STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155692		03/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE OF HUNTINGTON	1180 W 500 N HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/20/14 Facility Number: 002910 Provider Number: 155692 AIM Number: 200345390 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Heritage of Huntington was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building consisting of the I hall, L hall, Memory Care and the main dining room was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility with a basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with	K010000		

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

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

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	smoke detection in the corridors, in areas open to the corridor and hard wired smoke detectors in the resident rooms. The facility has a capacity of 78 and had a census of 59 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had a detached garage providing facility services including storage for the bus, lawn equipment, a golf cart and maintenance supplies that was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/27/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010021 SS=E	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: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 2 single fire doors was held open only by a device which would allow it to close automatically upon activation of the fire alarm system. This deficient practice could affect 1 of 6 smoke compartments. Findings include: Based on observation with Maintenance Technician # 1 on 03/20/14 at 12:35 p.m., the door to the medication room at the healthcare nurses' station was held open with a wire hook that was mounted to the wall. The medication room door was in the two hour fire separation wall between Healthcare and Assisted Living. Maintenance Technician # 1 acknowledged the medication room door	K010021	K021-E 1) Hook holding open door was removed. 2) All doors were inspected to ensure no devices for holding them open were present 3) Fire doors will be inspected quarterly to ensure no devices for holding them open are present. 4) Maintenance department will add inspection of fire doors to quarterly QA report 5) March 20, 2014	03/20/2014

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	was in the fire wall and removed the wire hook at the time of observation. 3.1-19(b)			

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K010029 SS=E	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 ensure the corridor doors to 1 of 1 laundry rooms, 1 of 1 boiler rooms and 1 of 1 kitchen window doors closed and latched into the door frame. This deficient practice could affect residents in 1 of 2 smoke compartments in the basement. Findings includes: a. Based on observation with Maintenance Technician # 1 on 03/20/14 from 12:19 p.m. and 12:40 p.m., the basement laundry room and the basement boiler room had double corridor doors. One door was equipped with a manual latching device that would latch into the door frame and the remaining door was designed to latch into the stationary door. Each door could not latch automatically, and independent of the other door into the	K010029	K029-E 1) Doors put in closed position. Facility immediately contacted contractor to install correct latching devices on doors 2) All other doors were inspected to ensure proper latching devices are present and working 3) Fire doors will be inspected quarterly to ensure proper latching devices are present and working 4) Maintenance department will add inspection of fire doors to quarterly QA report 5) April 30, 2014. Parts are on order with contractor. Per contractor they could not guarantee installation of latches prior to April 30. **Please note April 30, 2014 is a tentative date only.	04/30/2014

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	door frame. This was acknowledged by Maintenance Technician # 1 at the time of observations. b. Based on observation with Maintenance Technician # 1 on 03/20/14 at 12:12 p.m., the kitchen corridor window door could be held open by a device that would not release with the fire alarm, the window door lacked a self closing device and failed to automatically latch into the frame. This was acknowledged by Maintenance Technician # 1 at the time of observation. 3.1-19(b)			

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K010038 SS=E	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 1 of 5 exit discharge paths was readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for buildings shall comply with Chapter 7. LSC Section 7.2.5.4 requires a ramp with a rise greater than 6 inches shall have handrails. LSC Section 7.2.2.4.2 Exception #3 states existing ramps shall be permitted to have a handrail on one side only. This deficient practice could affect 16 of the I hall residents evacuated through the I southeast exit in the event of an emergency. Findings include: Based on observation with Maintenance Technician # 1 on 03/20/14 at 12:50 p.m., the I hall southeast exit discharge sidewalk ramp lacked a handrail. Based on an interview with Maintenance Technician # 1 at the time of observation, he confirmed the rise from the street measuring up to the where the sidewalk levels off was approximately 10 feet. 3.1-19(b)	K010038	K038-E 1) Contractor contacted to install handrail on sidewalk ramp 2) Exit ramps inspected by Maintenance dept for rise that would require handrail 3) Any new sidewalk or ramp will be evaluated for handrail requirement 4) Any new sidewalk or ramp will be evaluated for handrail requirement 5) April 30, 2014 Contractor: W.W. Williams Midwest 610 W Washington St. Bluffton, IN 46714	04/30/2014

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K010044 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 2 of 7 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect 16 residents in the I hall and at least 20 residents in the main dining room. Findings include: Based on observations with Maintenance Technician # 1 on 03/20/14 from 2:19 p.m. to 2:30 p.m., the fire door set on I hall and near the main dining room failed to latch into the door frame. Based on an interview with the Maintenance Technician # 1 at the time of observations, the push bar wasn't allowing the doors to latch into the frame. 3.1-19(b)	K010044	K044-E 1) Door was adjusted by maintenance staff to close properly 2) All fire doors were inspected by maintenance staff to ensure they close properly 3) Fire doors will be inspected by maintenance for proper closure during required fire alarm testing at least once each quarter 4) Fire doors will be inspected by maintenance for proper closure during required fire alarm testing at least once each quarter 5) March 20, 2014	03/20/2014

