STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E359	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 06/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNS HOME FOR THE AGED	1236 LINCOLN AVE EVANSVILLE, IN 47714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	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). Survey Date: 06/12/12 Facility Number: 000443 Provider Number: 15E359 AIM Number: 100289580 Surveyor: Lex Brashear, Life Safety Code Specialist At this Life Safety Code survey, St. Johns Home for the Aged was found not in compliance with Requirements for Participation in 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. This two story facility with a ground level was determined to be of Type I (443) construction and	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, spaces open to the corridors, and resident rooms. The facility has a capacity of 47 and had a census of 43 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/18/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 1. Based on observation and interview, the facility failed to ensure 2 of 4 fire doors in a two hour fire wall latched upon closing. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect any of the 43 residents, as well as staff and visitors evacuating the main entrance. Findings include: Based on observation on 06/12/12 at 11:10 a.m. during a tour of the facility with	K0011	**1. Corrective actions:** (1) Hardware was ordered on June 28, 2012 and the company will install the hardware when it comes, so that when the doors close there will be a positive latch. The company will insure that there will be an integrated mechanism so that the doors will close in sequence for the positive latching. (2) New doors, to be tagged at the factory, were ordered on June 28, 2012. Delivery 4-6 weeks. Company will install hardware. Fire rating tag will be monitored to prevent tag from being painted over. (3) The area above the fire doors will be sealed with material rated for 2 hours. This material was ordered on June 28, 2012. Any penetration by conduits, water lines, and low voltage lines will be sealed with fire-resistant caulk, and any future penetration will be sealed with the above type of caulking.**2. How other residents with potential to be affected will be identified and corrective actions to be taken:** Other residents living in the building are identified as having potential to be affected.(1)Hardware	08/17/2012

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	Maintenance Technician # 1 and Maintenance Technician # 2, the set of double doors installed in the two hour fire separation wall separating the health care center from the apartment building at ground level was not equipped with latching hardware. This was acknowledged by Maintenance Technician # 1 and # 2 at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the communicating opening was maintained in a two hour rated fire wall on 1 of 3 floors. LSC 19.1.1.4.2 refers to LSC 8.2. LSC 8.2.3.2.3.1 requires every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. Openings in a two hour fire wall are required to have at least a one and one half hour fire protection rating. This deficient practice could affect any of the 43 residents, as well as staff and visitors evacuating the main		will be installed so that when the doors close there will be a positive latch. The company will insure that there will be an integrated mechanism so that the doors will close in sequence for the positive latching. (2) New doors, tagged at the factory, will be delivered in 4-6 weeks. Company will install hardware. (3) The area above the fire doors will be sealed with material rated for 2 hours. This material was ordered on June 28, 2012. Any penetration by conduits, water lines, and low voltage lines will be sealed with fire-resistant caulk, and any future penetration will be sealed with the above type of caulking. **3. Measures or systemic changes to prevent recurrence:** (1) The doors will be put on an ongoing monthly preventive maintenance schedule where their operation will be checked by the maintenance staff, and any corrective action will be done at that time. (2) The new doors with fire rating tag will be put on a monthly preventive maintenance schedule where their operation will be checked by the maintenance staff, and the fire rating tag will be monitored to assure that it is not being painted over. Corrective action will be taken immediately if problems are indentified. (3) The maintenance department will have the doors on a preventive maintenance schedule (monthly). As part of the schedule,	

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	entrance. Findings include: Based on observation on 06/12/12 at 11:10 a.m. during a tour of the facility with Maintenance Technician # 1 and Maintenance Technician # 2, the set of double doors installed in the two hour fire separation wall separating the health care center from the apartment building at ground level was not provided with fire rating labels. This was acknowledged by Maintenance Technicians # 1 and # 2 at the time of observation. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 fire barriers to a nonconforming building was protected by a two hour fire wall on 1 of 3 floors. Findings include: Based on observation on 06/12/12 at 2:00 p.m. during a tour of the facility with		any time there is a change in penetration the maintenance department will make sure the penetration in sealed. **4. How corrective actions will be monitored/QA to be implemented:** Monthly preventive maintenance records will be monitored by maintenance supervisor, and results of this monitoring will be brought to the Quality Assurance (QA) committee meeting each quarter for one year (through June of 2013).	

