

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155232	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/26/2014
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NAME OF PROVIDER OR SUPPLIER  TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
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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: 02/26/14</p> <p>Facility Number: 000137 Provider Number: 155232 AIM Number: 100266140</p> <p>Surveyor: Dennis Austill, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Twin City Health Care 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 was determined to be of Type V (000) construction and was fully sprinklered with the exception of the canopy at the main entrance. The facility has a fire alarm system with smoke detection in the corridors, spaces</p>	K010000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirements under state and federal laws. Please accept this plan of correction as our credible allegation of compliance.	

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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K010029 SS=E	<p>open to the corridors and battery operated smoke detectors in all resident rooms. The facility has a capacity of 75 and had a census of 56 at the time of this survey.</p> <p>All areas where the residents have customary access and all areas providing facility services were sprinklered with the exception of the canopy at the main entrance.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 ensure the corridor door</p>	K010029	<b>K029 Corrective action for residents affected:</b> No residents were affected by this alleged negative practice. A	03/04/2014	

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	<p>to 1 of 3 hazardous areas such as combustibile storage areas over 50 square feet in size was provided with a smoke resistive door equipped with self closing devices that would cause the door to automatically close and latch into the door frame. This deficient practice could affect residents as well as staff and visitors in the corridor on the E Hallway near room 6.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/26/14 during the tour from 11:30 a.m. to 1:15 p.m., the corridor door to the Respiratory Therapy/Storage room had a pencil size hole through the door above the door knob and it was not equipped with a self closing device. This room was larger than 50 square feet in size and contained storage of combustibile material such as 30 to 40 cardboard boxes with plastic wrapped respiratory supplies. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p>		<p>self closing device has been installed for the door mentioned (Respiratory office). The pencil sized hole noted has also been corrected.</p> <p><b>Other residents having potential to be affected and corrective action:</b> No residents were affected by this alleged negative practice. Other doors requiring self closing devices were checked and working properly.</p> <p><b>Measures to ensure that the practice does not recur:</b> Maintenance Director was reeducated on the need for self-closing devices. Maintenance Director or designee will monitor all doors requiring self closing devices on a monthly basis.</p> <p><b>This corrective action will be monitored by:</b> Maintenance director or designee will keep a monthly log for door checks to ensure self-closing hardware. Any concerns will be reported to the administrator and will be corrected immediately. Monitoring will be ongoing for continued compliance.</p> <p><b>Completed 3/4/2014</b></p>		

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K010050 SS=C	<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. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct fire drills at unexpected times in 9 of 12 fire drills. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of fire drill report documentation with the Maintenance Director on 02/26/14 from 9:30 a.m. to 11:30 a.m., the following was noted:</p> <p>a. Three of four first shift drills were conducted between 9:30 a.m. and 10:30 a.m.</p> <p>b. Three of four second shift fire drills were conducted between 3:30 p.m. and 4:30 p.m.</p> <p>c. Three of four third shift fire drills were conducted between 3:15 a.m. and 4:15 a.m.</p> <p>Based on interview at the time of record</p>	K010050	<p><b>K050 Corrective action for residents affected:</b> No residents were affected by this alleged negative practice. Fire drills will be held at unexpected times under varying conditions, at least quarterly on each shift.</p> <p><b>Other residents having potential to be affected and corrective action:</b> No residents were affected by this alleged negative practice. Fire drills will be done at random times under varying conditions, at least quarterly on each shift.</p> <p><b>Measures to ensure that the practice does not recur:</b> The Maintenance Director was reeducated of the need for Fire drills to be performed at random times under varying conditions, at least quarterly on each shift.</p> <p><b>This corrective action will be monitored by:</b> Maintenance director or designee will maintain a log of dates and times of fire drills; the Administrator will monitor</p>	03/28/2014			

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K010056 SS=E	<p>review, the Maintenance Director acknowledged the fire drills were not held randomly.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to provide sprinkler coverage for 1 of 1 exterior canopies which was wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. Section 5-13.8.2 requires sprinklers shall be installed under roofs or canopies over areas where combustibles are stored and handled. This deficient practice could</p>	K010056	<p>monthly to ensure times are random per shift. <b>Completed 3/28/2014</b></p> <p><b>K056 Corrective action for residents affected:</b> No resident were affected by this alleged negative practice. Documentation has been obtained to verify the canopy material was inherently flame retardant. See attachment A.</p> <p><b>Other residents having potential to be affected and corrective action:</b> No residents were affected by this alleged negative practice. Documentation has been obtained to verify the canopy material was inherently flame retardant.</p>	03/28/2014	

