

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155630	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2013
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NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 904 E 11TH ST RUSHVILLE, IN 46173
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K010000	<p>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).</p> <p>Survey Date: 12/09/13</p> <p>Facility Number: 001126 Provider Number: 155630 AIM Number: 200011300</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist Brett Overmyer, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Flatrock River Lodge 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors,</p>	K010000	<p>Preparation and execution of the plan of correction for the survey does not constitute admission of agreement by this provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of correction is prepared and executed solely because it is required by the Federal and State law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents; nor are they of such character as to limit the provider's capacity to render adequate resident care. This plan of correction serves as the facility's written credible allegation that it will be in substantial compliance on or before January 8, 2014.</p>	
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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>and hard wired smoke detectors in all resident sleeping rooms. The healthcare portion of the facility has a capacity of 63 and had a census of 52 at the time of this survey.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except a detached wood framed pole barn used for storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/12/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010025 SS=E	<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 2 of 4 attic smoke barriers were constructed to provide at least a one half hour fire resistance rating. This deficient practice affects 37 residents who reside on the 300 Hall and 400 Hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor on 12/09/13 during observations of the smoke barrier walls above the drop ceiling assembly from 11:50 a.m. to 12:30 p.m., the 300 Hall smoke barrier wall had a half inch gap around three electrical conduit penetrations which were not firestopped and the 400 Hall smoke barrier wall had two open three inch electrical conduit penetrations and a one inch gap around a water pipe penetration which were not firestopped. This was verified by the maintenance supervisor at the time of</p>	K010025	The facility does assure all smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. The smoke barrier walls above the drop ceiling assembly in the 300 and 400 halls have been repaired with an approved fire stop caulk. An audit has been conducted and no other smoke barriers were found to be in need of repair. Maintenance supervisor will report to QA monthly for 3 months the quarterly for 1 quarter that all smoke barriers meet regulations then will report any negative finding based on Preventative Maintenance documentation thereafter. No residents were affected by this tag. Monitoring to done by administrator.	01/08/2014			

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	<p>observations and acknowledged by the administrator at the exit conference on 12/09/13 at 12:40 p.m.</p> <p>3.1-19(b)</p>			

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K010029 SS=E	<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>Based on observation and interview, the facility failed to ensure the corridor door to 3 of 11 hazardous areas, such as combustibile storage rooms over 50 square feet in size and a laundry room over 100 square feet in size, were provided with self closing devices which would cause the doors to automatically close and latch into the door frames. This deficient practice affects 37 residents who reside on the 100 Hall, 300 Hall and 400 Hall.</p> <p>Findings include:</p> <p>Based on observations on 12/09/13 during a tour of the laundry room, 100 Hall, 300 Hall and 400 Hall from 10:30 a.m. to 11:55 a.m. with the maintenance supervisor, the doors to the unoccupied resident rooms 108, 301, 414 and 416 which each measured one hundred fifty five square feet and stored combustibile</p>	K010029	The facility does ensure the corridor doors to hazardous areas are provided with self closing devices.Laundry room door has been adjusted and now latches into the foor frame. Any hazardous starage will be removed from rooms #108,#414 and #416. A self closing device will be added to room #301 to ensure door will self close in accordance with 8.4.1 anf or 19.2.5.4.An audit has been completed on all doors in facility to ensure all latches close properly and all hazardous areas have slef closing devices on the doors. Maintenance Supervisor will monitor for complaince and report to QA monthly for 3 months and quarterly for 1 quarter any negarive finding based on preventative maintenance documentation thereafter. No residents were affected by this tag.	01/08/2014			

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	<p>cardboard boxes of paper supplies, plastic bed mattress pads and mattresses, wooden chairs, and wooden tables each lacked self closing devices. Furthermore, the laundry room door failed to self close and latch into the door frame on three separate attempts. The lack of self closing devices on the doors to resident rooms 108,301, 414, and 416 and the laundry room door failing to latch into the door frame were verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 12/09/13 at 12:40 p.m.</p> <p>3.1-19(b)</p>			

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K010038 SS=F	<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</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through 3 of 6 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects 42 residents who use the main dining room.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility on 12/09/13 from 10:20 a.m. to 12:40 p.m. with the maintenance supervisor, the main dining room exit, the Rehabilitation Hall exit and the 200 Hall exit were magnetically locked and could be opened by entering a four digit code,</p>	K010038	<p>The facility does ensure the means of egress exits are readily accessible for residents without a clinical diagnosis requiring specialized security measures. The code for all doors locks has been added to all exit doors per LSD 19.2.2.2.4 Maintenance supervisor will monitor for compliance and report to QA monthly for 3 months then quarterly for 1 quarter Any negative finding based on preventative maintenance documentation thereafter. No residents were effected by this tag. The facility wishes to IDR this tag. Although he is very knowledgeable in many areas, the Maintenance Supervisor does not have first-hand knowledge of, or a need to have access to, resident diagnoses. See attached</p>	01/08/2014