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	Maintenance Technician # 1 and Maintenance Technician # 2, the fire wall directly above the set of fire doors which separated the health care center from the apartment building at ground level had a seven foot long by one foot high section that contained fiber insulation instead of cinder block like the remainder of the wall. This was acknowledged by Maintenance Technicians # 1 and # 2 at the time of observation. 3.1-19(b)			

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K0033 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 Based on observation and interview, the facility failed to ensure 2 of 12 stairway doors were equipped with positive latches. NFPA 101 at 7.1.3.2.1(c) requires openings be protected by fire door assemblies. NFPA 101 at 8.2.3.2.1(a) says the fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Windows, and NFPA 80 at 2-1.4 requires all swinging doors shall be closed and latched at the time of fire. This deficient practice could affect all 43 residents, as well as staff and visitors, while evacuating the main entrance. Findings include: Based on observation on 06/12/12 at 11:20 a.m. during a tour of the facility with Maintenance Technician # 1 and Maintenance Technician # 2, the	K0033	1. **Corrective actions:** Hardware was ordered on June 28, 2012, and company will install itso that when the doors close there will be a positive latch. The company will insure that there will be an integrated mechanism so that the doors will close in sequence for positive latching. 2. **How other residents with potential to be affected will be identified and corrective actions to be taken:** Other residents living in the building are identified as having potential to be affected. Hardware will be installed so that when the doors close there will be a positive latch. The company will insure that there will be an integrated mechanism so that the doors will close in sequence for positive latching. 3. **Measures or systemic changes to prevent recurrence:** The doors will be put on a monthly preventive maintenance schedule where their operation will be checked by the maintenance staff and any corrective action will be done at that time. 4. **How corrective actions will**	08/03/2012

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	stairway doors near the main entrance lounge from the ground level floor to the first and second floors were not equipped with positive latches. This was acknowledged by the Maintenance Technicians # 1 and # 2 at the time of observation. 3.1-19(b)		**be monitored/QA to be implemented:** Monthly preventive maintenance records will be monitored by maintenance supervisor, and results of this monitoring will be brought to the Quality Assurance (QA) committee meeting each quarter for one year (through June of 2013).	

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K0038 SS=E	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. 19.2.1 1. Based on observation and interview, the facility failed to ensure a handrail was provided for 1 of 1 exits with a ramp. LSC 19.2.1 refers to Chapter 7. LSC 7.2.5.4 states handrails shall be provided along both sides of a ramp run with a rise greater than six inches. Exception 3 says existing ramps shall be permitted to have a handrail on one side only. This deficient practice could affect any number of residents, as well as staff and visitors during an evacuation through the west ground level exit door. Findings include: Based on observation on 06/12/12 at 12:50 p.m. during a tour of the facility with Maintenance Technician # 2, the ground level west exit had an upward ramp fifteen feet long with a grade change of more than six inches from top to bottom. This ramp was not provided with handrails. This was acknowledged	K0038	**1. Corrective actions:** (1) Hardware was ordered on June 28, 2012, and handrail will be installed on the wall promptly upon arrival. (2) A work order for correction of this condition was placed with an outside company on June 29, 2012. The affected area will be torn out and the area will be prepped for a new concrete pad to be poured. Reinforcing rods will be installed to the existing and the new pad in order to prevent this kind of shift from happening again. **2. How other residents with potential to be affected will be identified and corrective actions to be taken:** Other residents living in the building are identified as having potential to be affected. (1)Hardware will be installed on the wall promptly upon its arrival. (2) The affected area will be torn out and the area will be prepped for a new concrete pad to be poured. Reinforcing rods will be installed to the existing and the new pad in order to prevent the kind of shift from happening again. **3. Measures or systemic changes to prevent recurrence:** (1) If any other area is identified, hardware will be purchased and installed to insure the residents' safety. The hardware will be checked	08/03/2012

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	by the Maintenance Technician # 2 at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 8 exits was maintained to provide safe access to the public way in accordance with LSC Section 7.1. LSC Section 7.1.6.3 requires walking surfaces shall be nominally level. This deficient practice could affect any number of residents, as well as staff and visitors during an evacuation through the west ground level exit door. Findings include: Based on observation on 06/12/12 at 12:50 p.m. during a tour of the facility with Maintenance Technician # 2, the ground level west exit discharged to a fifteen foot upward ramp. At the top of the ramp there was a two inch grade change in the connecting concrete slabs which could create a trip hazard for anyone traversing this area to evacuate to a public way. This		by the maintenance staff quarterly to insure that it is mounted and attached securely. (2)The concrete will be monitored to insure that the gap does not happen again. A quarterly inspection of exits of the residents' evacuation routes will be done by maintenance staff and used to identify problem areas; prompt corrective action will be taken. **4. <u>How corrective actions will be monitored/QA to be implemented</u>:** Quarterly preventive maintenance records will be monitored by maintenance supervisor, and results of this monitoring will be brought to the Quality Assurance (QA) committee meeting each quarter for one year (through June of 2013).	

