

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155787	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/31/2012
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NAME OF PROVIDER OR SUPPLIER INDIANA VETERANS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3851 N RIVER RD WEST LAFAYETTE, IN 47906
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K0000	<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: 01/31/12</p> <p>Facility Number: 001134 Provider Number: 155787 AIM Number: 200817200</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Indiana Veterans Home was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility was located in three buildings determined to be of Type I (443) construction</p>	K0000	<p><i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
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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>identified as Mitchell Hall (3 story), Pyle Hall (3 story) and MacArthur Hall (4 story). The buildings were surveyed as one since they were all constructed prior to March 1, 2003. The buildings were fully sprinklered. MacArthur and Pyle Halls have basements. There is a partial basement under the mechanical room on Mitchell Hall.</p> <p>The facility has a fire alarm system with smoke detectors in corridors, common areas and resident rooms. The facility has the capacity for 200 and a census of 170 residents.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/07/12.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>				

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K0018 SS=E	<p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>1. Based on observation and interview, the facility failed to ensure 6 of 6 self closing double door corridor door sets protecting the 3CD Mitchell lounge and lounges on the third and fourth floors on MacArthur would close to resist the passage of smoke. This deficient practice affects staff, visitors and 35 residents on the 3CD Mitchell hall and the third and fourth floors of MacArthur.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Manager on 01/31/12 between 3:00 p.m. and 5:30 p.m., two self closing corridor door sets providing access to the Mitchell 3CD lounge</p>	K0018	<p>1. How was the deficient practice corrected? a.The door coordinators were inspected on Mitchell 3CD, the doors were adjusted and was tested to ensure proper closure. b.The tape and magnet were immediately removed and disposed of. The nursing unit managers were made aware of the deficient practice. 2. How will you prevent it from occurring to others? a. All other door coordinators were tested and adjusted if needed. We are evaluating a different type of door coordinator that has less adjustment to it. b. All fire doors were checked on all nursing units for appropriate latching to assure compliance with life safety codes. 3. What systemic changes will be put into place to keep this from occurring? a. Modified door inspections will be updated to our PM system and reviewed by the</p>	03/01/2012			

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	<p>failed to self close. One door set was prevented by the malfunction of the door coordinator and the second when one door hit the other and could not close. Door sets for three lounges and an activity room on the third and fourth floors of MacArthur were prevented from closing when the door coordinators failed to allow the self closing doors to close, leaving four inch gaps. The Physical Plant Manager acknowledged the problem at the time of observations, he said the devices needed frequent adjustment.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure there were no impediments to closing doors protecting corridor openings on 2 of 3 floors in Mitchell Hall. This deficient practice affects staff, visitors and 101 residents on the second and third floors of Mitchell hall.</p> <p>Findings include:</p> <p>Based on observation with the</p>		<p>supervisors and Physical Plant Director monthly. b. All nursing staff will be inserviced in life safety codes regarding proper latching of doors and fire doors</p> <p>4. How will you monitor these changes? a. Modified door inspections will be updated to our PM system and will be checked weekly for one month, then bi-weekly for one month, then monthly thereafter and signed off by the Physical Plant Director. b. Fire doors to offices, supply rooms, lounges, etc , on each nursing unit, will be checked daily X one month, then weekly x one month, then monthly thereafter and reported to QA. 5. All changes will be complete by 3-1-12. Modified PM's added to Maintenance MP2 System - 2/18/12</p>		

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	<p>Physical Plant Manager on 01/31/12 between 3:00 p.m. and 5:30 p.m., the corridor door to the Mitchell linen supply room 327 was prevented from latching by a magnet placed over the latch to prevent it from engaging into the door frame. The Mitchell second floor lounge door was prevented from latching by tape across the latch. The Physical Plant Manager said at the time of observations, this was not an approved practice.</p> <p>3.1-19(b)</p>				

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K0021 SS=E	<p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure doors in smoke barrier door sets on 1 of 3 floors on Mitchell Hall would self close to restrict the passage of smoke. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect staff, visitors and 86 or more residents using the first floor Mitchell hall corridor.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Manager on 01/31/12 at 3:05 p.m., the first floor Mitchell smoke barrier door</p>	K0021	<p>1. What action was taken to correct the deficient practice? Doors were inspected by the smoking break room; the door was adjusted and was tested to ensure proper closure. 2. How are others identified and what corrective action will be taken to prevent it from occurring again or to others? All other door coordinators were tested and adjusted if needed. Indiana Veterans Home is evaluating a different type of door coordinator that needs less adjustment to it. 3. What measures or systemic changes were put into place to be sure this does not reoccur? Modified door inspections will be updated to our PM system and reviewed by the supervisors and Physical Plant Director monthly. 4. How will corrective actions be monitored? Modified door inspections will be updated to our PM system and will be checked weekly for one month, then</p>	03/01/2012	

