

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155794	X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING _____	X3) DATE SURVEY COMPLETED  04/03/2013
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NAME OF PROVIDER OR SUPPLIER  STRATFORD RETIREMENT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2460 GLEBE ST CARMEL, IN 46032
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K020000	<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: 04/03/13</p> <p>Facility Number: 011151 Provider Number: 155794 AIM Number: NA</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Stratford Retirement LLC was found not in compliance with Requirements for Participation in Medicare, 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 410 IAC 16.2.</p> <p>This facility located on the second story of a three story building determined to be of Type II (111) construction was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors</p>	K020000		
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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>hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 18 and had a census of 10 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/15/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K020038 SS=E	<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. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure the means of egress through delayed egress locks at 1 of 2 exits was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided an irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the</p>	K020038	<p>What corrective action will be done by the facility?The maglocks have been repaired to be compliant and will open within 15 seconds. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. What measures will be put into place to ensure this practice does not recur? The Facility Service Director or designee will monitor the entry door to ensure that the doors open within 15 seconds of pushing the doors during the fire drills. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Facility Service Director or designee will report the outcomes to the QA Committee on a monthly basis.</p>	04/23/2013			

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	<p>authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. This deficient practice could affect any residents, staff or visitors trying to exit through the main entry doors.</p> <p>Findings include:</p> <p>Based on observation with the Facility Services Director during a tour of the facility from 1:10 p.m. to 3:35 p.m. on 04/03/13, the main entry doors by the elevator were provided with delayed egress locks and were provided with the proper signage indicating the doors can be opened in 15 seconds by pushing on the door, however, when the doors were pushed, the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the Facility Services Director acknowledged the main entry doors by the elevator did not release the lock within 15 seconds after application of a force to the release device and open each exit door.</p> <p>3.1-19(b)</p>				

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K020039 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited care facilities and psychiatric hospitals, width of aisles or corridors is at least 6 feet. 18.2.3.3, 18.2.3.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 exit access corridors had a clear and unobstructed exit width of at least 8 feet (96 inches). This deficient practice could affect all residents, staff and visitors if access to the other exit was blocked in an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Facility Services Director during a tour of the facility from 1:10 p.m. to 3:35 p.m. on 04/03/13, the second floor Assisted Living exit access corridor measured five feet, four inches (64 inches) in clear width. The second floor Assisted Living exit access corridor provides one of two paths of egress from the second floor health care area since the elevator should not be used during a fire emergency. Based on interview at the time of observation, the Facility Services Director acknowledged the second floor Assisted Living exit access corridor did not have a clear an unobstructed width of at least 8 feet (96 inches).</p>	K020039	<p>What corrective action will be done by the facility? An outside expert (Siemens) has been contracted by the facility to complete the Fire Safety Evaluation System (FSSES). How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice.</p>	05/31/2013	

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K020046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.18.2.9.1</p> <p>Based on record review, observation, and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 2 of 2 battery operated emergency lights. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted at 30 day intervals and an annual test to 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 could affect five residents, staff and visitors in the Therapy Gym.</p> <p>Findings include:</p> <p>Based on record review with the Facility Services Director during record review from 9:45 a.m. to 12:25 p.m. on 04/03/13, monthly and annual functional testing of facility battery operated emergency lights was not available for review. Based on observations with the Facility Services Director during a tour of the facility from</p>	K020046	<p>What corrective action will be done by the facility? The testing of the Emergency Lighting Equipment has been tested and placed on the monthly Fire Extinguisher Inspection in the Preventative Maintenance Work Order System to ensure monthly checks are completed. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. What measures will be put into place to ensure this practice does not recur? The Facility Service Director or designee will ensure that all battery operated emergency lights will be tested on a monthly basis. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Facility Service Director or designee will report the outcomes to the QA Committee on a monthly basis.</p>	04/22/2013			

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	<p>1:10 p.m. to 3:35 p.m. on 04/03/13, two battery operated lights were observed in the Therapy Gym. Based on interview at the time of record review and of the observations, the Facility Services Director acknowledged monthly and annual functional testing documentation for battery operated emergency lights in the facility was not available for review.</p> <p>3.1-19(b)</p>			

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K020048 SS=B	<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. 18.7.1.1 Based on record review, observation and interview; the facility failed to include the use of kitchen K-class fire extinguishers in 1 of 1 written fire safety plans for the facility. LSC 18.7.2.2 requires written health care occupancy fire safety plans shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>This deficient practice affects five staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of "The Stratford Fire/Evac. Manual" documentation with the Facility Services Director during record review from 9:45 a.m. to 12:20 p.m. on 04/03/13, the facility's written fire safety plan did not address the use of the K-class fire extinguisher located in the kitchen in relationship with the use of the</p>	K020048	<p>What corrective action will be done by the facility? The use of the K-class fire extinguisher in association with the kitchen overhead hood extinguishing system has been added to the Stratford Fire/Evac Manual. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. What measures will be put into place to ensure this practice does not recur? The Facility Services Director or designee will review the Stratford Fire/Evac Manual on an annual basis to ensure that the policy is in effect. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The review of the Fire/Evac will be reviewed during the QA meeting on an annual basis.</p>	04/22/2013			

