

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151324	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2013
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NAME OF PROVIDER OR SUPPLIER JASPER COUNTY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1104 E GRACE ST RENSSELAER, IN 47978
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K0000	<p>A Life Safety Code Recertification Survey for a Critical Access Hospital (CAH) was conducted by the Indiana State Department of Health in accordance with 42 CFR 485.623(d).</p> <p>Survey Date: 02/07/13</p> <p>Facility Number: 005072 Provider Number: 150078 AIM Number: 100269660A</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist Robert Sutton,, Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Jasper County Hospital, was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 485.623(d), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19,</p>	K0000		
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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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	<p>Existing Health Care Occupancies.</p> <p>The facility consisted of three separate buildings: the main hospital, a second, identified as the Medical Outreach Building (MOB) for outpatient rehabilitation services, and an administration building added in 2011. A long term Residential Care facility occupies the west side of the second floor and an outpatient physicians office is located in a southwest section of the first floor. The main hospital, a three story building building with a basement was partially sprinklered. The MOB was a one story building with a sprinklered basement. The administration building was sprinklered and protected by the fire alarm system. The buildings were determined to be Type II (222) construction.</p> <p>Sprinklered areas of the main building included the Emergency Room, Registration, main lobby and entrance areas located on the</p>			

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	<p>first floor north of the fire wall, basement of the 1983 addition, the boiler room, all environmental storage areas and offices, the water lab, equipment room # 2 and the corridor outside the pharmacy.</p> <p>The facility has a fire alarm system with smoke detectors in hazardous areas and corridors. The facility has the capacity for 25 patients and had a census of 19 patients.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/13/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K0018	<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 there were no impediments to closing doors protecting corridor openings in 1 of 5 smoke compartments. This deficient practice affects staff, visitors and 10 or more patients on the first floor.</p> <p>Findings include:</p> <p>Based on observation with the Vice President of Support Services on 02/07/13 between 11:30 a.m. and 3:30 p.m., the cardiac ultrasound and radiology exam room were</p>	K0018	Door hold open devices will be removed from all doors indicated in Statement of Deficiencies. Completion Date: March 7, 2013 Responsible Party: Facilities Director	03/07/2013			

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	each equipped with kick down door stops. The double doors separating the outpatient recovery suite from the exit corridor were held open by a wooden wedge. The Vice President of Support Services acknowledged at the time of observations, the doors were prevented from closing.			
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K0021	<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>Based on observation and interview, the facility failed to ensure 1 of 4 doors to a hazardous area, such as room for the collection of soiled linens and trash, was held open only by a device which would allow the doors to close upon activation of the fire alarm system. This deficient practice affects visitors, staff and 14 patients on the Med/Surg floor.</p> <p>Findings include:</p> <p>Based on observation with the Vice President of Support Services on</p>	K0021	<p>Door to soiled utility room on Medical-Surgical Unit will remain closed, sign to be placed. Completion Date: March 7, 2013 Responsible Parties: Facilities Director and Acute Care Services Director</p>	03/07/2013			

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	02/07/13 at 1:50 p.m., the door to the hazardous waste room on the Med/Surg floor was equipped with a self closer which, when the door was opened wide, prevented the door from closing. The room was used for the collection of bagged soiled linens and trash which were piled high above the rim of the collection receptacles. The Vice President of Support Services acknowledged at the time of observation, the device prevented the door from self closing.			

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K0025	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through ceiling smoke barriers in 2 of 16 rooms in the surgery suite were protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect staff and 4 or more</p>	K0025	<p>Ceiling smoke barrier penetrations sealed with fire stopping. Area above drop ceiling in disinfecting room verified as sealed. Completion Date: February 21, 2013 Responsible Party: Facilities Director</p>	03/07/2013	

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	<p>surgery patients.</p> <p>Findings include:</p> <p>Based on observation with the Vice President of Support Services on 02/07/13 between 1:00 p.m. and 1:40 p.m., ceiling conduit penetrations for two substerile rooms in the surgery suite were unsealed leaving one quarter inch annular gaps around the penetrations. The same penetration gap was noted around a ceiling penetration in the disinfecting room ceiling. The Vice President of Support Services agreed at the time of observations, the gaps should have been sealed.</p>				