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	<p>set located near the smoking room failed to self close twice, when tested. The Physical Plant Manager acknowledged at the time of observation, the doors should have closed.</p> <p>3.1-19(b)</p>		<p>bi-weekly x one month, then monthly thereafter and reported to QA by Physical Plant director 5. Changes will be complete by Modified PM's added to our MP2 system by - 2/18/2012 Evaluations of new coordinators will be completed by – 3/01/2012</p>		

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K0029 SS=E	<p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to provide an automatic closer for the door providing access to 1 of 8 MacArthur Hall hazardous areas such as a combustibile materials storage room larger than 50 square feet. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and 40 residents on MacArthur 3.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Manager on 01/31/12 at 4:00 p.m., a 15 by 15 foot room converted to store clean linen on the third floor of</p>	K0029	<p>1. What action was taken to correct the deficient practice? Doors on the linen room were closed immediately and after inspection a fire enclosure were installed to comply with safety code. 2. How are others identified and what corrective action will be taken to prevent it from occurring again or to others? All doors on other floors were inspected and made sure we complied with safety regulation.3. What measures or systemic changes were put into place to be sure this does not reoccur? We have entered into our MP2 - PM system a work order to inspect all spare room. This will ensure all doors have a working device upon activation of the fire alarm system. 4. How will corrective actions be monitored? The PM will be checked weekly x one month, then monthly thereafter and reported to QA by Physical Plant Director 5. Changes will be complete by: PM enter into our system – 03/01/2012</p>	03/01/2012	

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	<p>MacArhtur had no self closing device. The Physical Plant Manager said at the time of observation, he didn't realize the door was required to self close.</p> <p>3.1-19(b)</p>			
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K0048 SS=B	<p>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</p> <p>Based on record review and interview the facility failed to include the use of the kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice affects any residents, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on review of the facility Fire Response Plan on 01/31/12 at 2:50 p.m. with the Physical Plant Manager, the plan did not include</p>			K0048	<p>1. What action was taken to correct the deficient practice? The "K" class fire extinguisher was not included into our fire emergency plan. 2. How are others identified and what corrective action will be taken to prevent it from occurring again or to others? All fire plans was reviewed and the "K" class fire extinguisher will be included. 3. What measures or systemic changes were put into place to be sure this does not reoccur? The fire plan will be review by the safety coordinator quarterly 4. How will corrective actions be monitored? The Safety Coordinator will review quarterly and report to QA annually 5. Changes will be complete by: Fire plan reviewed and revised – 03/01/2012</p>		03/01/2012

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	<p>the use of the K class fire extinguishers located in kitchens in relationship with the use of the kitchen overhead extinguishing system. The Physical Plant Manager acknowledged at the time of record review, the fire extinguishers had not been included as part of the written plan.</p> <p>3.1-19(b)</p>			
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K0062 SS=F	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 1. Based on record review and interview, the facility failed to ensure sprinkler waterflow alarm devices were tested quarterly for 3 of 3 buildings. NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 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 shall be tested quarterly. NFPA 25, 9-7.1 requires the fire department connections shall be inspected quarterly. NFPA 25, 1-8.1 requires records shall indicate the procedure performed (inspection, test, or maintenance), the organization that performed the work, the results and the date. Finally, NFPA 25, 1-8 requires records of inspection, test, and maintenance of the system and its	K0062	1. What action was taken to correct the deficient practice? a. The sprinkler inspections for IVH were reviewed and made sure they are all up to date. Third quarter for Pyle was found. b. Siemens contractor were called in and inspected the gauge and replaced the gauge on 2/ 9/2012. c. All fire hydrants were functioning from April 27, 2011 to January 31, 2012. All fire hydrants were inspected and minor repairs were made units working properly and ordered new parts which was installed on 2/06/2012 2. How are others identified and what corrective action will be taken to prevent it from occurring again or to others? a. All other safety inspections for IVH were reviewed and we verified that first quarter 2012 inspections were completed on 01/26/2012 b. All gauges were inspected on 02/09/2012 throughout the facility. All gauges will have to be changed again during the month of 2/2017. c. All other hydrants that not on the repair list were also inspected by a certified contractor, they verified that they are in working order. 3. What measures or systemic changes were put into place to be sure this does not reoccur? a. A master spreadsheet will be	03/01/2012			