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	<p>affect residents, staff and visitors using the main entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/26/14 from 11:30 a.m. to 1:15 p.m., a canopy of canvas or vinyl construction over a metal frame outside of the main entrance was not provided with sprinkler protection. The canopy was attached to the building and extended over 30 feet from the building. Based on interview during the exit conference, the Administrator acknowledged the facility did not have documentation available for review to verify the canopy material was inherently flame retardant and was not provided with sprinkler protection.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p><b>Measures to ensure that the practice does not recur:</b></p> <p>Maintenance was re-educated on the importance of maintaining appropriate fire ratings.</p> <p><b>This corrective action will be monitored by:</b> Administrator or designee will review quarterly fire ratings documentation. Any negative findings will be obtained immediately; monitoring will be ongoing to ensure continued compliance.</p> <p><b>Completed 3/28/2014</b></p>				

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K010066 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observations and interview, the facility failed to ensure cigarette butts were deposited into noncombustible containers which were provided in 3 of 4 areas. This deficient practice had the potential to affect staff utilizing the exits during a fire emergency.</p> <p>Findings include:</p> <p>Based on observations on 02/26/14 with the Maintenance Director during the tour from 11:30 a.m. to 1:15 p.m., there were</p>	K010066	<p><b>K066 Corrective action for residents affected:</b> No residents were affected by this alleged negative practice. Signage has been posted within building reminding staff to use the cigarette noncombustible containers after smoking.</p> <p><b>Other resident having potential to be affected and corrective action:</b> No residents were affected by this alleged negative practice. Staff re-educated on importance of using noncombustible containers when putting out cigarettes.</p> <p><b>Measure to ensure that the practice does not recur:</b> The Maintenance</p>	03/21/2014	

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K010068 SS=E	<p>discarded cigarette butts on the ground near the main entrance, the kitchen exit near the generator and the "C" hallway exit. Based on interview at the time of observation, the Maintenance Director acknowledged the discarded cigarette butts on the ground.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 rooms with a gas water heater was provided with makeup combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could affect any resident using the "D" Hallway as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 02/26/14 with the Maintenance Director during the tour from 11:30 a.m. to 1:15 p.m., the "D" hallway Environmental/Supply room</p>	K010068	<p>Director or designee will monitor on normal scheduled days cigarette noncombustible containers and ensure surrounding areas are void of cigarette butts.</p> <p><b>This corrective action will be monitored by:</b> The Maintenance Director or designee will monitor on normal scheduled days cigarette noncombustible containers and ensure surrounding areas are void of cigarette butts. Any concerns will be reported to the administrator and will be corrected immediately. Monitoring will be ongoing for continued compliance.</p> <p><b>Completed 3/21/2014</b></p> <p><b>K068 Corrective action for residents affected:</b> No residents were affected by this alleged negative practice. Signage has been posted at vent to ensure nothing is blocking opening.</p> <p><b>Other resident having potential to be affected and corrective action:</b> No residents were affected by this alleged negative practice. Signage has been posted at vent to ensure nothing is blocking opening.</p> <p><b>Measure to ensure that the practice does not recur:</b> Housekeeping staff were re-educated 03/05/14 on the importance of keeping vent clear and open.</p> <p><b>This corrective action will be</b></p>	03/21/2014	

