

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/09/2016
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NAME OF PROVIDER OR SUPPLIER SYMPHONY OF CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307
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K 0000 Bldg. 01	<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: 08/09/16</p> <p>Facility Number: 013452 Provider Number: 155835 AIM Number: 201299290</p> <p>At this Life Safety Code survey, the health care portion of Symphony of Crown Point, the first floor, 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 18, New Health Care Occupancies and with 410 IAC 410 IAC 16.2</p> <p>This two story facility was determined to be of Type V (111) construction and fully sprinklered. A 2 hour fire wall is provided to divide the facility into two separate buildings. Each separate building is subdivided into two smoke compartments. Separation between the first floor healthcare occupancy and the</p>	K 0000	The facility respectfully requests consideration for paper compliance/desk review for the attached plan of correction as response for the noted citations.	
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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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K 0029 SS=D Bldg. 01	<p>second floor residential occupancy is provided by a 2 hour horizontal floor/ceiling assembly and fire barriers. The rated floor/ceiling system is supported by 2 hour rated construction. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 70 Comprehensive beds and had a census of 59 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review on 08/17/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Loading dock room greater than 100 square feet, a hazardous area, would</p>	K 0029	<p>K 029</p> <p>1. What corrective action(s) will</p>	09/08/2016

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	<p>be smoke resistive. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance and Maintenance #1 on 08/09/16 at 12:45 p.m., the Loading dock room set of double doors both latched into the frame. When closed, the doors left a half inch gap. Based on interview at the time of observation, the Director of Maintenance and Maintenance #1 acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p>		<p>be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A smoke resistive weather strip was installed to the loading dock double doors.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p>No residents will be affected by the deficient practice.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur;</p> <p>The loading dock double door will be inspected for proper function monthly x 6 months and then every month thereafter.</p>	

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K 0050 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Based on record review and interview, the facility failed to ensure 12 of 12 fire drills included the verification of	K 0050	4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place Maintenance Director and/or designee will report findings in QA monthly x 6 months and appropriate actions will be taken as needed. 5. By what date the systematic changes will be completed. Changes will be completed and implemented by 9/8/16.	09/08/2016	

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	<p>transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. 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. This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of titled "Fire Drill Report" with the Director of Maintenance and Maintenance #1 on 08/09/16 at 10:08 a.m., the documentation for the drills failed to include verification of transmission of the fire alarm signal to the monitoring station. Based on interview at the time of record review, the Director of Maintenance and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p>		<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>A report was received from the fire alarm monitoring company showing verification of transmission of the fire alarm signal to the monitoring system on the days of the fire drills.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p>The deficient practice does affect the facility. A review was completed of all 2016 fire drills to verify transmission of the alarm to the monitoring company.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur;</p> <p>The Maintenance Director and/or designee will request verification of the alarm to the monitoring</p>		

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K 0051 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system.		<p>company on all future fire drills.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>Maintenance Director and/or designee will report findings in QA monthly x 6 months and appropriate actions will be taken as needed.</p> <p>5. By what date the systematic changes will be completed.</p> <p>Changes will be completed and implemented by 9/8/16.</p>	

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	<p>Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to ensure 5 of 6 smoke detectors in the Mechanical Rooms was not installed lower than 12 inches from the ceiling. NFPA 72, 2-3.4.3.1 states smoke detectors if mounted on a sidewall shall be located between 4 and 12 inches from the ceiling. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance and Maintenance #1 on 08/09/16 between 11:57 a.m. and 1:36 p.m., Mechanical Room 1A East, 1A West, 1C North, 1C West, 1C East Mechanical rooms each contained a hard-wire smoke detector which was mounted on the wall three feet from the ceiling. Based on interview at the time or observation, the Director of Maintenance and Maintenance #1 acknowledged the</p>	K 0051	<p>K 051</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>ESCO (the company that manages the smoke detectors) have been contacted and will be in the facility the week of August 29, 2016 to relocate the smoke detectors.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p>Residents do not have the potential to be affected by the deficient practice.</p>	09/08/2016

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K 0062 SS=C	<p>aforementioned conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur;</p> <p>All smoke detectors will be code as of September 8, 2016.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>Maintenance Director and/or designee will report findings of relocation of smoke detectors to QA after completion. No additional monitoring needed after the relocation.</p> <p>5. By what date the systematic changes will be completed.</p> <p>Changes will be completed and implemented by 9/8/16.</p>		

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Bldg. 01	<p>Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler system components was inspected quarterly for 2 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2-3.3 requires waterflow alarm devices and pressure switches that provide audible or visual signals to be tested quarterly. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Director of Maintenance and Maintenance #1 on 08/09/16 at 2:20 p.m., there was no second quarter of 2016 and no fourth quarter of 2015 sprinkler system inspection report available. Based on interview at the time of record review, the Director of Maintenance and</p>	K 0062	<p>K 062</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>The sprinkler system was inspected on July 21, 2016.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p>The deficient practice could affect residents. Sprinkler system was inspected July 21, 2016.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur;</p> <p>A contract is signed for quarterly inspections of the sprinkler system. A quarterly audit will be completed by the Maintenance Director and/or</p>	09/08/2016

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K 0066 SS=D Bldg. 01	<p>Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99) (1) Smoking shall be 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 shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</p>		<p>designee to ensure the inspection is completed.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>Maintenance Director and/or designee will report findings to QA quarterly x 6 months and appropriate actions will be taken as needed.</p> <p>5. By what date the systematic changes will be completed.</p> <p>Changes will be completed and implemented by 9/8/16.</p>	