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	<p>kitchen overhead extinguishing system. Based on interview at the time of record review, the Facility Services Director acknowledged the written fire safety plan for the facility did not include the policy to activate the overhead hood extinguishing system to suppress a fire before using a K-class fire extinguisher. Based on observation with the Facility Services Director during a tour of the facility from 1:10 p.m. to 3:35 p.m. on 04/03/13, one K-class fire extinguisher was observed installed in the kitchen.</p> <p>3.1-19(b)</p>			

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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 document fire drills on the first and second shift for 1 of 4 calendar quarters. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Fire Plan: Emergency or Drill Evaluation Form" documentation with the Facility Services Director during record review from 9:45 a.m. to 12:20 p.m. on 04/03/13, documentation of fire drills conducted on the first and second shift in the third quarter of 2012 was not available for review. Based on interview at the time of record review, the Facility Services Director stated facility staff operates on two shifts per day with the first shift from 7:00 a.m. to 7:00 p.m. and the second shift from 7:00 p.m. to 7:00 a.m. Based on interview at the time of record review,</p>	K020050	<p>What corrective action will be done by the facility? The Fire Drill Policy and Procedure has been changed to reflect compliance. The fire drills have been entered into the Preventative Maintenance Work Order System to regenerate automatically to ensure compliance. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. What measures will be put into place to ensure this practice does not recur? The Facility Services Director or designee will conduct a fire drill for each shift on a quarterly basis. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Facility Services Director or designee will report the outcomes to the QA Committee on a monthly basis.</p>	04/24/2013	

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	<p>the Facility Services Director acknowledged fire drill records for the first and second shift in the third quarter of 2012 were not available for review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to ensure documentation of first and second shift fire drills for 3 of 4 quarters included the transmission of a fire alarm signal. LSC 18.7.1.2 requires fire drills in ambulatory health care facilities to include the transmission of the fire alarm signal. When drills are conducted between 9:00 p.m. and 6:00 a.m., a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency/Fire Plan: Emergency or Drill Evaluation Form" documentation with the Facility Services Director during record review from 9:45 a.m. to 12:20 p.m. on 04/03/13, fire drills conducted on the first and</p>						

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	<p>second shift for the second and fourth quarter of 2012 and the first quarter of 2013 did not include documentation of fire system activation. The aforementioned first shift fire drills were documented as occurring on 06/29/12 at 1:30 p.m., 12/28/12 at 11:15 a.m. and on 02/11/13 at 10:30 a.m. The aforementioned second shift fire drills were documented as occurring on 05/31/12 at 6:20 a.m. and 12/28/12 at 6:02 a.m. Based on interview at the time of record review, the Facility Services Director stated facility staff operates on two shifts per day with the first shift from 7:00 a.m. to 7:00 p.m. and the second shift from 7:00 p.m. to 7:00 a.m. Based on interview at the time of record review, the Facility Services Director acknowledged documentation for fire drills conducted on the aforementioned shifts and calendar quarters did not include the transmission of the fire alarm signal.</p> <p>3.1-19(b) 3.1-51(c)</p>				

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K020062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review, observation and interview; the facility failed to ensure sprinkler waterflow alarm devices were tested quarterly for two of four quarters. LSC 9.7.5 states all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, at 2-3.3 requires waterflow alarm devices including, but not limited to mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. NFPA 25, 9-4.4.2.1 requires the priming level to be tested quarterly. NFPA 25, 9-7.1 requires the fire department connections to be inspected quarterly. NFPA 25, 1-8.1 requires records shall be kept to indicate the procedure performed (inspection, test, or maintenance), the organization which performed the work, the results and the date. Finally, NFPA 25, 1-8 requires the records of inspection, test, and maintenance of the system and its components shall be made available to the</p>	K020062	<p>What corrective action will be done by the facility? The quarterly inspections have been added to the contract with Seimens which is our existing fire sprinkler company. A quarterly reminder has been entered into the Preventative Maintenance Work Order system on 4-22-13. The fire sprinkler system had just reached its 5 year mark on 3-28-2013 as evidenced by the certificate of substantial completion. Gauge testing and calibration is scheduled for the next quarterly inspection on 5-7-13. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. What measures will be put into place to ensure this practice does not recur? The Facility Services Director or designee will monitor the fire sprinkler inspections on a quarterly basis. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Facility Services Director or designee will report the findings</p>	05/07/2013
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	<p>authority having jurisdiction upon request. Typical records include but are not limited to valve inspections, flow, drain, and pump tests; and trip tests of dry pipe, deluge and preaction valves. This deficient practice affects all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Siemens "Report of Inspection" documentation with the Facility Services Director during record review from 9:45 a.m. to 12:20 p.m. on 04/03/13, a quarterly sprinkler system inspection was conducted on 04/05/12 in the second quarter of 2012 and on 02/06/13 in the first quarter of 2013 but no quarterly sprinkler inspection records for the third and fourth quarter of 2012 were available for review. Based on observation with the Facility Services Director during a tour of the facility from 1:10 p.m. to 3:35 p.m. on 04/03/13, the inspection tag affixed to the sprinkler system riser by Siemens had no inspection date recorded for the third and fourth quarter of 2012. Based on interview at the time of record review and observation, the Facility Services Director acknowledged documentation of quarterly sprinkler system inspection records was not available for review for the third and fourth quarter of 2012.</p>		to the QA Committee on a quarterly basis.				