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K010069 SS=E	<p>had a gas fueled water heater with the fresh air intake vent in the exterior door blocked by a rug and cardboard box covering the opening. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on observation, record review and interview; the facility failed to ensure 1 of 1 electrically powered cooking stoves was provided with an automatic electrical shut off switch connected to the kitchen fire extinguishing system. NFPA 96, 1998 Edition Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 7-4.1 requires upon activation of any fire extinguishing system for a cooking operation, all sources of fuel and electric power that produce heat to all equipment requiring protection by that system shall automatically shut off. This deficient practice could affect any residents who use the main dining room located</p>	K010069	<p><b>monitored by:</b> Housekeeping supervisor will check vent daily on normal scheduled days to ensure vent is open and unobstructed. Maintenance Director will monitor weekly. Any concerns will be reported to the administrator and will be corrected immediately. Monitoring will be ongoing for continued compliance. <b>Completed 3/21/2014</b></p> <p><b>K069 Corrective action for residents affected:</b> No residents were affected by this alleged negative practice. Inspection reports from contractor will include verification of electrical shut off testing. Elwood Fire has been scheduled for inspection of electrical shutoff testing.</p> <p><b>Other resident having potential to be affected and corrective action:</b> No residents were affected by this alleged negative practice. Inspection reports will include verification of electrical shut off testing. Elwood Fire has been scheduled for inspection of electrical shutoff testing. Electrical shutoff has been installed to the electric stove.</p> <p><b>Measure to ensure that the practice does not recur:</b> Maintenance Director was reeducated on 3/05/14</p>	03/28/2014			

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K010072 SS=B	<p>adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on review of the Range Hood Suppression System Inspection Reports dated 01/28/14 and 07/22/13 on 02/26/14 during record review from 9:30 a.m. to 11:30 a.m. with the Maintenance Director, the reports had no verification of electrical shut off testing for the two inspections. Based on observation and interview from 11:30 a.m. to 1:15 p.m. with the Maintenance Director and Dietary Supervisor, an electrical shutoff for the electric stove could not be verified.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of impediments to full instant use in the case of fire or other emergency for 2 of 5</p>	K010072	<p>of the need for inspection reports to include verification of electrical shut off testing. Electrical shutoff has been installed for the electric stove.</p> <p><b>This corrective action will be monitored by:</b> Maintenance Director or designee will maintain log as to inspections to ensure verification of electrical shut off testing, any concerns will be reported to the administrator and will be correctly immediately. Monitoring will be ongoing for continued compliance.</p> <p><b>Completed 3/28/2014</b></p> <p><b>K072 Corrective action for residents affected:</b> No resident were affected by this alleged negative practice. Exit path sidewalk will be continuously maintained and free of impediments to full instant use.</p>	03/28/2014	

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	<p>exits. This deficient practice could affect at least 30 residents as well as staff and visitors if exiting from the "E" or "A" Hallways.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director from 11:30 a.m. to 1:15 p.m. on 02/26/14, the exit path between "A" Hallway and "B" Hallway was covered with at least five inches of snow. The exit path was a sidewalk that circled around the exterior of the facility with connections from each hallway that eventually lead to a public way. Based on interview at the time of observation, the Maintenance Director acknowledged the exit path between "A" Hallway and "B" Hallway exits was snow covered.</p> <p>3.1-19(b)</p>		<p><b>Other resident having potential to be affected and corrective action:</b></p> <p>No residents were affected by this alleged negative practice. Snow removal contractor notified of importance of keeping entire sidewalk clear. Maintenance director or designee will check frequently during inclement weather to ensure that the sidewalk pathway is continuously maintained and free of impediments to full instant use.</p> <p><b>Measure to ensure that the practice does not recur:</b> The Maintenance Director was reeducated of importance of keeping entire sidewalk clear. Maintenance director or designee will check frequently during inclement weather to ensure that the sidewalk pathway is continuously maintained and free of impediments to full instant use.</p> <p><b>This corrective action will be monitored by:</b> Maintenance Director or designee will monitor daily during inclement weather to ensure that the sidewalk pathway is continuously maintained and free of impediments to full instant use.</p> <p>Any concerns will be reported to the administrator and will be corrected immediately. Monitoring will be ongoing for continued compliance.</p> <p><b>Completed 3/28/2014</b></p>		

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K010074 SS=A	<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. 19.7.5.1, 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. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure curtains in 1 of 100 rooms were flame retardant. This deficient practice would not affect residents and visitors but could affect staff in the laundry.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility on 02/26/14 from 11:30 a.m. to 1:15 p.m., a blanket being used as a curtain over a door in the laundry leading to the exterior lacked attached documentation it was inherently flame retardant.</p>	K010074	<p><b>K074 Corrective action for residents affected:</b> No residents were affected by this alleged negative practice. Staff re-educated on 02/28/14 on the prohibited use of non-flame retardant material as a curtain. The blanket was removed from the window.</p> <p><b>Other residents having potential to be affected and corrective action:</b> No residents were affected by this alleged negative practice. Staff re-educated on 02/28/14 on the prohibited use of non-flame retardant material as a curtain.</p> <p><b>Measure to ensure that the practice does not recur:</b> Daily log posted in laundry room for supervisor to ensure that non appropriate material is not being used as curtain.</p>	03/28/2014			

