

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 154005	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2014
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NAME OF PROVIDER OR SUPPLIER RIVER BEND HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 N RIVER RD WEST LAFAYETTE, IN 47906
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K010000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 482.41(b).</p> <p>Survey Date: 05/15/14</p> <p>Facility Number: 005172 Provider Number: 154005 AIM Number: 100273160A</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, River Bend Hospital was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 482.41(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies.</p> <p>The two story facility was determined to be of Type II (222) construction and partially sprinklered. The first floor was fully sprinklered except a kitchen freezer which was attached to the outside of the building. The facility has a fire alarm system with system based smoke alarms in corridors and in hazardous areas. The</p>	K010000		
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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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K010018	<p>facility has a capacity of 16 patients and had a census of 15.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/20/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 2 of 12 smoke compartments could automatically latch into the door frame. This deficient</p>	K010018	<p>1. Door frames will have to be refitted to have the doors latch into the frames and not to each other.2. Having refitted the frames will resolve it happening again.3. A contractor will have to</p>	07/25/2014

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	<p>practice affects staff, visitors and 10 or more patients in the administrative wing and patient care unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/15/14 between 12:30 p.m. and 3:00 p.m., the double door sets providing access to the following areas did not latch automatically into the door frames:</p> <p>a. the door sets providing access to the conference room and medical records storage room each required one door to latch into the door frame with a manual flush bolt before the second door would latch into the first door and secure them both tightly into their door frames;</p> <p>b. the door set providing access to the A unit activity room had a double door set without any automatic latch. The door set relied on a key operated deadbolt to secure it tightly into the door frame. The maintenance director acknowledged at the time of observations, the doors could not latch automatically into their door frames.</p>		be called in.4. 30 Days		

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K010021	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>1. Based on observation and interview, the facility failed to ensure doors in 3 of 12 smoke barrier door sets were held open only by a device which would allow it to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 10 or more patients on the first and second floors.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/15/14 between 12:30 p.m. and 3:00 p.m., one door in each of the smoke barrier double door sets near the first floor conference</p>	K010021	<p>1. Adjust door closer to close door properly. 2. Check all doors for proper closing when fire drills are done. 3. Maintenance Department 4. 10 dayscontinued:1. Remove the feature that holds the door open2. By removing the feature on he door.3. Maintenance Department4. 15 days</p>	07/10/2014
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	<p>room, near A119 and near the second floor activities room failed to close when tested twice to ensure their proper operation. The door coordinators on each door frame held the door with the astragal open, the second door closed and the coordinators failed to release the first doors leaving six inch gaps. The maintenance director acknowledged at the time of observations, the coordinators were malfunctioning.</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 4 self closing doors to hazardous areas, such as a kitchen, were held open only by devices which would allow the doors to close upon activation of the fire alarm system. This deficient practice affects visitors, staff and 10 or more patients.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/15/14 at 1:55 p.m., two self closing doors between the food service area and the kitchen stood wide open. Both doors were equipped self closers which, when the doors were pushed wide open, had a feature on the self closers which prevented the doors from closing without being pulled closed. The maintenance supervisor acknowledged at the time of observation,</p>			

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K010029	<p>the doors would not automatically close when opened fully.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to provide automatic door closers on 6 of 12 doors providing access to hazardous areas such as a kitchen and hazardous materials storage room. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon</p>	K010029	This was the same issue as identified and appealed on a previous survey (2011). We submitted information that removed this issue from the document, and we were deemed in compliance. We ask that the same be done with this survey. 1. Install self closing door closers on doors. 2. Installing these	07/16/2014	

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	<p>activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch into the door frame when closed to keep the door tightly closed. This deficient practice could affect visitors, staff and 10 or more patients in the center second floor smoke compartment and first floor dining room.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 05/15/14 at 1:55 p.m., a rolling steel door which protected the three by four foot opening between the kitchen and dining room was not self closing. The maintenance director acknowledged at the time of observation, the door had to be manually closed to provide separation between the two spaces.</p> <p>b. Based on observation with the maintenance director on 05/15/14 at 2:10 p.m., the biohazard materials storage room on the second floor contained three receptacles one half or more full of soiled linens and trash. The receptacles were each larger than 32 gallons in capacity. The door separating the room from the exit corridor had no self closer. The maintenance director acknowledged at the time of observation, the door would not automatically close.</p> <p>c. Based on observation with the</p>		<p>closers will correct the issue. 3. Maintenance Department 4. 15 days. continued: 1. Install positive latches on these doors. 2. Installing these latches will correct the issue. 3. Maintenance Department 4. 15 days.</p>				