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	<p>components shall be made available to the 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 occupants in the facility.</p> <p>Findings include:</p> <p>Based on a review of Sprinkler Inspection maintenance and testing records with the Physical Plant Manager on 01/31/12 at 1:15 p.m., quarterly sprinkler inspections were not found for the second and fourth quarters of 2011 for Mitchell Hall, for the fourth quarter of 2011 for MacArthur Hall, and for the third and fourth quarters of 2011 for Pyle Hall. The Physical Plant Manager asked an administrative assistant at the time of record review, to request missing records from the sprinkler inspection contractor. No other records were provided at the time of exit on 01/31/12 at 5:30 p.m.</p>		<p>implemented with all 2012 safety inspection for the entire year, per month. Every month the supervisors, scheduler, and the Physical Plant Director will review and signoff on all inspections. b. All gauges were replaced, they are good until 2017. We will still implement a PM in our MP2 system to check all gauges once a year. c. A master spreadsheet will be implemented with all 2012 safety inspection for the entire year, per month. Every month the supervisors, scheduler, and the Physical Plant Director will review and signoff on all inspections. 4. How will corrective actions be monitored? a. The schedule will be checked weekly for three months, then monthly thereafter and reported to QA by Physical Plant Director b. Will check out monthly for three months and yearly thereafter c. This will be checked weekly for three months, then quarterly and yearly thereafter reported to QA by Physical Plant Director 5. Changes completed by: 3/1/2012</p>				

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	<p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 automatic sprinkler system gauges on Pyle Hall was replaced or calibration tested every five years as required by NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems 2-3.2. 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 visitors, staff and 13 residents on Pyle Hall.</p> <p>Findings include:</p> <p>Based on a review of Sprinkler Inspection maintenance and test records with the Physical Plant Manager on 01/31/12 at 1:15 p.m., sprinkler system gauge documentation was not found. During a tour of the Pyle Hall on 01/31/12 at 4:15 p.m., one</p>						

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	<p>sprinkler system gauge had a date of 2000, usually the date of installation or calibration. The Physical Plant Manager said at the time of observation, he could not say when the gauge was last calibrated or replaced.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure 7 of 12 private fire hydrants were continuously maintained in reliable operating condition. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected and the necessary corrective action shall be taken. This deficient practice could affect all staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on record review with the Physical Plant Manager on 01/31/12 at 1:35 p.m., the Fire</p>			
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	<p>Hydrant Report dated 04/27/11 noted hydrants # 1, # 2, # 4, # 5, # 9, # 10 and # 12 required maintenance to address draining problems, missing grease skirts, rusted operating nuts and a four inch cap on hydrant # 1 which could not be removed for maintenance. The Physical Plant Manager said at the time of record review, the repairs were not yet done.</p> <p>3.1-19(b)</p>			
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K0064 SS=E	<p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 3 kitchens was provided with a K class fire extinguisher. 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. This deficient practice could affect any visitor and resident in the adjacent Mitchell Hall dining room and 4 kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Manager on 01/31/12 at 3:20 p.m., the Mitchell Hall kitchen was not provided with a K class fire extinguisher. The Physical Plant Manager said at the time of observation there should have been one but acknowledged it was nowhere in the kitchen.</p> <p>3.1-19(b)</p>	K0064	<p>1. What action was taken to correct the deficient practice? a. The class "K" fire extinguisher was missing in the Mitchell kitchen. It was found in the Pyle kitchen and returned immediately to the Mitchell kitchen the same day the deficient practice occurred. b. The 6 year verification collar was noted missing on several extinguishers during the audit. When ACE Fire Protection Service inspected the units they found them to be current and did not require the collar yet. 2. How are others identified and what corrective action will be taken to prevent it from occurring again or to others? a. The two kitchens (Mitchell and Pyle) were inspected for other missing extinguishers, and a weekly checklist will be implemented to ensure the extinguisher is located in its proper place. b. All fire extinguishers in all the IVH building were inspected by Ace Fire Protection on 02/01/2012 3. What measures or systemic changes were put into place to be sure this does not reoccur? a. The kitchen does a weekly check sheet on items that need to be completed. This will be added to that sheet, and a maintenance PM will be added to verify the location of the extinguisher. b. When the security and safety</p>	03/01/2012			

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	2. Based on observation and interview, the facility failed to provide 2 of 12 portable fire extinguishers with a verification of service collar. NFPA 10, the Standard for Portable Fire Extinguishers, at 4-4.4.2 requires each extinguisher that has undergone maintenance which includes internal examination or has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch. Each extinguisher that has undergone the six year maintenance procedure shall have a "Verification of Service Collar"		inspects the fire extinguishers, they will also inspect for the 6 year collar. 4. How will corrective actions be monitored? a. Inspections will be monitored by check sheet and maintenance PM's. They will be checked weekly x one month, then monthly thereafter and reported to QA by Physical Plant Director. Weekly cleaning schedule, made up by the Dietary Manager, states to verify extinguishers are in proper locations. b. Will be checked weekly for one month, then monthly thereafter and reported to QA by Physical Plant Director 5. Changes will be complete by: 03/01/2012		