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	<p>Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99) (2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 facility was maintained free of cigarette butts. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations with the Director of Maintenance and Maintenance #1 on 08/09/16 at 12:50 p.m., there were at least 25 cigarette butts on the ground near the employee entrance. Based on interview at the time of observation, the Director of Maintenance and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0066	<p>K 066</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>The cigarette butts were removed from the area. All staff in-serviced regarding the facility policy of being a smoke free facility.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p>The deficient practice does not affect residents.</p>	09/08/2016	

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K 0069 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities shall be protected in accordance with 9.2.3.		<p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur;</p> <p>The employee entrance will be monitored for cigarette butts weekly x 6 months to ensure the policy is being followed.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>Maintenance Director and/or designee will report findings to QA monthly x 6 months and appropriate actions will be taken as needed.</p> <p>5. By what date the systematic changes will be completed.</p> <p>Changes will be completed and implemented by 9/8/16.</p>		

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	<p>18.3.2.6, 19.3.2.6, NFPA 96</p> <p>Based on record review and interview; the facility failed to ensure 1 of 1 range hood's fire extinguishing equipment was inspected and approved every 6 months by properly trained and qualified persons. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, in 8-2 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made at least every 6 months by properly trained and qualified persons. NFPA 96, 8-2.1 requires all actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire actuated dampers shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on record review with the Director of Maintenance and Maintenance #1 on 08/09/16 at 11:05 a.m., the most recent range hood fire extinguishing equipment inspection report was dated 04/14/16. No documentation was available for the prior</p>	K 0069	<p>K 069</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>The range hood fire extinguisher equipment inspection report is not available for the six months prior to 4/14/16. The equipment was inspected 4/14/16.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p>The deficient practice does not affect residents.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur;</p> <p>There is a present contract in place for required inspection of equipment.</p>	09/08/2016	

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K 0076 SS=D Bldg. 01	<p>six month inspection. Based on interview at the time of observation, the Director of Maintenance and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 cylinders in the 1A Transfill room of nonflammable</p>	K 0076	<p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>Maintenance Director and/or designee will report findings to QA monthly x 6 months and appropriate actions will be taken as needed.</p> <p>5. By what date the systematic changes will be completed.</p> <p>Changes will be completed and implemented by 9/8/16.</p> <p>1. What corrective action(s) will</p>	09/08/2016	

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	<p>gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Director of Maintenance and Maintenance #1 on 08/09/16 at 12:23 p.m., 1A transfill room had three oxygen cylinders that were freestanding on the floor. Based on interview at the time of observation, the Director of Maintenance and Maintenance #1 acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>be accomplished for those residents found to have been affected by the deficient practice;</p> <p>The oxygen cylinders were moved to a stand in the oxygen room.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p>The deficient practice does not affect residents.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur;</p> <p>The Maintenance Director and/or designee will audit the oxygen rooms weekly x 6 months then monthly thereafter to ensure the oxygen cylinders are supported in a stand.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>Maintenance Director and/or</p>	

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K 0130 SS=F Bldg. 01	<p>NFPA 101 MISCELLANEOUS Miscellaneous</p> <p>List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.THER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 2 of 2 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that</p>	K 0130	<p>designee will report findings to QA monthly x 6 months and appropriate actions will be taken as needed.</p> <p>5. By what date the systematic changes will be completed.</p> <p>Changes will be completed and implemented by 9/8/16.</p> <p>K 130</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>The two separate unsealed penetration areas above the drop ceiling near resident room A149 and C101 were filled with fire caulk.</p>	09/08/2016	

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	<p>pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation with the Director of Maintenance and Maintenance #1 on 08/09/16 at 1:51 p.m. then again at 2:01 p.m., two separate one eighth inch unsealed penetrations above the drop ceiling in the fire barrier near</p>		<p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;</p> <p>The deficient practice could affect all residents.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur;</p> <p>Upon completion of any contracted work, the Maintenance Director and/or designee will inspect area for any unsealed penetration.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>Maintenance Director and/or designee will report findings to QA monthly x 6 months and appropriate actions will be taken as needed.</p> <p>5. By what date the systematic changes will be completed.</p> <p>Changes will be completed and implemented by 9/8/16.</p>	

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K 0144 SS=F Bldg. 01	<p>resident room A149. Then again one and one half inch unsealed penetration above the drop ceiling in the fire barrier near resident room C101. Based on interview at the time of each observation, the Director of Maintenance and Maintenance #1 acknowledged each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 110, The Standard for Emergency and Standby Power Systems, Section 6-4.2.2 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. This deficient practice could affect all</p>	K 0144	<p>K 144</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>The generator monthly load test completed August 29, 2016 with a load percentage documented. Load bank documentation has completed date. Contract in place for all required generator testing and maintenance.</p> <p>2. How other residents having the potential to be affected by the</p>	09/08/2016

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	<p>staff, residents, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Director of Maintenance and Maintenance #1 on 08/09/16 at 11:05 a.m., the load percentage was not documented on twelve of the last twelve months of generator testing. Additionally, a load bank was discovered without the information of the date performed. Based on interview at the time of record review, the Director of Maintenance and Maintenance #1 acknowledged the aforementioned condition and confirmed that load bank documentation did not include a date.</p> <p>3-1.19(b)</p>		<p>same deficient practice will be identified and what corrective action(s) will be taken;</p> <p>The deficient practice could affect all residents. Generator load test completed with load percentage documented.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur;</p> <p>Maintenance Director updated audit tool to include load percentage. Monthly inspections to now have percentage documented.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>Maintenance Director and/or designee will report findings to QA monthly x 6 months and appropriate actions will be taken as needed.</p> <p>5. By what date the systematic changes will be completed.</p> <p>Changes will be completed and implemented by 9/8/16.</p>	