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	was acknowledged by the Maintenance Technician # 2 at the time of observation. 3.1-19(b)			

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K0048 SS=F	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 provide a complete written fire safety plan for the protection of 43 of 43 residents in the event of an emergency addressing all items required by NFPA 101, 2000 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (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 This deficient practice could affect all occupants in the event of an emergency. Findings include:	K0048	1. **Corrective actions:** Procedures for the operation of the ABC extinguisher and the class K extinguisher have been written up and will be placed in the disaster plan books by July 2, 2012. 2. **How other residents with potential to be affected will be identified and corrective actions to be taken:** Other residents living in the building are identified as having potential to be affected. Procedures have been written for the operation of ABC and class K extinguishers. 3. **Measures or systemic changes to prevent recurrence:** The procedures will be reviewed annually when the disaster manual is reviewed. 4. **How corrective actions will be monitored/QA to be implemented:** Results of annual review of procedures for these two types of extinguishers will be presented at the QA meeting which follows the annual review of the disaster manual.	07/02/2012

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	Based on a review of the facility's written fire safety plan in the Disaster Manual on 06/12/12 at 11:00 a.m. with Maintenance Technician # 1 and Maintenance Technician # 2 present, the fire safety plan did not address how to use the ABC type fire extinguishers located throughout the building, or mention the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview at the time of record review, Maintenance Technicians # 1 and # 2 acknowledged the written fire safety plan did not include how to use the ABC type fire extinguishers, or mention kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using the K-class fire extinguisher. 3.1-19(b)			

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K0050 SS=C	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. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drills in the Fire Drills and Inspections book on 06/12/12 at 10:30 a.m. with Maintenance Technician # 1 and Maintenance Technician # 2 present, four of four second shift (evening) fire drills since April of 2011 were performed between 3:49 p.m. and 4:20 p.m. During an interview at the time of record review, Maintenance Technicians # 1 and # 2 acknowledged the times of the	K0050	1. **Corrective actions:** A second-shift drill was performed in the latter part of the shift on 6/28/12. Second shift drills will be performed at varied times per shift (2:30 p.m. – 11:00 p.m.). Varying the times of drills will be monitored by tracking all drills per quarter on the drill sheet. **2. How other residents with potential to be affected will be identified and corrective actions to be taken:** Other residents living in the building are identified as having potential to be affected. Drills for each shift will be performed at varied times during the shift, and this will be monitored by tracking all drills per quarter on the drill sheet. **3. Measures or systemic changes to prevent recurrence:** When drills are scheduled, the proposed times will be reviewed by the maintenance supervisor and the administrator to insure that the drills are held at varied times. **4. How corrective actions will**	06/28/2012

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	second shift fire drills were not varied. 3-1.19(b)		**be monitored/QA to be implemented:** Results of the above monitoring will be reviewed by the maintenance supervisor and brought to the Quality Assurance meeting each quarter through June of 2013.	

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K0062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 Based on observation and interview, the facility failed to ensure 23 of over 800 sprinkler heads in the facility were free of corrosion. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2-2.1.1 requires sprinklers to be free of paint and corrosion. Any sprinkler shall be replaced that is painted or corroded. This deficient practice could affect mostly kitchen staff while in the kitchen and dishwashing room. Findings include: Based on observations on 06/12/12 between 12:20 p.m. and 12:30 p.m. during a tour of the facility with Maintenance Technician # 2, fifteen of twenty sprinkler heads in the kitchen, and eight of eight sprinkler heads in the dishwashing room were covered with corrosion. This was	K0062	**1. Corrective actions:** New sprinkler heads were ordered on July 28, 2012 and will be installed by the sprinkler company to replace the defective ones. **2. How other residents with potential to be affected will be identified and corrective actions to be taken:** Other residents living in the building are identified as having potential to be affected. The sprinkler company will install new sprinkler heads that are more corrosive resistant in order to insure longer life and fewer problems with failure. **3. Measures or systemic changes to prevent recurrence:** The area affected will be monitored to insure that if any sprinkler heads show signs of corrosion they will be replaced. The area will be monitored quarterly by the maintenance staff. **4. How corrective actions will be monitored/QA to be implemented:** Results of the above monitoring will be reviewed by the maintenance supervisor and brought to the Quality Assurance meeting each quarter through June of 2013.	08/03/2012

