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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155525 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>09/10/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>SHADY NOOK CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>36 VALLEY DR<br>LAWRENCEBURG, IN 47025 |
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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: 09/10/14</p> <p>Facility Number: 000304<br/>Provider Number: 155525<br/>AIM Number: 100266810</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Shady Nook Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a basement was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping</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<br>SS=E  | <p>rooms. The facility has a capacity of 94 and had a census of 74 at the time of this survey.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 09/15/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observations and interview, the facility failed to ensure the smoke barriers in 1 of 1 basement ceiling, 4 of 12 basement room walls and 1 of 1 basement corridor walls were constructed</p> | K010025   | K 025 * All deficient smoke barriers to be filled with a material capable of maintaining smoke resistance to protected areas by the maintenance department for the protection of all residents. * A | 10/14/2014  |  |   |  |

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|                    | <p>to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so 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 affect maintenance and laundry staff.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor during a tour of the basement on 09/10/14 from 9:20 a.m. to 10:50 a.m., the following locations had wall penetrations not firestopped;</p> <ol style="list-style-type: none"> <li>1. The basement center corridor had two, two inch gaps around two air conditioning condensate pipes which passed through the east wall with no fire stopping used to seal the gaps.</li> <li>2. The basement record storage room had a three inch gap around a metal duct penetration in the southwest wall with no fire stopping used to seal the gap.</li> <li>3. The basement electric room had two, one inch gaps around two electric conduit penetrations in the southwest wall and one, two inch gap around an electric conduit penetration in the northeast wall</li> </ol> |               | <p>monthly audit of the building will be maintained by the maintenance director in the areas requiring smoke barriers for the protection of all residents. * A monthly audit of the building will be maintained by maintenance for areas requiring smoke barriers. * The monthly audits will be conducted by the maintenance department and turned into the QAPI Director for review. If these are not maintained at a 100% rate they will automatically become a QA project.</p> |                      |

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| K010038<br>SS=E  | <p>with no fire stopping used to seal the gaps.</p> <p>4. The basement boiler room had a two inch gap around a metal duct penetration in the southwest wall with no fire stopping used to seal the gap.</p> <p>5. The basement laundry room ceiling had a one inch gap around an electric conduit penetration above the dryers not fire stopped, a two inch circular area of drywall in the ceiling on the south side of the dryers, two, one half inch gaps around two water pipe penetrations in the ceiling by the water mixing valve not fire stopped, and a two inch gap around an electric conduit penetration in the west wall not fire stopped.</p> <p>The basement corridor walls, basement room walls and basement ceiling not fire stopped was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/10/14 at 3:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure not more than one delayed egress lock device was provided in any egress path as permitted by NFPA</p> | K010038   | K 038 * The outside gate to the courtyard off of the A Street wing of the facility will have the current delayed egress lock removed for the protection of all of the | 10/14/2014  |  |   |  |

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| K010046  | <p>101 19.2.2.2.4 Exception No. 2 in 1 of 6 egress paths provided with delayed egress locking devices. A.19.2.2.2.4 states, the intent of the provision is that a person following the natural path of the means of egress not encounter more than one delayed release device along that path of travel to an exit. Thus, each door from the multiple floors of a building that opens into an enclosed stair is permitted to have its own delayed release device, but an additional delayed release device is not permitted at the level of exit discharge on the door that discharges people from the enclosed stair to the outside. This deficient practice could affect 22 residents who reside in the A Street Hall.</p> <p>Findings include:</p> <p>Based on observation on 09/10/14 at 2:30 p.m. with the maintenance supervisor, the A Street Hall exit door and the ten foot sidewalk leading to a gate were both provided with delayed egress locks. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 09/10/14 at 3:15 p.m.</p> <p>3.1-19(b)<br/>NFPA 101</p> |   | <p>residents on A Street. * The outside gate to the courtyard off of the A Street wing of the facility will have the current delayed egress lock removed for the protection of all of the residents on A Street. This will be completed by the facility maintenance department. * The outside gate of A Street will be monitored by the maintenance director. * The maintenance director will report quarterly to the QAPI Director that there has not been any changes made to this area. If anything changes it will be corrected.</p> |   |  |   |  |

