

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155740	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/11/2014
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NAME OF PROVIDER OR SUPPLIER TIMBERCREST CHURCH OF BRETHREN	STREET ADDRESS, CITY, STATE, ZIP CODE 2201 EAST ST NORTH MANCHESTER, IN 46962
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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: 06/11/14</p> <p>Facility Number: 000448 Provider Number: 155740 AIM Number: 100275140</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Timbercrest Church of Brethren Home 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 100, 200, 300 and 400 halls was surveyed with Chapter 19, Existing Health Care Occupancies</p> <p>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</p>	K010000		

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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K010025 SS=E	<p>hard wired smoke detection in the corridors and areas open to the corridor. Battery operated smoke detectors were installed in the resident rooms on the 100, 200, 300 and 400 halls. The facility has a capacity of 65 and had a census of 60 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached maintenance garage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/17/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p>						

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	<p>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 penetrations through 2 of 4 smoke barriers were protected to maintain the fire 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 practice could affect 20 or more residents as well as staff and visitors in the facility if smoke from a fire were to infiltrate the protective barriers.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance from 1:30 p.m. to 3:30 p.m. on 06/11/14, the following was noted:</p> <p>a. At the 300 hall north smoke barrier above the ceiling tile, there was a four inch sprinkler pipe penetrating that smoke barrier with a one inch gap around the pipe that was not firestopped.</p> <p>b. At the 400 hall north smoke barrier</p>	K010025	<p>Openings around the penetrations in the smoke barrier walls on the north side of the 300 Hall and the north side of the 400 Hall will be filled with an approved fire resistive material by July 11, 2014. See Attachment "1" & "2".</p> <p>All smoke stop barriers in the Health Care and Crestwood units will be inspected and resealed if needed by September 30, 2014.</p>	07/11/2014			

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K010048 SS=C	<p>above the ceiling tile, there was a four inch sprinkler pipe penetrating that smoke barrier with a two inch gap around the pipe that was not firestopped. Based on interview at the times of observation, the Director of Maintenance acknowledged the sprinkler pipe penetrations had not been firestopped.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to develop a written fire safety plan to address staff response to the activation of smoke detectors installed in 61 of 61 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 	K010048	<p><u>K-048</u></p> <p>The Fire Emergency Procedure for the Health Care and Crestwood units will be reviewed to include instructions to staff to activate manual pull stations anytime an audible alarm goes off from a battery-operated smoke detector in a resident's room. The policy will be revised by July 8, 2014. Staff working in the Health Care and Crestwood units will be introduced to this new requirement by July 11, 2014. See Attachments "A", "B" & "C".</p>	07/11/2014

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K010050 SS=F	<p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Timbercrest Emergency Response Plan Manual with the Director of Maintenance on 06/11/14 at 1:30 p.m., the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in the resident sleeping rooms. Based on interview at the time of record review, the Director of Maintenance acknowledged the facility's written fire safety plan did not include staff response to the activation of the battery operated smoke detectors installed in resident sleeping rooms on the 100, 200 300 and 400 halls.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for</p>						

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	<p>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>1. Based on record review and interview, the facility failed to insure fire drills included the transmission of a fire alarm signal in 3 of 7 fire drills conducted between 6:00 a.m. and 9:00 p.m. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. 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 Director of Maintenance at 12:00 p.m. on 06/11/14, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m., the following was noted:</p> <p>a. On 02/17/14, 8:30 a.m., the fire drill documentation did not indicate the fire alarm system had been activated.</p> <p>b. On 08/17/13, 1:15 p.m., the fire drill</p>	K010050	<p>1. All Fire Alarm Drills between the hours of 6:00 a.m. and 9:00 p.m. will include confirmation that the alarm was received by the alarm monitoring company and the local fire department. It will be the responsibility of the person conducting the drill to contact the fire department for such confirmation and record it on the fire drill form. See Attachment "D".</p> <p>2. Beginning immediately, all fire drills will include a scenario indicating the exact locations of the purported fire (hallway, resident room, storage area, etc.) the type of materials involved in the fire and the occupancy of the area. Those responding will be interviewed regarding the actions they would have taken had there actually been a fire.</p> <p>3. The fire drill documentation will indicate if the fire alarm system was activated, if the notice of alarm was received by the local fire department and the scenario that was used for the drill. See attached form. See Attachment "E".</p>	07/11/2014			

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	<p>documentation did not indicate the fire alarm system had been activated.</p> <p>c. On 07/23/13, 3:45 p.m., the fire drill documentation did not indicate the fire alarm system had been activated.</p> <p>Based on interview during the record review with the Director of Maintenance, there was no other documentation available for review to verify the fire alarm system had been activated.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to conduct fire drills under varied conditions in 8 of 12 fire drills. 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 Director of Maintenance at 12:00 p.m. on 06/11/14, the fire drills conducted on 03/20/14, 02/17/14, 01/08/14, 12/18/13, 10/31/13, 09/28/13, 06/30/13 and 04/29/13 lacked a description of the conditions or a scenario. Based on interview at the time of record review, the Director of Maintenance acknowledged the aforementioned fire drill report</p>						