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	acknowledged by Maintenance Technician # 2 at the time of each observation. 3.1-19(b)			

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K0064 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This	K0064	1. **Corrective actions:** The company was notified and the placard was installed near the Class K extinguisher on June 27, 2012.The kitchen and maintenance staff will be inserviced on July 2, 2012 regarding the procedure of its use. 2. **How other residents with potential to be affected will be identified and corrective actions to be taken:** Other residents living in the building are identified as having potential to be affected. The placard has been installed near the Class K extinguisher, and the kitchen and maintenance staff will be inserviced on the procedure for its use. 3. **Measures or systemic changes to prevent recurrence:** Any new staff (kitchen or maintenance) will be inserviced on the procedure for the use of the class K extinguisher. Semi-annually all kitchen and maintenance staff will be reinstructed by the maintenance supervisor regarding the procedure for use of the Class K extinguisher. This semi-annual review will be ongoing. 4. **How corrective actions will be monitored/QA to be implemented:** Confirmation of compliance will be monitored by the maintenance supervisor and reported at the QA meeting	06/27/2012

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	deficient practice could affect mostly staff while working in the kitchen. Findings include: Based on observation on 06/12/12 at 12:25 p.m. during a tour of the facility with Maintenance Technician # 2, there was a Class K portable fire extinguisher in the kitchen which lacked a placard. Based on interview at the time of observation, Maintenance Technician # 2 acknowledged the Class K portable fire extinguisher lacked a placard. 3.1-19(b)		following each semi-annual review through June of 2013.	

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K0069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on observation and interview, the facility failed to ensure mesh filters were not used for cooking equipment beneath 1 of 1 kitchen range hoods. LSC 19.3.2.6 refers to LSC 9.2.3. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, at 3-1 states mesh filters shall not be used. This deficient practice could affect mostly kitchen staff. Findings include: Based on observation on 06/12/12 at 12:10 p.m. during a tour of the facility with Maintenance Technician # 2, the kitchen range hood was equipped with fifteen mesh filters. This was acknowledged by Maintenance Technician # 2 at the time of observation. 3.1-19(b) 2. Based on record review, interview and observation; the	K0069	**1. Corrective actions:** (1) Fifteen baffle-type filters were ordered on June 28, 2012 and will be installed promptly upon their arrival. A preventive maintenance schedule will be set up for inspecting and cleaning the filters. (2) The hood was cleaned on 6/13/12, and the contract has been revised to specify cleaning on a semi-annual basis. **2. How other residents with potential to be affected will be identified and corrective actions to be taken:** Other residents living in the building are identified as having potential to be affected. (1) Fifteen baffle type filters were ordered and will be installed and a preventive maintenance schedule will be set up for inspecting and cleaning of the filters. (2) The hood-cleaning contract has been revised to specify cleaning on a semi-annual basis. **3. Measures or systemic changes to prevent recurrence:** (1) Monthly preventive maintenance schedule will be set up for inspecting and cleaning the fifteen baffle-type filters, which will be done by the maintenance staff. (2) At the time of our maintenance department's sixth monthly cleaning of the filters, the service will be called to clean the hood. A preventive maintenance log will be made to insure the	08/03/2012

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	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 could affect mostly kitchen staff. Findings include: Based on review of the kitchen range inspection reports in the inspections folder on 06/12/12 at 10:30 a.m. with Maintenance		timely cleaning of both the filters and the hood. This schedule will be developed and maintained by the maintenance supervisor. **4. How corrective actions will be monitored/QA to be implemented:** Monthly preventive maintenance will be monitored by maintenance supervisor, who will assure that the filters have been cleaned monthly and the hood has been cleaned every six months. The results of this monitoring will be brought to the Quality Assurance (QA) committee meeting each quarter for one year (through June of 2013).	

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	Technician # 1 and Maintenance Technician # 2 present, there was no documentation to show the kitchen range hood had been cleaned within the past twelve months. Based on observation at 12:15 p.m. during a tour of the facility with Maintenance Technician # 2, there was a sticker on the kitchen range hood which indicated the range hood was last cleaned on 01/11. This was confirmed by Maintenance Technician # 2 at the time of observation. 3.1-19(b)			