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| SS=F               | <p><b>LIFE SAFETY CODE STANDARD</b><br/>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review and interview, the facility failed to ensure 15 of 15 battery backup lights were tested annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. 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 all residents in the facility.</p> <p>Findings include:</p> <p>Based on record review on 09/10/14 at 9:00 a.m. with the maintenance supervisor, the facility had fifteen battery backup lights listed on the Shady Nook Care Center Battery Operated Emergency</p> | K010046       | <p>K 046 * All battery backup lights will be tested at thirty day intervals. The equipment will be fully operational for at least thirty seconds for the duration of the test and written records of visual inspections and tests shall be kept by the facility. The annual ninety minute test for the fifteen backup lights will be completed by an outside vendor, Crossman. This practice shall be maintained for the protection of all residents. * All battery backup lights will be tested at thirty day intervals. The equipment will be fully operational for at least thirty seconds for the duration of the test and written records of visual inspections and tests shall be kept by the facility. The annual ninety minute test for the fifteen minute battery backup lights will be completed by an outside vendor, Crossman. This practice shall be maintained for the protection of all residents. * This practice will be put into place by the director of maintenance and the facility QAPI Director will monitor. * If this practice is found to be deficient it will automatically become a QA project.</p> | 10/14/2014           |

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| K010050<br>SS=F    | <p>Lights Test Log for Year 2013 and 2014. Based on a review of the 2013 and 2014 test logs, there was no annual ninety minute test listed for the fifteen battery backup lights. Based on an interview with the maintenance supervisor on 09/10/14 at 9:20 a.m., an annual 90 minute test was not conducted over the past year for the fifteen battery operated emergency lights. The lack of an annual ninety minute test for the fifteen battery backup emergency lights was verified by the maintenance supervisor at the time of record review and interview, and acknowledged by the administrator at the exit conference on 09/10/14 at 3:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2<br/>Based on record review and interview, the facility failed to ensure 1 of 3 shift fire drills were held at varying times over the past year to protect 74 of 74 resident. This deficient practice could affect all</p> | K010050       | K 050 * A practice of conducting additional third shift/off times will be put into place for the protection of all residents. * A practice of conducting additional third shift/off times will be put into | 10/14/2014           |

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| K010062<br>SS=E  | <p>resident in the facility.</p> <p>Findings include:</p> <p>Based on a review of the Fire Drill Reports with the maintenance supervisor on 09/10/14 at 9:45 a.m., the Fire Drill Reports for third shift were held at the following similar times over the past year; first shift drills 02/19/14 at 10:15 p.m., 08/07/14 at 10:15 p.m., 11/19/13 at 10:15 p.m. The similar timed fire drill records for third shift was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 09/10/14 at 3:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to replace 13 of over 300 sprinklers in the facility covered in corrosion and rust. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance</p> | K010062   | <p>place for the protection of all residents. * The fire drills are provided by an outside consultant, Craig Beckley, who will expand his practice for the facility for three defined shifts. * A quarterly report will be turned into the QAPI director by the maintenance director and if there is a discrepancy of the anticipated time frames it will automatically become a QA project.</p> <p>K 062 * A third party vendor, Eckardt, has been contacted to repair/replace said sprinkler covers that are currently corroded. This is for the protection of all residents. * This third party vendor, Eckardt, has been contacted to repair/replace the cited sprinkler covers (both interior &amp; exterior) that are currently deficient for the</p> | 10/14/2014  |  |   |  |

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|                    | <p>of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations on 09/10/14 during a tour of the facility from 10:00 a.m. to 3:00 p.m. with the maintenance supervisor, the first floor main entrance overhang had nine sprinklers completely covered in green corrosion, the basement boiler room had one sprinkler completely covered in brown rust, the basement exit overhang had two sprinklers completely covered in green corrosion and the first floor Main Hall east exit had one sprinkler completely covered in green corrosion. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/10/14 at 3:15 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 6 of over 300 sprinkler heads in the facility were maintained. This deficient practice could</p> |               | <p>protection of all residents. * The maintenance director will then perform an audit to insure that all sprinkler heads are in good repair and will turn this report into the QAPI Director on a monthly basis. * A quarterly report will then continually be completed by the maintenance director and if the system is not consistently maintained it will automatically become a QA project.</p> |                      |

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| K010067<br>SS=F    | <p>affect 46 residents who use the main dining room.</p> <p>Findings include:</p> <p>Based on observations on 09/10/14 during a tour of the facility with the maintenance supervisor from 10:00 a.m. to 3:00 p.m., the three sprinklers in the basement electric room, the sprinkler in the basement class room, the first floor liquid oxygen storage room sprinkler, and the first floor main dining room storage room sprinkler were missing the escutcheon.</p> <p>This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/10/14 at 3:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining rooms for 48 of 48 resident rooms. LSC 19.5.2.1 requires air conditioning, heating, ventilating</p> | K010067       | K 067* Shady Nook Care Center wishes to request an annual waiver for K 067. The request form and supporting documentation have been electronically attached to this request. The facility has received the waiver each year since the | 10/14/2014           |

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| K010069<br>SS=F    | <p>ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 09/10/14 during the tour of the facility from 10:00 a.m. to 3:00 p.m., all resident rooms were using the egress corridor as a return air system. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 09/10/14 at 3:15 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96<br/>1. 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.</p> | K010069       | <p>early1990's.</p> <p>K 069 * An outside vendor, Richards, that services the ventilation and fire protection of commercial cooking operations (range hood inspection &amp; exhaust hood cleaning) will provide semi</p> | 10/14/2014           |