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K010048 SS=C	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 written plan that included the different types and the use of fire extinguishers provided in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (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 This deficient practice could affect all occupants. Findings include: Based on a record review with Maintenance Technician # 1 on 03/20/14 at 11:10 a.m., the "Disaster Plan" did not address the types of fire extinguishers throughout the facility including the kitchen K-class fire extinguisher in relationship with the use of the kitchen	K010048	K048-C 1) Disaster plan reviewed 2) Disaster plan already included the different types of fire extinguishers used in the Facility. **Exhibit A** Updated policy to include detailed use of Class K and Class ABC fire extinguishers . **Exhibit B** 3) Any new fire extinguisher added to facility will be checked against disaster policy to ensure inclusion 4) Annual inspection of fire extinguishers will add notation for type of extinguisher. Any type indicated not already on form from previous year will be added to disaster policy 5) April 19, 2014	04/19/2014

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	hood extinguishing system. This was confirmed by Maintenance Technician # 1 at the time of record review when he was unable to locate the information in the disaster plan. 3.1-19(b)			

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K010050 SS=F	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 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on third shift for 4 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on review of the "Fire Drill Reporting Form" with Maintenance Technician # 1 at 11:25 a.m., actual fire drills were not conducted on the third shift for the last four quarters. Based on an interview with Maintenance Technician # 1 at the time of record review, an actual fire drill was not conducted but the third shift fire drill time was used as a training session where the staff member is required to give step by step instructions of what they would do in case of a fire.	K010050	K050-F 1) Fire drill policy reviewed 2) Fire drill policy updated to include coded announcement. "Code F " will be used for third shift fire drills. **Exhibit C** 3) All Staff will be in-serviced on the code word announcement, "Code F". The Fire drill reporting form will be collected by the Director of Maintenance for each shift quarterly with any concerns discussed and action plans implemented as needed. **Exhibit D** 4) Fire drill reporting form will be collected by the Director of Maintenance for each shift quarterly with any concerns discussed and action plans implemented as needed 5) April 19, 2014	04/19/2014

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	3.1-19(b) 3.1-51(c)			

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K010064 SS=D	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 Based on observation and interview, the facility failed to ensure 1 of 1 beauty shop portable fire extinguishers received annual maintenance. 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 an extinguisher will operate effectively and safely. This deficient practice could affect affect 2 residents in the beauty shop. Findings include: Based on observation and interview with Maintenance Technician # 1 on 03/20/14 at 2:30 p.m., he confirmed the beauty shop had a disposable portable fire extinguisher which lacked an annual maintenance tag. 3.1-19(b)	K010064	K064-D 1) Disposable fire extinguisher in beauty shop replaced with annually inspected fire extinguisher 2) No other disposable fire extinguishers present in facility 3) Facility will only permit fire extinguishers that can be inspected annually 4) Maintenance department will ensure all fire extinguishers are inspected annually. 5) April 4, 2014	04/04/2014

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K010070 SS=C	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 Based on record review and interview, the facility failed to ensure 1 of 1 policies regarding the use of portable space heaters in the facility was in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect any number of residents. Findings include: Based on an record review with Maintenance Technician # 1 on 03/20/14 at 10:57 a.m., the "Space Heater" policy does not state the space heater's heating element shall not exceed 212 degrees F. This was acknowledged by Maintenance Technician # 1 at the time of record review. 3.1-19(b)	K010070	K070-D 1) Policy regarding space heaters updated to include maximum element temperature of 212 degrees. **Exhibit E** 2) No other policies address space heaters 3) Any policy regarding space heaters will address maximum element temperature of 212 degrees 4) Any policy regarding space heaters will address maximum element temperature of 212 degrees. 5) March 21, 2014 *No space heaters are currently in use in the Facility	03/21/2014

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K010144 SS=F	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. Based on record review and interview, the facility failed to ensure the load testing for the past 12 of 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintains the minimum exhaust gas temperatures or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all resident	K010144	K144-F 1) Contacted W.W. Williams Midwest to get explanation on the 2 gauges in question. 2) No other generators at facility 3) The following will be added to the monthly load test form to make the test performed easier to interpret. "Generator-400kw, 480 volt, Full load amps 602". a. Name plate full load amps = 602 b. 34% of 602 = 204.7 amps c. 480 volts x 1.732 x 204.7 amps (34%) x .8 divided by 1000 = 136 kw d. 34% of 400 kw = 136 kw e. Therefore, 34% of load does equal 34% of amps 4) Monthly load test form will be maintained in maintenance QA 5) March 20, 2014	03/20/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155692	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER HERITAGE OF HUNTINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1180 W 500 N HUNTINGTON, IN 46750	