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K010073 SS=E	<p>simulations were not descriptive.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>Based on observation and interview, the facility failed to ensure combustibile decorations were flame retardant in 1 of 4 smoke compartments. This deficient practice affects visitors, staff and 10 or more residents on the 200 hall.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance on 06/11/14 during the tour from 1:30 p.m. to 3:30 p.m., there was a twelve foot by sixteen foot wood lattice drop ceiling over the 200 hall sitting area. Based on interview at the time of observation, the Director of Maintenance was unaware of any materials used to make the wood lattice drop ceiling flame retardant.</p> <p>3.1-19(b)</p>	K010073	<p><u>K-073</u></p> <p>The wooden lattice drop ceiling in the 200 Hall will be removed by July11, 2014. See Attachment "F".</p>	07/11/2014			

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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>1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which 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.</p> <p>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>Chapter 6-4.2.2 of NFPA 110 requires</p>	K010144	<p>1. An annual load test conforming to the requirements of Chapter 6-4.2.2 of the NFPA 110 has been scheduled for July 22, 2014. See Attachment "G" (Email confirmation of test schedule.)</p> <p>2. The number of seconds required for the emergency generator to transfer the load will be documented for each monthly generator test. The Director of Maintenance will acknowledge the test having been properly performed and documented by checking and initialing the generator test form. The form will be revised by July 8, 2014; responsible staff will be re-inserviced on the testing procedure by July 11, 2014. See Attachment "H" (Revised Generator Test Log)</p>	07/22/2014
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	<p>diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of generator test logs on 06/11/14 at 10:45 a.m. with the Director of Maintenance, the amperage during load for the past twelve months was documented but it could not be verified to be 30 percent of the EPS nameplate rating in kilowatts. Based on interview at the time of record review, the Director of Maintenance acknowledged the facility had been running the generator and recording the amperage, but was not using a formula to convert the readings into kilowatts. Additionally, the Director of Maintenance acknowledged the load on the generator was less than 30 percent of the nameplate rating. No other equivalent method was used to comply with percentage of load capacity for the past twelve months. Finally, based on</p>						

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	<p>interview with the Director of Maintenance, the facility has not had an annual load bank test for the generator.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to document the generator was capable of automatically restoring electrical power within 10 seconds during load testing for the last 5 of 12 months. NFPA 99, 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. NFPA 99, 3-5.3.1 requires the emergency system shall be installed and connected to the alternate power source so all functions specified herein for the emergency system will be automatically restored to operation within 10 seconds after the interruption of the normal power source. This deficient practice could affect all residents in the facility as well as visitors and staff if the generator could not supply electricity within 10 seconds of a power failure.</p> <p>Findings include:</p> <p>Based on review of generator test logs on 06/11/14 at 10:45 a.m. with the Director of Maintenance, the number of seconds</p>						

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K020000	<p>for the generator to transfer the load was not documented for January 2014, February 2014, April 2014, May 2014 or on the June 3rd, 2014 load test. Based on interview at the record review, the Director of Maintenance acknowledged the time of load transfer had not been recorded for the aforementioned months and did not know why they had been missed.</p> <p>3.1-19(b)</p> <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: 06/11/14</p> <p>Facility Number: 000448 Provider Number: 155740 AIM Number: 100275140</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Timbercrest Church of Brethren Home</p>	K020000		

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	<p>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 section of the building consisting of the kitchen, main dining room and the Crestwood hall was surveyed with Chapter 18, New Health Care Occupancies</p> <p>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 hard wired smoke detection in the corridors, in areas open to the corridor and in the resident rooms in Crestwood. The facility has a capacity of 65 and had a census of 60 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached maintenance garage.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K020018 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 clean linen closets with double corridor doors closed and latched automatically into the door frame. This deficient practice could affect at least 10 residents on the Crestwood hall as well as an undetermined number of staff and visitors.</p> <p>Findings includes:</p> <p>Based on observation with the Director of Maintenance on 06/11/14 from 1:30 p.m. to 3:30 p.m., the Crestwood hall clean linen closet had a set of double corridor doors. One door was equipped with a slide bolt latch which had to be manually latched to allow the other door to latch into the first door. This was acknowledged by the Director of Maintenance at the time of observation.</p> <p>3.1-19(b)</p>	K020018	<p><u>K-018</u></p> <p>The doors to the Crestwood Linen closet will be modified to provide automatic latching into the door frame by July 30, 2014. See Attachment "I" (Email Confirmation of Hardware Order)</p>	07/30/2014			

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K020050 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. 18.7.1.2</p> <p>1. Based on record review and interview, the facility failed to insure fire drills included the transmission of a fire alarm signal in 3 of 7 fire drills conducted between 6:00 a.m. and 9:00 p.m. LSC 19.7.1.2 requires that fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include: Based on review of fire drill reports with the Director of Maintenance at 12:00</p>	K020050	<p>1. All Fire Alarm Drills between the hours of 6:00 a.m. and 9:00 p.m. will include confirmation that the alarm was received by the alarm monitoring company and the local fire department. It will be the responsibility of the person conducting the drill to contact the fire department for such confirmation and record it on the fire drill form. See Attachment "D".</p> <p>2. Beginning immediately, all fire drills will include a scenario indicating the exact locations of the purported fire (hallway, resident room, storage area, etc.) the type of materials involved in the fire and the occupancy of the area. Those responding will be interviewed regarding the actions they would have taken had there actually been a fire.</p> <p>3. The fire drill documentation will indicate if the fire alarm system was activated, if the notice of alarm</p>	07/11/2014