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|                    | <p>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 all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Range Hood Inspection Report on 09/10/14 at 12:40 p.m. during a tour of the kitchen with the maintenance supervisor, the most recent range hood fire extinguishing equipment inspection report located in a plastic pouch attached to the range hood pull station box was dated 02/13/14. Furthermore, the report had a check mark in the block listed the inspection as an annual inspection and the maintenance supervisor did not have another semi</p> |               | <p>annual inspections in a more timely manner for the protection of all residents. * An outside vendor, Richards, that services the ventilation and fire protection of commercial operations (range hood inspection &amp; exhaust hood cleaning) will provide semi annual inspections in a more timely manner for the protection of all residents. * This practice is to be monitored by the maintenance director. * The outside vendors findings will be provided by the maintenance director to the QAPI director on a semi-annual basis. If this becomes a deficient practice it will automatically be made a QA project,</p> |                      |

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|  | <p>annual report for the next inspection which would have been due during the month of August 2014. The lack of a current semi annual range hood inspection was verified by the maintenance supervisor at the time of record review and interview and acknowledged by the administrator at the exit conference on 09/10/14 at 3:00 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned at least semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1 requires systems serving moderate volume cooking operations shall be inspected semiannually. This deficient practice</p> |   |   |   |  |   |  |

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| K010144<br>SS=F    | <p>could affect all resident in the facility.</p> <p>Findings include:</p> <p>Based on record review on 09/10/14 at 12:40 p.m. during a tour of the kitchen with the maintenance supervisor, the most recent kitchen exhaust hood cleaning report, which was located in the kitchen supervisors' office, was dated 11/12/13. Based on an interview with the kitchen supervisor on 09/10/14 at 12:50 p.m., the exhaust hood is not cleaned semi annually, it is cleaned on an annual basis. The lack of semi annual kitchen exhaust cleaning was verified by the maintenance supervisor at the time of record review and interview and acknowledged by the administrator at the exit conference on 09/10/14 at 3:00 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.<br/>3.4.4.1.<br/>1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 12 of 52 weeks over the past year over the past year were available for review. Chapter 3-4.4.1.3 of NFPA 99 requires storage</p> | K010144       | * The generator will be inspected weekly and additionally an exercised unload for 30 minutes will also be conducted each month for the protection of all residents. A letter from the facility natural gas provider will also be obtained to verify that the natural | 10/14/2014           |

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|                    | <p>batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. 6-4.1 requires Level 1 and Level 2 EPSS, including all appurtenant components, shall be inspected weekly and shall be exercised under load monthly at a minimum. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of the Emergency Generator Weekly Inspection Log with the maintenance supervisor on 09/10/14 at 9:30 a.m., there was no record of weekly inspections including storage battery tests for the generator set for the last week of each month over the past year. Based on an interview with the</p> |               | <p>gas is being provided by a reliable source. * The generator will be inspected weekly every week and additionally an exercised under load for 30 minutes will also be conducted each month for the protection of all residents. A letter to verify from the facility natural gas provider will also be obtained to verify that the natural gas is being provided by a reliable source. * This practice will be conducted by the maintenance director and records will be maintained as required. * The maintenance director will provide a quarterly report for the QAPI Director to monitor. If this is found to become a deficient practice it will automatically become a QA project.</p> |                      |

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|                    | <p>maintenance supervisor on 09/10/14 at 9:40 a.m., the emergency generator is inspected weekly for three weeks in each month, and the last week of each month, the generator is tested under load and a weekly inspection is not performed the last week of each month. The lack of a weekly inspection of the emergency generator during the last week of each month over the past year was verified by the maintenance supervisor at the time of record review and interview, and acknowledged by the administrator at the exit conference on 09/10/14 at 3:00 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on interview, the facility failed to ensure the fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS):</p> <ul style="list-style-type: none"> <li>a) Liquid Petroleum products at atmospheric pressure</li> <li>b) Liquefied petroleum gas (liquid or vapor withdrawal)</li> <li>c) Natural or synthetic gas</li> </ul> <p>Exception: For Level 1 installations in locations where the probability of</p> |               |   |                      |

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|  | <p>interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview with the maintenance supervisor on 09/10/14 at 9:45 a.m., the fuel source for the emergency generator was natural gas. Additionally, based on interview, the facility did not have a letter from their natural gas provider indicating the natural gas was from a reliable source. The lack of a letter from the natural gas provider indicating the natural gas was from a reliable source was verified by the maintenance supervisor at the time of interview and acknowledged by the administrator at the exit conference on 09/10/14 at 3:00 p.m.</p> <p>3.1-19(b)</p> |   |   |   |  |   |  |