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K010038	<p>maintenance director on 05/15/14 at 2:15 p.m., four kitchen access doors equipped with self closers each had no automatic positive latch. Instead the doors were equipped with deadbolt latches which required a key to secure them in their door frames. The maintenance director acknowledged at the time of observations, the doors could not latch automatically to secure them in the door frames.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the discharge means of egress for 1 of 3 grade level exits from the second floor were arranged to be accessible. LSC 7.1.3.2.3 requires an exit enclosure shall not be used for any purpose with the potential to interfere</p>	K010038	<p>1. Picnic table was removed from sidewalk and removed from area.2. Picnic table was removed from area.3. Maintenance Department4. Completed.</p>	06/26/2014
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K010048	<p>with its use as an exit. LSC 7.1.10.1, "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice affects staff, visitors and 10 or more patients using second floor level exits to grade from the A unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 05/15/14 at 2:15 p.m., the second floor emergency exterior exit from the A units discharged onto a sidewalk. The path of egress was blocked by picnic tables on the north side of the building. The maintenance director said at the time of observation, the picnic tables were not usually located on the sidewalk, they were probably put there by the mowing crew who had not returned them to keep the exit discharge clear.</p> <p>NFPA 101 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. 19.7.1.1 Based on record review and interview, the facility failed to provide a complete written fire safety plan addressing all items required by NFPA 101, 2000</p>	K010048	<p>1. Rewriting of the Fire Plan to accommodate Life Safety rules.2. Update plans to follow Life Safety Rules.3. Safety Director.4. 10 days.</p>	07/09/2014			

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	<p>edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants in the event of an emergency when the written fire plan should be immediately available.</p> <p>Findings include:</p> <p>Based on a record review with the maintenance director on 05/15/14 at 3:30 p.m., the Fire Protection plan gave conflicting instruction. Page 2 instructed staff to use the RACE procedure "in the event of fire." The next section of the fire plan titled Specific Instructions In Case Of Fire noted at II., If a small fire, pull alarm, try to extinguish.....; section IV. noted, "If fire of larger area occurs,...." and then gave direction to pull the alarm, close doors and move patients. The maintenance director acknowledged</p>						

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K010050	<p>at the time of record review, staff were not trained in fire fighting, there was no such thing as a small fire, and the Specific Instructions conflicted with rescuing patients before any attempt to extinguish a fire they might or might not be able to control. Additionally, the plan failed to identify smoke barriers and the specific evacuation of a smoke compartment, identify the types of fire extinguishers available and address the use of the K-class fire extinguisher located in the kitchen in relationship to activation of the kitchen hood extinguishing system.</p> <p>NFPA 101 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p>			

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	<p>Based on record review and interview, the facility failed to conduct fire drills at varied times during 4 of the past 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of monthly Fire Drill Reports with the maintenance director on 05/15/14 at 2:55 p.m., first shift fire drills during the second and third quarters of 2013 were conducted at 2:17 p.m. and 2:00 p.m.; second shift drills during the fourth quarter of 2013 and the first quarter of 2014 were conducted at 3:00 p.m. and 3:10 p.m., third shift drills were conducted at 6:00 a.m., 6:08 a.m. (two quarters), 6:03 a.m., during the second, third, and fourth quarters of 2013 and the first quarter of 2014. The maintenance director acknowledged at the time of record review, there had been little variation in the times for fire drills conducted.</p>	K010050	<p>1. Vary fire drills to accommodate Life Safety Rules.2. Safety Director will monitor all drills.3. Safety Director.4. Completed.</p>	06/26/2014	

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K010051	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure a smoke detector connected to the fire alarm system in 1 of 1 medical records offices was properly separated from an air supply or return vent. NFPA 72, National Fire Alarm Code, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect visitors, staff, and 10 or more patients.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K010051	<p>1. Remove the vent and redirect it to flow away from smoke detector.2. Vents will be checked for direction when cleaned.3. Maintenance will check vents after they are cleaned4. Completed.</p>	06/26/2014			

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K010061	<p>maintenance director on 05/15/14 at 1:15 p.m., a smoke detector was located 24 inches between two ceiling air vents in the medical records department. The maintenance director confirmed the distance measurement and agreed at the time of observation, the air flow could impede the function of the smoke detector because the vent cover for one of the vents had the louvers directed toward the smoke detector.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 Based on record review, observation and interview; the facility failed to electronically supervise 1 of 3 sprinkler system water control valves. LSC Section 9.7.2.1 requires supervisory attachments to be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code and a distinctive supervisory signal to be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. This deficient practice could affect all occupants, if the valve was tampered with and not detected.</p>	K010061	1. The valve is no longer needed since the system has been expanded and will be removed from service.	08/15/2014