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NAME OF PROVIDER OR SUPPLIER  TWIN CITY HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 627 E NORTH ST GAS CITY, IN 46933
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K010130 SS=E	<p>Based on interview at the time of observation with the Maintenance Director, there was no documentation regarding flame retardancy for the blanket being used as a curtain available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, interview and record review; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be</p>	K010130	<p><b>This corrective action will be monitored by:</b> Housekeeping supervisor or designee will monitor daily with Maintenance Director checking weekly to ensure that non appropriate material is not being used as curtain. Any concerns will be reported to the administrator and will be corrected immediately. <b>Corrected 3/28/2014</b></p> <p><b>K130 Corrective action for residents affected:</b> No residents were affected by this alleged negative practice. Contractor has inspected the rolling fire door and is scheduled to be inspected annually.</p> <p><b>Other residents having potential to be affected and corrective action:</b> No residents were affected by this alleged negative practice. Inspection of rolling door has been added to the annual inspection log and contractor has been notified that this must be inspected annually.</p> <p><b>Measure to ensure that the practice does not recur: The</b> Maintenance Director was reeducated on 02/27/14 of the need for Inspection of the rolling fire inspection requirement has been added to the annual inspection log and contractor notified that this must be inspected annually.</p> <p><b>This corrective action will be</b></p>	03/19/2014

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	<p>maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident using the main dining room adjacent to the kitchen including staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 02/26/14 during the tour from 11:30 a.m. to 1:15 p.m. with the Maintenance Director, there was a rolling fire door protecting the opening from the kitchen to the main dining room without an attached inspection tag. Based on record review from 9:30 a.m. to 11:30 a.m., the rolling fire door was installed and inspected on 09/16/11. Based on interview at the time of record review, the Maintenance Director acknowledged there was no documentation of an annual inspection or test since installation to check for proper operation and full closure of the vertical rolling fire door.</p> <p>3.1-19(b)</p>		<p><b>monitored by:</b> Maintenance Director or designee will monitor and ensure annual inspections are completed in timely manner. Any concerns will be reported to the administrator and will be corrected immediately. Monitoring will be ongoing for continued compliance.</p> <p><b>Completed 3/19/2014</b></p>		

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K010144 SS=C	<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>Based on record review and interview, for 12 of 12 months the facility failed to accurately document load testing of the generator to meet the requirements of NFPA 110, the Standard for Emergency and Standby Powers Systems. NFPA 110, Section 6-4.7 requires the generator routine maintenance and operational testing program to be overseen by a properly instructed individual. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the "Emergency Generator - Monthly Test Log" with the Maintenance Director on 02/26/14 during record review from 9:30 a.m., to 11:30 a.m., the standby KW nameplate rating was listed as 95 KW, 30% of standby rating was listed as 32 KW and the load for each month in 2013 was listed as 230 KW. Based on interview at time of record review, the Maintenance Director acknowledged he was not sure how to calculate the load percentage and acknowledged the monthly load could not exceed the generator's load capacity.</p>	K010144	<p><b>K144 Corrective action for residents affected:</b> No resident affected by this alleged negative practice. Correct formula established and currently being used on "Emergency Generator-Monthly Test Log". Maintenance Director re-educated by Corporate Life Safety to proper formula.</p> <p><b>Other residents having potential to be affected and corrective action:</b> No residents were affected by this alleged negative practice. Maintenance Director was re-educated to correct way of using formula on "Emergency Generator-Monthly Test Log".</p> <p><b>Measure to ensure that the practice does not recur:</b> Emergency generator monthly log will be reviewed by administrator every month X 6 months then quarterly thereafter.</p> <p><b>This corrective action will be monitored by</b> The Administrator will review documentation of monthly load tests every month. Any concerns will be reported to the administrator and will be corrected immediately. Emergency generator monthly log to be reviewed by the administrator every month X 6 months then quarterly thereafter. Quarterly monitoring will be ongoing</p>	03/28/2014	

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	3.1-19(b)		for continued compliance. Corrected 3/28/2014		