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Facility Services Director during a tour of the facility from 1:10 p.m. to 3:35 p.m. on 04/03/13, the sprinkler gauge on the sprinkler system riser had a manufacture date of 2005. Based on interview at the time of observation, the Facility Services Director stated recalibration documentation for the sprinkler gauge was not available for review and acknowledged the pressure gauge had exceeded the five year requirement for recalibration or replacement.</p> <p>3.1-19(b)</p>						

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K020069 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen 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 affects occupants of the kitchen where five staff were observed on duty.</p> <p>Findings include:</p> <p>Based on review of Siemens "Restaurant Systems Work Order" documentation with the Facility Services Director during</p>	K020069	<p>What corrective action will be done by the facility? The 6 month inspection for the hood system has been entered into the facility's Preventive Maintenance Work Order System. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. What measures will be put into place to ensure this practice does not recur? The Facility Services Director or designee will monitor the inspection of the hood system every 6 months. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Facility Services Director or designee will report the outcomes to the QA Committee bi-annually.</p>	04/22/2013			

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	<p>record review from 9:45 a.m. to 12:20 p.m. on 04/03/13, range hood fire extinguishing equipment inspections were performed by Siemens on 03/27/12 and on 11/25/12. Based on interview at the time of record review, the Facility Services Director acknowledged documentation of range hood fire extinguishing equipment inspections every six months was not available for review.</p> <p>3.1-19(b)</p>			

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K020074 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 18.7.5.1, 1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4, 18.7.5.3</p> <p>Based on record review, observation and interview; the facility failed to ensure valences and window curtains in 1 of 1 smoke compartments were flame resistant. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Facility Services Director from 9:45 a.m. to 12:25 p.m. on 04/03/13, valence and window curtain flame resistant documentation was not available for review. Based on observations with the Facility Services Director during a tour of the facility from 1:10 p.m. to 3:35 p.m. on 04/03/13,</p>	K020074	<p>What corrective action will be done by the facility? Documentation for the flame spread rating could not be located. Valences and curtains will be treated with Firezoff from RDR Technologies. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents were adversely affected by this practice. What measures will be put into place to ensure this practice does not recur? The Facility Services Director or designee will monitor the valences and curtains to ensure that they are flame resistant. How will corrective action be monitored to ensure the</p>	05/03/2013	

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	<p>window valences in resident sleeping rooms 261 and 267 had no affixed documentation stating each valence was inherently flame retardant. In addition, each of two window curtains in the Dining Room had no affixed documentation stating each window curtain was inherently flame retardant. Based on interview at the time of the observations, the Facility Services Director stated the aforementioned valences and window curtains are treated with a flame retardant material but acknowledged documentation for flame retardant material treatment and valence and window curtain flame resistant documentation was not available for review.</p> <p>3.1-19(b)</p>		<p>deficient practice does not recur and what QA will be put into place? The Facility Services Director or designee will report the outcomes to the QA Committee on a monthly basis.</p>				

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K020144 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 the emergency generator was conducted for 3 of 12 months 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 that 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. 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. NFPA 99, 3-5.4.2 requires a written record of</p>	K020144	<p>What corrective action will be done by the facility? The generator service contractor which is Buckhorn Power Systems has sheduled the generator to perform a monthly load test. This test performs on the 4th Friday of each month. The staff has been trained to observe and document all generator and load inspections appropriately. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? No residents have been adversely affected by this practice. What measures will be put into place to ensure this practice does not recur? The Facility Services Director or designee will monitor the load test on a monthly basis. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Facility Services Director or designee will report the outcomes to the QA Committee on a monthly basis.</p>	04/26/2013

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	<p>inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator - Monthly Load Test Log" documentation with the Facility Services Director during record review from 9:45 a.m. to 12:20 p.m. on 04/03/13, monthly generator load test documentation for the period April, May and June 2012 was not available for review. Based on interview at the time of record review, the Facility Services Director stated the emergency generator ran during the aforementioned period but was not run under load and acknowledged monthly generator load test documentation for April, May and June 2012 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on interview and record review, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 12 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up</p>						

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	<p>the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator - Monthly Load Test Log" with the Facility Services Director during record review from 9:45 a.m. to 12:20 p.m. on 04/03/13, documentation of emergency power transfer times for the most recent twelve consecutive month period was not available for review. Based on interview at the time of record review, the Facility Services Director acknowledged documentation of emergency power transfer time for the most recent twelve consecutive month period was not available for review.</p> <p>3.1-19(b)</p>						