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K0029	<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</p> <p>1. Based on observation and interview, the facility failed to provide automatic door closers on 1 of 4 doors providing access to a hazardous area in the surgery suite. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect staff and 4 or more patients in the surgery suite.</p> <p>Findings include:</p> <p>Based on observation with the Vice President of Support Services on 02/07/13 at 1:10 p.m., the</p>	K0029	<p>(1) Automatic door closing device installed on storage room noted in Statement of Deficiencies. Completion Date: February 20, 2013 Responsible Party: Facilities Director(2) Environmental Services storage area is sprinkled. Wall penetrations will be sealed. Area missing from concrete wall verified to have fire rating at 2.0 hours. Spray-Fire Resistive Material (SFRM), column and lintel in this location also verified at 2.0 hours. Completion Date: March 7, 2013 Responsible Party: Facilities Director</p>	03/07/2013
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	<p>hazardous waste room in the surgical suite had bagged soiled linens and trash piled high in receptacles. The accumulated waste exceeded 32 gallons in a 64 square foot area. The door had no self closer. The Vice President of Support Services acknowledged there was nothing to ensure the door would self close.</p> <p>2. Based on observation and interview, the facility failed to ensure the one hour fire resistance of walls in 1 of 12 basement hazardous areas, such as the unsprinklered environmental services storage room, was maintained. This deficient practice could affect any visitors, staff or patient in the cafeteria access corridor in the adjacent smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the Vice President of Support Services on 02/07/13 at 3:45 p.m., the</p>			

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	environmental services supply room housed paper, cloth and cardboard combustibles in the 22 by 22 foot room. The wall separating the supply room from the adjacent exit corridor had five unsealed pipe and conduit penetrations in the drywall. In addition, a one by six inch section was missing from the concrete wall. The Vice President of Support Services said at the time of observation, the wall should have been sealed by contractors who worked on the wall.			

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K0046	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review and interview, the facility failed to provide documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours for 8 of 8 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice could affect visitors, staff, and any of 19 or more patients if emergency lighting failed and interfered with repair of any emergency generator or boiler.</p> <p>Findings include:</p> <p>Based on review of untitled inspection and test records for the</p>	K0046	Battery powered emergency lights will be tested every 30 days for 30 seconds and annually for 90 minutes. Completion Date: March 7, 2013 Responsible Party: Facilities Director	03/07/2013	

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	<p>emergency generators which included "emergency light test" with the Vice President of Support Services and Maintenance # 1 on 02/07/13 at 4:15 p.m., the generator test records included spaces for documenting tests for battery powered emergency lighting fixtures located at emergency generator locations. A check was recorded to indicate testing of all fixtures at each site. No entry for testing the lighting was entered for January 2012 through April 2012 and October and November of 2012. Maintenance # 1 said all all records for work done had been provided; the checkmarks indicated 30 second checks of the fixtures when done, and no annual check had been performed on any of the light fixtures.</p>			

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K0050	<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> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could affect all patients, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill Reports and interview with the Vice President of Support Services on 02/07/13 at 11:55 a.m., there was no record of a second shift fire drill for the first quarter of 2012. The Vice President of Support Services reviewed all the fire drill records a second time,</p>	K0050	<p>Fire Drill report missing from second shift in first quarter. Safety Committee Chairperson develops and reviews the fire drill schedule. Chairperson will review the drill reports prior to the end of each quarter to verify each drill per shift has occurred. Completion Date: March 7, 2013 Responsible Party: Safety Committee Chairperson</p>	03/07/2013			

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	acknowledged fire drill records were not complete and said he had provided all fire drill documentation.			