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	in the facility. Findings include: Based on review of the "Generator Monthly Load Test" with Maintenance Technician # 1 on 03/20/14 at 11:25 a.m., the generator test log showed a monthly load test for the past six months but the log indicated the amps percentage and the load percentage were the same number every month. The log did not provide information that the 400 KW diesel generator was exercised under operating conditions or maintaining the minimum exhaust gas temperatures at least monthly, for a minimum of thirty minutes. With the information provided the percentage of load could not be determined. Prior to September 2013 the generator was operated at less than 30 percent of the EPS nameplate rating. The last annual load bank was completed by W.W. Williams on 09/27/12. Based on an interview with Maintenance Technician # 1 at the time of record review, he was unable to explain why the amp percentage and the load percentage were the same and he was unable to provide additional documentation. 3.1-19(b)			

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K020000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/20/14 Facility Number: 002910 Provider Number: 155692 AIM Number: 200345390 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, The Heritage of Huntington was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The new building consisting of the Rehabilitation hall was surveyed with Chapter 18, New Health Care Occupancies. This one story facility with a basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in areas	K020000		

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	open to the corridor and hard wired smoke detectors in the resident rooms. The facility has a capacity of 78 and had a census of 59 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had a detached garage providing facility services including storage of the bus, lawn equipment, a golf cart and maintenance supplies that was not sprinklered. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K020048 SS=C	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. 18.7.1.1 Based on record review and interview, the facility failed to provide a written plan that included the different types and the use of fire extinguishers provided in the facility in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (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 This deficient practice could affect all occupants. Findings include: Based on a record review with Maintenance Technician # 1 on 03/20/14 at 11:10 a.m., the "Disaster Plan" did not address the types of fire extinguishers throughout the facility including the kitchen K-class fire extinguisher in relationship with the use of the kitchen	K020048	K048-C 1) Disaster plan reviewed 2) Disaster plan already included the different types of fire extinguishers used in the Facility. **Exhibit A** Updated policy to include detailed use of Class K and Class ABC fire extinguishers . **Exhibit B** 3) Any new fire extinguisher added to facility will be checked against disaster policy to ensure inclusion 4) Annual inspection of fire extinguishers will add notation for type of extinguisher. Any type indicated not already on form from previous year will be added to disaster policy 5) April 19, 2014	04/19/2014

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	hood extinguishing system. This was confirmed by Maintenance Technician # 1 at the time of record review when he was unable to locate the information in the disaster plan. 3.1-19(b)			

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K020050 SS=F	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. 18.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on third shift for 4 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on review of the "Fire Drill Reporting Form" with Maintenance Technician # 1 at 11:25 a.m., actual fire drills were not conducted on the third shift for the last four quarters. Based on an interview with Maintenance Technician # 1 at the time of record review, an actual fire drill was not conducted but the third shift fire drill time was used as a training session where the staff member is required to give step by step instructions of what they would do in case of a fire.	K020050	K050-F 1) Fire drill policy reviewed 2) Fire drill policy updated to include coded announcement. "Code F " will be used for third shift fire drills. **Exhibit C** 3) All Staff will be in-serviced on the code word announcement, "Code F". The Fire drill reporting form will be collected by the Director of Maintenance for each shift quarterly with any concerns discussed and action plans implemented as needed. **Exhibit D** 4) Fire drill reporting form will be collected by the Director of Maintenance for each shift quarterly with any concerns discussed and action plans implemented as needed 5) April 19, 2014	04/19/2014

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	3.1-19(b) 3.1-51(c)			
K020070 SS=C	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) 18.7.8 Based on record review and interview, the facility failed to ensure 1 of 1 policies regarding the use of portable space heaters in the facility was in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect any number of residents. Findings include: Based on an record review with Maintenance Technician # 1 on 03/20/14 at 10:57 a.m., the "Space Heater" policy does not state the space heater's heating element shall not exceed 212 degrees F. This was acknowledged by Maintenance Technician # 1 at the time of record review. 3.1-19(b)	K020070	K070-D 1) Policy regarding space heaters updated to include maximum element temperature of 212 degrees. **Exhibit E** 2) No other policies address space heaters 3) Any policy regarding space heaters will address maximum element temperature of 212 degrees 4) Any policy regarding space heaters will address maximum element temperature of 212 degrees. 5) March 21, 2014 *No space heaters are currently in use in the Facility	03/21/2014

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K020144 SS=F	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. Based on record review and interview, the facility failed to ensure the load testing for the past 12 of 12 months indicated a load test was conducted under operating temperature conditions, minimum exhaust gas temperatures or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating temperature conditions, maintains the minimum exhaust gas temperatures or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all resident	K020144	K144-F 1) Contacted W.W. Williams Midwest to get explanation on the 2 gauges in question. 2) No other generators at facility 3) The following will be added to the monthly load test form to make the test performed easier to interpret. "Generator-400kw, 480 volt, Full load amps 602". a. Name plate full load amps = 602 b. 34% of 602 = 204.7 amps c. 480 volts x 1.732 x 204.7 amps (34%) x .8 divided by 1000 = 136 kw d. 34% of 400 kw = 136 kw e. Therefore, 34% of load does equal 34% of amps 4) Monthly load test form will be maintained in maintenance QA 5) March 20, 2014	03/20/2014

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