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	<p>but the code was not posted next to each exit door in the facility. Based on interview with the maintenance supervisor during the observations, approximately forty one of the fifty two residents in the facility do not have a clinical diagnosis to be in a secure building. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code. The lack of the four digit code posted next to each exit door was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 12/09/13 at 12:40 p.m.</p> <p>3.1-19(b)</p>			

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K010046 SS=E	<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 observation and interview, the facility failed to ensure the lighting in 2 of 6 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the areas in darkness. LSC Section 7.8.1.4 requires illumination be arranged so the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. This deficient practice affect 26 residents who reside on the 200 Hall and 300 Hall.</p> <p>Findings include:</p> <p>Based on observations during a tour of the outside exits with the maintenance supervisor on 12/09/13 from 10:20 a.m. to 12:30 p.m., the 200 Hall and 300 Hall exits were provided with a single bulb light fixture on emergency power outside each exit door. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 12/09/13 at 12:40 p.m.</p> <p>3.1-19(b)</p>	K010046	<p>The facility does have lighting of at least 1 1/2 hour duration. Facility will change exit lighting on halls #200 and #300 to achieve compliance with LSC 7.8.1.4An audit has been completed on all exterior lighting at facility doors to ensure compliance Maintenance superviosr will monitor for compliance and report to QA monthly for 3 months then quarterly for 1 quarter andy negative findings vased on preventative maintenance documentation thereafter. No residents were effected by this tag.</p>	01/08/2014			

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K010050 SS=F	<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 interview and record review, the facility failed to conduct quarterly fire drills on each shift for 2 of 4 quarters over the past year. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Reports with the maintenance supervisor on 12/09/13 at 9:25 a.m., a fire drill was not documented for the second shift, second quarter of the year 2013 and third quarter first shift for the year 2013. Additionally, based on interview with the maintenance supervisor during the review of the Fire Drill Reports, there was no other documentation available for review to verify these drills were conducted. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at</p>	K010050	The facility does conduct quarterly fire drills on each shift. All fire drills will be conducted in accordance with 19.7.1.2 Maintenance supervisor will report findings to QA monthly for 3 months then quarterly for one quarter Any negative findings based on preventative maintenance documentation thereafter. No residents were effected by this tag. Monitoring done by administrator.	01/08/2014			

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	the exit conference on 12/09/13 at 12:40 p.m. 3.1-19(b) 3.1-51(c)			

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K010052 SS=E	<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 Based on observation and interview, the facility failed to ensure 1 of 68 photoelectric smoke detectors was located where airflow would not prevent the operation of the detector. NFPA 72, 2-3.5.1 requires in spaces served by the air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect any residents who use the activity lounge, located in the center Administration Hall.</p> <p>Findings include:</p> <p>Based on observation on 12/09/13 at 11:20 a.m. with the maintenance supervisor, the minimum data set office smoke detector was located within two feet of a supply air duct. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 12/09/13 at 12:40 p.m.</p> <p>3.1-19(b)</p>	K010052	The facility does install, test and maintain the fire alarm system in accordance with NFPA 70 and 72. The smoke detector has been moved to a location at least 5 feet from an air handling system. Per LSC 72.2-3.5.1 An audit has been completed to insure all smoke detector locations are in accordance with LSC listed above. Maintenance supervisor will monitor for compliance and report to QA monthly for 3 months then quarterly for 1 quarter any negative findings based on preventative maintenance documentation thereafter. No residents were effected by this tag.	01/08/2014			

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K010062 SS=E	<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>1. Based on observation and interview, the facility failed to replace 2 of 2 sprinklers covered in corrosion in the dishwashing room. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 42 residents who use the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 12/09/13 at 11:25 a.m. with the maintenance supervisor, the two sprinklers in the kitchen dishwashing room were both completely covered in green corrosion. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 12/09/13 at 12:40 p.m.</p>	K010062	The facility does maintain the automatic spsrinkler system is in reliable operating condition and inspect and test periodically.The 2 spsrinkler heads in the dish room have been replaced and an additional sprinkler head have been added to the sprinkler head storage bos in the mechanical room. An audit has been completed on all sprinkler heads to insure reliable operating condition. Maintenance supervisor will monitor for compliance and report to QA monthly for 3 months then quarterly for 1 quarter any negative findings based on preventative maintenance documentation thereafter. No residents were effected by this tag.	01/08/2014			

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to provide 1 of 3 sprinkler types with a supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation on 12/09/13 at 9:15 a.m. with the maintenance supervisor, the main entrance porch overhang was provided with pendant quick response sprinklers. Based on observation of the spare sprinkler cabinet with the</p>			