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	<p>p.m. on 06/11/14, the documentation for the drills performed between the hours of 6:00 a.m. and 9:00 p.m., the following was noted:</p> <p>a. On 02/17/14, 8:30 a.m., the fire drill documentation did not indicate the fire alarm system had been activated.</p> <p>b. On 08/17/13, 1:15 p.m., the fire drill documentation did not indicate the fire alarm system had been activated.</p> <p>c. On 07/23/13, 3:45 p.m., the fire drill documentation did not indicate the fire alarm system had been activated.</p> <p>Based on interview during the record review with the Director of Maintenance, there was no other documentation available for review to verify the fire alarm system had been activated.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to conduct fire drills under varied conditions in 8 of 12 fire drills. 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 Director of Maintenance at 12:00 p.m. on 06/11/14, the fire drills</p>		<p>was received by the local fire department and the scenario that was used for the drill. See attached form. See Attachment "E".</p>		

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K020064 SS=A	<p>conducted on 03/20/14, 02/17/14, 01/08/14, 12/18/13, 10/31/13, 09/28/13, 06/30/13 and 04/29/13 lacked a description of the conditions or a scenario. Based on interview at the time of record review, the Director of Maintenance acknowledged the aforementioned fire drill report simulations were not descriptive.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6 Based on observation and interview, the facility failed to ensure 1 of 25 portable fire extinguishers was given maintenance at periods not more than one year apart. 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. 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. This deficient practice would have a minimal</p>	K020064	<u>K-064</u> A new fire extinguisher has been placed in the Crestwood Elevator Machine Room. See Attachment "J". The inspection form has been modified to include the listing of this extinguisher. See Attachment "K".	07/11/2014			

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K020144 SS=F	<p>affect on residents, staff and/or visitors.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance at 2:45 p.m. on 06/11/14, the annual maintenance tag attached to the portable fire extinguisher located in the Crestwood elevator machine room indicated the last annual maintenance procedure for the extinguisher was performed in 2011. Based on interview at the time of observation, the Director of Maintenance acknowledged the annual maintenance procedure for the aforementioned portable fire extinguisher had not been completed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating</p>	K020144	<p>1. An annual load test conforming to the requirements of Chapter 6-4.2.2 of the NFPA 110 has been scheduled for July 22, 2014. See Attachment "G" (Email confirmation of test schedule.)</p> <p>2. The number of seconds</p>	07/22/2014

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	<p>temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which 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.</p> <p>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>Chapter 6-4.2.2 of NFPA 110 requires diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.</p> <p>This deficient practice could affect all residents as well as staff and visitors.</p>		<p>required for the emergency generator to transfer the load will be documented for each monthly generator test. The Director of Maintenance will acknowledge the test having been properly performed and documented by checking and initialing the generator test form. The form will be revised by July 8, 2014; responsible staff will be re-inserviced on the testing procedure by July 11, 2014. See Attachment "H" (Revised Generator Test Log)</p>				

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	<p>Findings include:</p> <p>Based on review of generator test logs on 06/11/14 at 10:45 a.m. with the Director of Maintenance, the amperage during load for the past twelve months was documented but it could not be verified to be 30 percent of the EPS nameplate rating in kilowatts. Based on interview at the time of record review, the Director of Maintenance acknowledged the facility had been running the generator and recording the amperage, but was not using a formula to convert the readings into kilowatts. Additionally, the Director of Maintenance acknowledged the load on the generator was less than 30 percent of the nameplate rating. No other equivalent method was used to comply with percentage of load capacity for the past twelve months. Finally, based on interview with the Director of Maintenance, the facility has not had an annual load bank test for the generator.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to document the generator was capable of automatically restoring electrical power within 10 seconds during load testing for the last 5 of 12 months. NFPA 99, Health Care</p>						

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	<p>Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-5.3.1 requires the emergency system shall be installed and connected to the alternate power source so all functions specified herein for the emergency system will be automatically restored to operation within 10 seconds after the interruption of the normal power source. This deficient practice could affect all residents in the facility as well as visitors and staff if the generator could not supply electricity within 10 seconds of a power failure.</p> <p>Findings include:</p> <p>Based on review of generator test logs on 06/11/14 at 10:45 a.m. with the Director of Maintenance, the number of seconds for the generator to transfer load was not documented for January 2014, February 2014, April 2014, May 2014 or on the June 3rd, 2014 load test. Based on interview at the record review, the Director of Maintenance acknowledged the time of load transfer had not been recorded for the aforementioned months and did not know why they had been missed.</p> <p>3.1-19(b)</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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