This deficient practice could affect all patients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Director of Nursing (DON) from 9:30 a.m. to 11:10 a.m. on 04/28/15, a written policy in the event the automatic sprinkler system is out of service for four hours or more in a twenty four hour period was not available for review. Based on interview at the time of record review, the DON acknowledged a written fire watch policy in the event the automatic sprinkler system is out of service for four</p>			

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K 0144 Bldg. 01	<p>hours or more in a twenty four hour period was not available for review.</p> <p>416.44(b)(1) LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1, NFPA 110, 8.4.2</p> <p>1. Based on record review and interview, the facility failed to ensure monthly load testing for the emergency generator was conducted for 10 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. LSC 21.5.1 states utilities shall comply with the provisions of Section 9.1. LSC 9.1.3 states emergency generators shall be tested and maintained in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>A. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as</p>	K 0144	<p>A new inspection sheet for every 30 days testing the generator with a load. It will include temperature, how quickly it transfers to generator (should be 10 seconds or less), exhaust gas temperature, percentage of load capacity. The Director of Nursing will be working with the company that maintains the generator. A Quality Assessment will be maintained by the Director of Nursing and results will be reported quarterly to the QA committee.</p>	06/05/2015

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	<p>recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>NFPA 110, 6-4.2.2 states diesel powered EPS installations which do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads for a total of two continuous hours.</p> <p>NFPA 110, 6-3.4 requires a written record of inspections, tests, exercising and repairs shall be regularly maintained on the premises. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emer.-Gen. Test Run" and "Weekly Inspection" documentation with the Director of Nursing (DON) during record review from 9:30 a.m. to 11:10 a.m. on 04/28/15, monthly load testing documentation for the emergency generator for the ten month period of June 2014 through September 2014 and November 2014 through April 2015 does not state the emergency generator was exercised for a minimum of 30 minutes each month and did not document the operating temperature, percentage of load capacity or minimum exhaust gas temperature for each monthly load test</p>			

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	<p>conducted. Based on interview at the time of record review, the DON stated the emergency generator is load tested on a weekly basis but acknowledged the aforementioned documentation does not state the emergency generator was exercised for a minimum of 30 minutes at least once per month and did not state the operating temperature, percentage of load capacity or minimum exhaust gas temperature for each monthly load test conducted.</p> <p>2. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 10 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p>			

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	Based on review of "Emer.-Gen. Test Run" and "Weekly Inspection" documentation with the Director of Nursing (DON) during record review from 9:30 a.m. to 11:10 a.m. on 04/28/15, documentation of emergency power transfer time to the emergency generator for monthly load testing documentation for the ten month period of June 2014 through September 2014 and November 2014 through April 2015 was not available for review. Based on interview at the time of record review, the DON acknowledged emergency power transfer time for monthly load testing documentation for the aforementioned ten month period was not available for review.			