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	<p>around the neck of the extinguisher indicating date of 6 year maintenance. This deficient practice could affect visitors, staff and 50 or more residents using the first floor Mitchell hall services in the auditorium.</p> <p>Findings include:</p> <p>Based on observation with the Physical Plant Manager on 01/31/12 between 3:00 p.m. and 5:30 p.m., portable fire extinguishers 8-1-7, 8-1-3, and 8-1-9 on the first floor of the Mitchell building each lacked a verification of service collar. The Physical Plant Manager acknowledged at the time of observations, there was nothing to identify when a six year service was done.</p> <p>3.1-19(b)</p>			
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K0069 SS=B	<p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>Based on record review and interview, the facility failed to ensure fire extinguishing equipment for 3 of 3 range hoods was inspected and approved every 6 months by properly trained and qualified persons. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-2.1 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. Furthermore, NFPA 96, 8-2.1.1 requires actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, fire-actuated dampers, etc., shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice affects occupants of the Mitchell and Pyle Kitchens where 10 staff were observed.</p>			K0069	<p>1. What action was taken to correct the deficient practice? We reviewed all hood inspections, the last inspection was completed on 11/02/11, the next inspection is already schedule with our contractor on 5/01/2012. 2. How are others identified and what corrective action will be taken to prevent it from occurring again or to others? All other Hood Inspections were reviewed and checked the dates to ensure we do not miss others. 3. What measures or systemic changes were put into place to be sure this does not reoccur? A master spreadsheet will be implemented with all safety inspection for the entire year. Every month the supervisors, scheduler, and the Physical Plant Director will review and signoff on all inspections and repairs if needed. 4. How will corrective actions be monitored? Will be checked monthly for three months, then quarterly thereafter and reported to QA by Physical Plant Director 5. Changes will be complete by: 03/01/2012</p>		03/01/2012

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	<p>Findings include:</p> <p>Based on a review of the Range Hood Inspection records with the Physical Plant Manager on 01/31/12 at 1:05 p.m., the inspection and service records for the commercial range fire suppression systems for the Pyle Kitchen, Pyle Snack Bar, and the Mitchell Kitchen were dated 11/02/11. No records were found for the previous six month inspections. The Physical Plant Manager said at the time of record review, there were no other records for the previous six month interval, he thought the inspections were required annually.</p> <p>3.1-19(b)</p>						

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K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on interview and record review, the facility failed to provide the complete documentation for testing 4 of 4 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. 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 affects all residents, staff and visitors.			K0144	1. What action was taken to correct the deficient practice? a. All documents were reviewed and revised to include all information to comply with the generator standard. PM's was revised for weekly, monthly and annually. The new weekly PM started on 2/03/2012. b. Batteries and cables were inspected on generators. The documents were reviewed and revised to include all information to comply with standard. PM's was revised for weekly, monthly and annually. The new weekly PM started on 2/03/2012. 2. How are others identified and what corrective action will be taken to prevent it from occurring again or to others? a) All 4 generators were included on the above action. Modified preventive maintenance documents will be used weekly, monthly, and annually. b) All 4 generators were included on the above action. Modified preventive maintenance documents will be used weekly, monthly, and annually. 3. What measures or systemic changes were put into place to be sure this does not reoccur? a) Modified PM's work orders were added to our MP2 system that our maintenance will perform as required. b) Modified PM's work orders were added to our MP2 system that our		02/03/2012

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	<p>Findings include:</p> <p>Based on review of the Generator Testing records with the Physical Plant Manager and generator operator on 01/31/12 at 1:40 p.m., the records were incomplete or missing. No record of the actual percentage of load carried or the operating temperature during load testing, regular monthly testing and weekly checks for each generator were provided. In addition, a transfer time of 23 seconds was recorded for the the last quarterly load test for 2011. The generator operator said at the time of record review, load testing was done quarterly.</p> <p>3.1-19(b)</p> <p>2. Based on interview and record review, the facility failed to provide complete documentation for testing 4 of 4 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires weekly maintenance of the emergency generator set shall be in accordance with NFPA 110, the</p>		<p>maintenance will perform as required. 4. How will corrective actions be monitored? a) PM's will be checked weekly for three months, then monthly thereafter and reported to QA by Physical Plant Director b) PM's will be checked weekly, for three months, then monthly thereafter and reported to QA by Physical Plant Director 5. Changes will be complete by: Started new revised forms on 2/3/2012 Review new revised form and update if necessary - 3/1/2012</p>				

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	<p>Standard for Emergency and Standby Power Systems. NFPA 110, 6-3.6 requires storage batteries used for generator sets in Level 1 and 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Generator Testing records with the Physical Plant Manager and generator operator on 01/31/12 at 1:40 p.m., the records were incomplete, missing documentation for weekly battery, belts, and coolant checks for the emergency generators. The Physical Plant Manger said at the time of record review, the documentation should have been done but the generator operator acknowledged it was not always recorded.</p>						

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