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K0052	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 72 of 72 smoke detectors had been sensitivity tested. NFPA 72, at 7-3.2.1 states, Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked</p>	K0052	<p>A revised report of the sensitivity testing for the smoke detectors was received on March 8, 2013, and included a further description of the devices which were in question by the ISDH. (Attachment) Also included in the attachment is verification of repair of the failed horn/strobe in an e-mail dated August 29, 2012. The Hospital replaced the identified panel batteries on August 30, 2012. The fire system contractor provided proposals for correcting failed devices to the Hospital on March 8, 2013. A review of the proposal options will be completed by March 22, 2013, with approval provided to the contractor at that time. The repairs will commence as soon as the contractor is able to secure materials and schedule labor to complete the process. During the repair process the field technician will test the sensitivity on the device in Obstetrical Patient Room 241 which was occupied during the inspection visit and verify the correction of the horn/strobe devices previously listed as failed. Completion Date: May 7, 2013 Responsible Party:</p>	05/07/2013
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	<p>sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector." This deficient practice affects all occupants.</p> <p>Findings include:</p>		Vice President of Support Services.		

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	Based on a review of the facility fire system service and inspection records on 02/07/13 at 12:10 p.m. with the Vice President of Support Services, a record of smoke detector sensitivity testing was not found. The Vice President of Support Services offered an Annual Fire Alarm Test & Inspection report dated 07/17/12 as a current sensitivity test report, but the documentation indicated only function testing was done. His subsequent call to the fire system contractor charged with performing fire system inspections and testing resulted in no more information.			
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K0062	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure sprinkler waterflow alarm devices were tested quarterly for 3 of 4 quarters. NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, at 2-3.3 requires waterflow alarm devices including but not limited to mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. NFPA 25, 9-4.4.2.1 requires the priming level shall be tested quarterly. NFPA 25, 9-7.1 requires the fire department connections shall be inspected quarterly. NFPA 25, 1-8.1 requires the records shall indicate the procedure performed (inspection, test, or maintenance), the organization that performed the</p>	K0062	<p>Quarterly inspection of sprinkler system added to contract with current vendor. Next inspection due in March 2013. Completion Date: April 7, 2013 Responsible Party: Vice President of Support Services</p>	04/07/2013	

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	<p>work, the results and the date.</p> <p>Finally, NFPA 25, 1-8 requires records of inspection, test, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to valve inspections, flow, drain, and pump tests; and trip tests of dry pipe, deluge and preaction valves. This deficient practice affects all occupants in the facility including staff, visitors, and patients.</p> <p>Findings include:</p> <p>Based on a review of sprinkler inspection reports with the Vice President of Support Services 02/07/13 at 12:45 p.m., quarterly sprinkler inspections for the first, second, and fourth quarters of 2012 were not found. The Vice President of Support Services said at the time of record review, there were no quarterly sprinkler inspection records for 2012 because the inspections had not been done.</p>			
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K0064	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>1. Based on observation and interview, the facility failed to ensure monthly checks were provided for 9 portable fire extinguishers located on 3 of 4 floors. NFPA 10, the Standard for Portable Fire Extinguishers, in 4-4.1 requires extinguishers shall be subjected to maintenance not more than one year apart or when specifically indicated by a monthly inspection. NFPA 10, 4-2.2 defines maintenance as a "thorough check" of the extinguisher. It is intended to give maximum assurance the extinguisher will operate effectively and safely. NFPA 10, 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check that an extinguisher is available and will operate. This deficient practice could affect affect visitors, staff</p>	K0064	<p>(1) Due to an extended absence, the responsible party for fire extinguisher monthly inspections did not complete their task during the fourth quarter of 2012. The Safety Committee Chairperson will assign not less than two individuals to inspect fire extinguishers monthly to prevent further occurrences. Completion Date: March 7, 2013 Responsible Party: Safety Committee Chairperson(2) Fire extinguishers in Covered Emergency Entrance lowered to proscribed height. Completion Date: February 20, 2013 Responsible Party: Facilities Director</p>	03/07/2013			

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	<p>and 19 or patients.</p> <p>Findings include:</p> <p>Based on observation with the Vice President of Support Services on 02/07/13 between 11:00 a.m. and 4:30 p.m., the service and inspection tags on the portable fire extinguishers indicated monthly fire extinguisher checks were not done for fire extinguishers located:</p> <ul style="list-style-type: none"> a. In ICU between 08/01/12 and 01/22/13; b. At the penthouse landing between 08/12 and 02/07/13; c. Near 307 between 08/12 and 02/07/13; d. Near the med surg supply storage room between 10/12 and 01/22/13; e. Near 302 between 08/01/12 and 01/22/13; f. Near 319 between 08/01/12 and 01/12/13; g. Near the nursery between 08/12/12 and 12/12; h. Near the conference room between 08/12/12 and 02/07/13; 			