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	<p>maintenance supervisor on 12/09/13 at 10:40 a.m. which was located in the mechanical room sprinkler riser room, there were no spare pendant quick response sprinklers in the spare sprinkler cabinet. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 12/09/13 at 12:40 p.m.</p> <p>3.1-19(b)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155630		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 12/09/2013	
NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE				STREET ADDRESS, CITY, STATE, ZIP CODE 904 E 11TH ST RUSHVILLE, IN 46173			
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K010067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on interview and record review, the facility failed to ensure 4 of 4 fire dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on an interview with the maintenance supervisor on 12/09/13 during record review from 9:00 a.m. to 10:35 a.m., when asked if the facility had any fire dampers and inspection records, the maintenance supervisor indicated</p>	K010067	The facility will inspect and provide necessary maintenance in accordance with NFPA 90A. LSC 9.2.1The facility fire dampers will be serviced and inspected per PFPA 90A 1999 Edition 3.4.7An audit has been completed of all fire dampers. Maintenance supervisor will monitor for compliance and report to QA when the inspection is completed. Any negative findings based on preventative maintenance documentation thereafter.No residents were effected by this tag.	01/08/2014			

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	<p>there are four fire dampers located at each of the four smoke barrier walls on 100 Hall, 200 Hall, 300 Hall and 400 Hall. Furthermore, it was stated the four fire dampers may be inspected every four years by the fire alarm system inspection company. Based on a review of the Superior Systems Inc. Inspection records dating from 02/28/13 and 08/06/13, there was no record the four fire dampers were inspected. Based on a telephone conversation between Superior Systems Inc. and the maintenance supervisor on 12/09/13 at 9:55 a.m., the maintenance supervisor indicated Superior Systems Inc. had no records the four fire dampers were inspected over the past four years. The lack of a four year fire damper inspection was verified by the maintenance supervisor at the time of interview and record review and acknowledged by the administrator at the exit conference on 12/09/13 at 12:40 p.m.</p> <p>3.1-19(b)</p>				

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K010130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire door was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 42 residents who use the main dining room, which is located adjacent to the kitchen rolling fire door.</p> <p>Findings include:</p> <p>Based on observation on 12/09/13 at 11:10 a.m. with the maintenance supervisor, there was a metal rolling fire</p>	K010130	The facility does ensure the care and maintenance of the facility rolling fire door. The rolling fire door will be inspected and recorded annual maintenance inspection in our maintenance records. per NFPA 80 1999 edition. Section 15-2.4.3There is one rolling fire door in facility. Inspection will be completed by Jan 8th of 2014 and annually thereafter. Maintenance supervisor will monitor for compliance and report to QA for 1 month.No residents were effected by this tag.	01/08/2014	

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	<p>door without an inspection tag protecting the opening from the kitchen to the main dining room. Based on interview on 12/09/13 at 11:20 a.m. with the maintenance supervisor, a new fire alarm system inspection company was hired about a year ago and the facility forgot to renew the rolling fire door inspection. The lack of an annual rolling fire door inspection was verified by the maintenance supervisor at the time of interview and acknowledged by the administrator at the exit conference on 12/09/13 at 12:40 p.m.</p> <p>3.1-19(b)</p>			

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K010144 SS=F	<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>Based on record review and interview, the facility failed to exercise the generator for 12 of the past 12 months to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. 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. 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</p>	K010144	<p>The facility does follow the requirements in Chapter 6-4.2 of NFPA110The Maintenance supervisor does test the amps of each leg of the three phase system and does the calculation to convert amps to watts to verify that the generator load is greater the 30% of the 20kw on the nameplate rating on the generator. The load must be greater than 6kw. Name plate rating is a 20 kw and will be added to he monthly Generator load test form. By initialing the form the maintenance supervisor is stating he has done the test and it test 30% of the nameplate rating 20kw.Maintenance supervisor will monitor for compliance and report to QA for 3 months quarterly for 1 quarter any negative finding based on preventative maintenance documentation thereafter. No residents were effected by these tags. Administrator to monitor for compliance. IDR request for K-0144The facility believes the requirement for NFPA 110(99). Sec 6-4.1. NFPA 110(2), Sec. 8.4.1 does not state that the actual % of the load test has to be documented, it only states it would need to be exercised under a load of at least 30%.The facility</p>	01/08/2014

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	<p>deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Generator Monthly Load Test Log with the maintenance supervisor on 12/09/13 at 9:30 a.m., the monthly load test reports dating from 11/12/12 through 11/15/13 failed to indicate a percent of load or exhaust gas temperatures on each monthly load test report. The monthly load tests reports indicated a check mark under a column labeled load is at least 30% of the nameplate rating. The lack of a percent of load listed on the monthly load test reports was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 12/09/13 at 12:40 p.m.</p> <p>3.1-19(b)</p>		<p>policy and procedure for generator monthly Load Test Log requires the initials of the person generating the load and requires the load is at least 30% of the name plate rating in accordance with the law. The facility Generator monthly Load Test was initialed by the maintenance supervisor verifying the load was at least 30% of the nameplate rating each month. See attached facility Thirty-Day Maintenance Summary</p>		