

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/16/2013
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NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342
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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: 07/16/13</p> <p>Facility Number: 000366 Provider Number: 155469 AIM Number: 100288900</p> <p>Surveyor: Joe L. Brown, Jr., Life Safety Code Specialist and Robert Sutton, Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Sebo's Nursing and Rehabilitation Center 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</p>	K010000	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.	

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>Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was surveyed as three separate buildings: Building 0102 was determined to be of Type V (000) construction and fully sprinklered, Building 0202 renovated in 1972 and 1999 was determined to be of Type II (111) construction and fully sprinklered; and Building 0302 was determined to be of Type V (111) construction which encompasses the north and southeast sections of the facility was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas opened to the corridors, and hard wired smoke detectors in the resident sleeping rooms. The facility has a capacity of 138 with a census of 132 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered.</p>			
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	<p>All areas providing facility services were sprinklered except for the detached shed used for the facility storage.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/18/13.</p>				

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K010018 SS=E	<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 3 of 71 doors to resident rooms in the east and west hall closed and latched into the door frame. This deficient practice had the potential to affect those residents in the east and west halls.</p> <p>Findings include:</p> <p>Based on observation on 07/16/13 with the Environmental Director during the tour from 10:00 a.m. to 2:30 p.m., the doors to resident rooms 51, 54, and 67 did not latch into the door frame. Based on</p>	K010018	<p>K 018</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Doors to Resident Rooms 51, 54, 67 were adjusted and are latching into their door frames.</p> <p>How the facility will identify other residents having the potential to be affected by the</p>	08/14/2013
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	<p>interview at the time of observation, on 07/16/13 from 10:00 a.m. to 2:30 p.m., the Environmental Director acknowledged the doors to resident rooms 51, 54, and 67 did not latch into their door frames.</p> <p>3.1-19(b)</p>		<p>same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this alleged deficient practice. A facility wide review of resident doors was completed with corrective actions taken to ensure doors shut and are latching into door frame.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>The Administrator/ designee conducted educational training with Maintenance Director Designee with emphases given on completing audit of preventative maintenance program to ensure all doors are checked every 30 days to maintain compliance.</p> <p>A copy of the preventative maintenance program has been</p>		

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			<p>provided for review.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>Monthly the Administrator/Designee will review documented preventative maintenance tools to ensure all areas are checked and in compliance as required.</p> <p>The Maintenance Director /designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going.</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 openings through 2 of 10 smoke barriers were protected to maintain the smoke resistance of each 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 practice had the potential to affect those residents in blueberry hall</p>	K010025	<p>K025</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The one inch penetration in the sides of the walls above smoke door to blueberry hall has been closed with fire rated caulk, and the one and a half inch hole penetration on both sides of the walls above the smoke doors in the employee exit room have been closed with fire rated caulk.</p> <p>How the facility will identify other residents having the potential to be affected by the</p>	08/14/2013			

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	<p>and the employee exit room.</p> <p>Findings include:</p> <p>Based on observation on 07/16/13 with the Environmental Director during the tour from 10:00 a.m. to 2:30 p.m., there was a one inch penetration in the sides of the walls above the smoke doors in the blueberry hall, and a one and a half inch hole penetration on both sides of the walls above the smoke doors in the employee exit room. Based on interview at the time of observation, on 07/16/13 from 10:00 a.m. to 2:30 p.m., the Environmental Director acknowledged the penetrations in the smoke barrier were done by contractors and he would make sure the penetrations were sealed.</p> <p>3.1-19(b)</p>		<p>same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this alleged deficient practice. A walking round audit was performed to identify any further penetrations that may cause a break in the smoke barrier. No other areas were identified.</p> <p>The Administrator/ designee conducted educational training with Maintenance Director Designee with emphases given on completing audit of preventative maintenance program to ensure smoke barriers are checked every 30 days to maintain compliance.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>Monthly the Administrator/Designee will review documented preventative maintenance tools to ensure all smoke barrier areas are checked</p>		

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			<p>and in compliance as required.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>The Maintenance Director /designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly thereafter to maintain compliance.</p>		

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K010045 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>Based on observation and interview, the facility failed to ensure the lighting for 1 of 10 exit means of egress were arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice had the potential to affect all resident, visitors and staff needing to exit the facility through the Special Care dining room.</p> <p>Findings include:</p> <p>Based on observation and interview on 07/16/13 with the Environmental Director during the tour from 10:00 a.m. to 2:30 p.m., the exit means of egress outside the Special Care dining room exit was equipped with one light fixture with only one bulb. Based on interview at the time of record review on 07/16/13 from 10:00</p>	K010045	<p>K045</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The exit means of egress outside the special care dining room has a new two bulb fixtures for the exit lighting to be sufficient.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this alleged deficient practice. A walking</p>	08/14/2013			

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	a.m. to 2:30 p.m., the Environmental Director acknowledged only one light fixture with one bulb was provided at the exit. 3.1-19(b)		round audit was performed to identify any further exit means of egress had sufficient lighting arrangement as required. No other areas were identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The Administrator/ designee conducted educational training with Maintenance Director designee with emphases given on completing audit of preventative maintenance program to ensure that lighting fixtures near exits with means of egress is checked every 30 days to maintain compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Monthly the Administrator/Designee will		

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			<p>review documented preventative maintenance tools to ensure all exit lighting fixtures are checked and in compliance as required.</p> <p>The Maintenance Director /designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, if auditing and monitoring will be done quarterly moving forward.</p>	

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K010046 SS=C	<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 1 of 1 emergency light fixtures of at least 1½ hour duration was tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice had the potential to affect residents who evacuated through the special care</p>	K010046	<p>K046</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The log for the monthly test of the battery operated emergency light system was located and given at the exit of the Life Safety survey. This log is maintained and will be continued to use per policy guidelines.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this alleged</p>	08/14/2013			