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	<p>i. Near Out Patient Recovery between 12/06/12 and 02/07/13. The Vice President of Support Services acknowledged at the time of observations, the fire extinguisher inspections should have been done, they had been interrupted when a staff member took a leave of absence.</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers were installed correctly in the emergency ambulance bay. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires that the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be no more than three and one half feet (42 inches) above the floor. This deficient practice affects could affect staff, visitors and 2 or more patients entering the emergency room via</p>			

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	<p>the ambulance bay.</p> <p>Findings include:</p> <p>Based on observation with the Vice President of Support Services on 02/07/13 at 2:20 p.m., portable fire extinguishers were measured at 67 inches above the finished floor in the ambulance bay. The Vice President of Support Services acknowledged at the time of observation the fire extinguishers were mounted higher than the maximum number of inches allowed above the floor.</p>				

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K0144	<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 observation and interview, the facility failed to ensure 1 of 3 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning.</p>	K0144	<p>(1) Remote annunciator to be installed. Quotation requested February 15, 2013. Completion Date: May 7, 2013 Responsible Party: Vice President of Support Services (2) Weekly battery tests and monthly load tests will be performed. Completion Date: March 7, 2013 Responsible Party: Facilities Director (3) Emergency Stop devices will be installed on all generators. Quotation requested February 15, 2013. Completion Date: May 7, 2013 Responsible Party: Vice President of Support Services</p>	05/07/2013			

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	<p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect visitors, staff, and 4 or more patients in surgery, radiology and diagnostic testing areas.</p> <p>Findings include:</p>				

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	<p>Based on observations with the Vice President of Support Services on 02/07/13 between 1:30 p.m. and 4:00 p.m., three emergency generators served different parts of the hospital building. Ancillary remote alarm annunciators were provided at the reception desk for two of the generators. The annunciator panels were not identified for the generators they served. The Vice President of Support Services had to go through a process of elimination to determine the 2011 Cummins generator had no remote annunciator. He said he did not know why a remote annunciator had not been installed for the newest generator.</p> <p>2. Based on record review and interview, the facility failed to ensure records for weekly battery checks and monthly load tests for 3 of 3 emergency generators were completed to demonstrate load testing conducted using one of the</p>			
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	<p>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. 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</p>			

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	<p>operations.</p> <p>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 occupants.</p> <p>Findings include:</p> <p>Based on review of the untitled emergency generator test records provided for each of three emergency generators by the Vice President of Support Services on 02/07/13 at 4:05 p.m., the records included "amp draw, battery volt, water temperature, and oil</p>				

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	<p>pressure" readings for February, May, June, September, and December of 2012 and January of 2013. Other months had notes reflecting a power outage had occurred. No readings were recorded. A column for "transfer to EPS" had check marks for the month of February, May and June. The Vice President of Support Services could not describe what testing had actually been done based on the records and called Maintenance # 1 to explain. Maintenance # 1 said monthly load tests were done "whenever there was time," the generators were "three phase generators and the readings for each phase were not recorded," he was not sure what percent load was carried on each generator and he was unable to calculate the load from the information available. The record did not include the time for the transfer of power from the main source to the generator. Maintenance # 1 said no weekly inspections of the generators was</p>			

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	<p>done.</p> <p>3. Based on observation and interview, the facility failed to ensure 3 of 3 emergency generators were equipped with remote manual stops. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient</p>			

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	<p>practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the emergency generator maintenance and service records on 02/07/13 at 4:05 p.m. with the Vice President of Support Services and Maintenance # 1, there was no documentation available indicating the horsepower of each generator. Based on observation of generator equipment on 02/07/13 between 11:00 a.m. and 3:30 p.m. with the Vice President of Support Services, no evidence of a remote shut off device was found for the three generators. Maintenance # 1, interviewed on 02/07/13 at 4:15 p.m., said he thought the generators all exceeded 100 horsepower and he was not aware of a remote shut off device for either generator installed before 2003 and one generator put in service in 2011.</p>				

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