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K010069	<p>Findings include:</p> <p>Based on observation with the maintenance director on 05/15/14 at 2:45 p.m., a sprinkler system water control valve located in the maintenance shop lacked electronic supervision. A review of sprinkler system test and inspection records with the maintenance director on 05/15/14 at 3:05 p.m. revealed the deficiency was noted on a 10/11/13 inspection and test report. The maintenance director acknowledged at the times of observation and record review, there was no electronic supervision of the valve.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review and interview, the facility failed to ensure 1 of 1 range hood's fire extinguishing equipment was inspected and approved every 6 months by properly trained and qualified persons. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-2.1 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made</p>	K010069	<p>1. Cleaning and any inspections to the hood fire system will be done every 6 months and will be kept together in the same binder. 2. Inspections and cleaning of the kitchen hood fire system will be kept in the same binder for observation. 3. Safety Director. 4. Completed. The documentation that was unavailable is now complete and will show the ongoing monitoring was done (will be available for inspection upon return visit) and will continue to be</p>	08/05/2014

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	<p>at least every 6 months by properly trained and qualified persons. Furthermore, NFPA 96, 8-2.1.1 requires actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, fire actuated dampers, etc., shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice could affect visitors, staff and 10 or more patients in the adjacent dining room.</p> <p>Findings include:</p> <p>Based on a review of contracted Range Hood System Reports with the maintenance director on 05/15/14 at 3:25 p.m., the last inspection and service record for the commercial range hood fire equipment extinguishing system was dated 07/26/13. The record prior to that evidenced inspection and service in 2012. The maintenance director said at the time of record review, he was unaware the time between inspections had exceeded the minimum six months allowed.</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control</p>		done.		

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	<p>and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect visitors, staff and 10 or more patients in the adjacent dining room.</p> <p>Findings include:</p> <p>Based on review of Pro Clean Exhaust System Cleaning documentation with the maintenance director on 05/15/14 at 3:20 p.m., the last documented inspection and cleaning was done in February 2014. The</p>			
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K010070	<p>cleaning was also noted on a sticker affixed to the range hood during a tour with the maintenance director on 05/15/14 at 1:50 p.m. The previous record for the exhaust system cleaning evidenced cleaning in February of 2013. The maintenance director said at the time of observation, if there was no record in the binder containing the records, a six month cleaning/service had not been done.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and interview, the facility failed to provide evidence 1 of 1 space heaters was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice could affect visitors, staff and 10 or more patients.</p> <p>Findings include:</p>	K010070	<p>1. Heater was removed.2. P&P to address this issue.3. Safety Committee.4. 10 days.</p>	07/09/2014

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K010144	<p>Based on observation with the maintenance director on 05/15/14 at 12:30 p.m., a space heater was operating at the reception desk. The maintenance director said at the time of observation, he had no evidence the space heater element would not exceed the 212 F degree limit, he thought it was a fan. The receptionist confirmed at the time of observation the device was blowing warm air. During record review on 05/15/14 at 3:10 p.m., the maintenance director said he had no written policy for the use of space heaters but they were generally prohibited everywhere in the building.</p> <p>NFPA 101 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.</p> <p>1. Based on record review and interview, the facility failed to provide evidence monthly generator load tests were performed for during 11 of the past 12 months using one of the three following methods: under operating temperature</p>	K010144	<p>1. Found the documentation for generator.2. Keep documentation handed in each week.3. Maintenance Engineer.4. Completed.</p>	06/26/2014

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	<p>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. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be 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 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. This deficient practice could affect all patients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Generator Check Lists with the maintenance director on 05/15/14 at 3:10 p.m., there were no records of generator load tests for the past year except the preventive</p>			

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	<p>maintenance test conducted by the generator contractor on 02/28/14. The maintenance director said at the time of record review, the engineer responsible for performing the tests had taken another job during the past week and he was unable to locate the most recent generator testing information.</p> <p>2. Based on interview and record review, the facility failed to provide documentation for weekly testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires weekly maintenance of the emergency generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-3.6 requires storage batteries used for generator sets in Level 1 and 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. 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 affects all patients, staff and</p>			

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	<p>visitors.</p> <p>Findings include:</p> <p>Based on review of Generator Check Lists with the maintenance director on 05/15/14 at 3:10 p.m., there were no records of weekly generator inspections for the past year except the preventive maintenance test and inspection conducted by the generator contractor on 02/28/14. The maintenance director said at the time of record review, the engineer responsible for performing the tests had taken another job during the past week and he was unable to locate the most recent generator testing information.</p>						