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	<p>unit dining room.</p> <p>Findings include:</p> <p>Based on observation and interview on 07/16/13 with the Environmental Director during the tour from 10:00 a.m. to 2:30 p.m., a battery operated emergency light was observed in the special care exterior emergency egress. Based on interview at the time of observation on 07/16/13 from 10:00 a.m. to 2:30 p.m., the Environmental Director acknowledged there were no written records of a monthly test or an annual test regarding the battery operated emergency light available for review.</p> <p>3.1-19(b)</p>		<p>deficient practice.</p> <p>The monthly log will be maintained and used to ensure that the equipment is fully operational.</p> <p>A battery test run was performed the day of the Life Safety Survey and was run without incident.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>The Administrator/ designee conducted educational training with Maintenance Director with emphases given on easily accessible records for review of the preventative maintenance programs performed. Logs are to be maintained in a systematic way so that compliance can be easily maintained and readily available for review.</p> <p>How the corrective action(s)</p>		

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			<p>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>Monthly the Administrator/Designee will review documented preventative maintenance tools to ensure all battery operated lighting tests are performed as required and located in the designated area for review.</p> <p>The Maintenance Director /designee will present a summary of the audits to the Quality Assurance committee monthly for three months. The Quality Assurance committee will then decide if further auditing and monitoring will be done quarterly.</p>		

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K010051 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure smoke detectors connected to the fire alarm system in 2 of 10 smoke compartments were properly separated from an air supply. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice had the potential to affect all residents,</p>	K010051	<p>K051</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The smoke detectors located too close to the air supply in room 43, the Indiana dining room, and the special care north emergency exit door way were moved.</p>	08/14/2013
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NAME OF PROVIDER OR SUPPLIER SEBO'S NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342		
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	<p>staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/16/13 with the Environmental Director during the tour from 10:00 a.m. to 2:30 p.m., one smoke detector located in resident room 43 was about eight inches from the air vent, and the Indiana room dining room smoke detector was about twelve inches from the air vent, and the special care north emergency exit smoke detector was about twelve inches from the air vent. Based on interview at the time of observation on 07/16/13 from 10:00 a.m. to 2:30 p.m., the Environmental Director confirmed the distances between the vents and agreed the air flow could interfere with smoke detector function.</p> <p>3.1-19(b)</p>		<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>A facility walk through was completed and identified no other smoke detectors to be less than 36in from air supply units.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>The Administrator/ designee conducted educational training with Maintenance Director designee with emphases given on the 36 inch requirement for spacing of smoke detectors to air supply units.</p> <p>Maintenance Director/Designee will perform random audits over</p>		

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			<p>the next three months to ensure that any smoke detector identified below the standard of 36inches will be noted and changed. A log will be kept of this audit and used to summarize for quality assurance committee review.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>The Maintenance Director /designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, a periodic review can be done quarterly.</p>		

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K010066 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observations and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container which was provided for 1 of 1 area where smoking was permitted. This deficient practice had the potential to affect residents, staff and visitors utilizing the designated employee smoking area used during a fire emergency.</p>	K010066	<p>K066</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Cigarette butts found outside of the provided noncombustible container were picked up.</p>	08/14/2013			

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	<p>Findings include:</p> <p>Based on observation on 07/16/13 with the Environmental Director during the tour from 10:00 a.m. to 2:30 p.m., there were discarded cigarette butts by the exit door of the kitchen on the west side of the facility. Based on interview at the time of observation on 07/16/13 from 10:00 a.m. to 2:30 p.m., the Environmental Director acknowledged the facility's employees disposed of cigarette butts on the ground.</p> <p>3.1-19(b)</p>		<p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this alleged deficient practice.</p> <p>A routine schedule has been made to clean the resident smoking areas 2 times a day to ensure that cigarette butts are properly disposed of.</p> <p>Education was provided to the assigned staff for supervision of residents during smoke breaks to encourage proper disposal of the cigarette butts.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>Housekeeping supervisor/Designee will audit the cleaning schedule of the resident</p>		

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			<p>smoking break area 3 times a week to ensure that area I kept clear of cigarette butts.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p> <p>The Housekeeping Director /designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly.</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 for 12 of 12 months, the facility failed to exercise the generator 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</p>	K010144	<p>K144</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The log for the required monthly generator test was located and given at the exit of the Life Safety survey. This log is maintained and will be continued to use per policy guidelines.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</p> <p>All residents have the potential to be affected by this alleged</p>	08/14/2013

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	<p>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.</p> <p>This deficient practice has the potential to affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/16/13 with the Environmental Director during the tour from 10:00 a.m. to 2:30 p.m., the generator was run under load on a monthly basis but the amperage was not recorded and the percentage of load capacity was not recorded. Based on interview at the time of record review on 07/16/13 from 10:00 a.m. to 2:30 p.m., the Environmental Director acknowledged the generator was</p>		<p>deficient practice.</p> <p>The monthly log will be maintained and used to ensure that the equipment is fully operational.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>The Administrator/ designee conducted educational training with Maintenance Director Designee with emphases given on easily accessible records for review of the preventative maintenance programs performed. Logs are to be maintained in a systematic way so that compliance can be easily maintained and readily available for review.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</p>				

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	checked on a monthly basis but the amperage was not recorded and the percentage of load capacity was not recorded. 3.1-19(b)		Monthly the Administrator/Designee will review documented preventative maintenance tools to ensure monthly generator tests are performed as required and located in the designated area for review. The Maintenance Director /designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly.		