

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155551		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/04/2011	
NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 604 RENNAKER STREET LA FONTAINE, IN46940			
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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: 05/04/11</p> <p>Facility Number: 000447 Provider Number: 155551 AIM Number: 100289950</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Rolling Meadows Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type III (211)</p>	K0000					

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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K0018 SS=B	<p>construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and all resident rooms on the 200 hall. The facility has a capacity of 115 and had a census of 96 at the time of this survey.</p> <p>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 05/06/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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>				

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	<p>Based on observation and interview, the facility failed to ensure 1 of 10 doors protecting corridor openings in the front nurses' station area were smoke resistive. This deficient practice could affect any resident at the front nurses' station.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator, Maintenance Supervisor and Housekeeping/Laundry Supervisor on 05/04/11 at 11:45 a.m., there was a pencil size hole above the door knob of the corridor door to the medical cart room in the front nurses' area. This was confirmed by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K0018	<p>Corrective Actions : No residents were affected by the practice. The pencil size hole in the medical cart room has been filled and properly sealed.</p> <p>Identifications and corrective actions taken for other residents having the potential to be affected by the alleged practice : No residents were identified as having the potential to be affected.</p> <p>Measures taken to and systematic changes made to ensure the alleged deficient practice does not reoccur : All doors that need a door handle lock set will be changed out with the same locking mechanism to ensure no holes in doors. All doors in facility will be documented weekly on our TELS system by our maintenance staff.</p> <p>How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not reoccur : Maintenance Supervisor report of monitoring will be forwarded to the Administrator for monthly QA review, response and compliance. Plan will be adjusted accordingly.</p> <p>Corrections completed : June 3, 2011</p>	06/03/2011	

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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 ensure the corridor door to 1 of 1 combustibile storage rooms measuring over 50 square feet in size was provided with a self closing device. This deficient practice could affect residents in the area around the Medical Supply room in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor on 05/04/11 at 12:51 p.m., the corridor door to the Medical Supply room, which measured over 50 square feet in size and containing cardboard boxes and fifteen bottles of rubbing alcohol,</p>	K0029	<p>Corrective Actons : No residents were affected by this practice. The corridor door to the Medical supply room was installed with a self closing device.</p> <p>Identifcation off and corrective actions taken ffor other residents having the potential to be affected by the alleged practice : No residents were identified as having the potential to be affected. No other required doors were lacking a self closing device.</p> <p>Measures taken to and systematic changes made to ensure the alleged defficient practice does not reoccur : The inspection of all doors requiring self closing devices will be conducted weekly and documented in the TELS system</p> <p>How the corrective actions will be monitored and the QA system implemented to ensure the alleged defficient practice does not reoccur : Maintenance Supervisor report of monitoring will be forwarded to the Administrator for monthly QA review, response and compliance.</p>	06/03/2011	

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K0046 SS=C	<p>lacked a self closing device. This was confirmed by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency light fixtures of at least 1½ hour duration was tested monthly in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K0046	<p>Plan will be adjusted accordingly</p> <p>Correctons completed : June 3, 2011</p> <p>Correctve Actons : No residents were affected by this practice. A new maintenance supervisor has been hired. The weekly generator check is now being completed as scheduled.</p> <p>Identffcaton off and correctve actons taken ffor other residents having the potential to be affected by the alleged practice : No residents were identified as having the potential to be affected. The weekly generator inspection is currently being completed and documented as scheduled.</p> <p>Measures taken to and systematic changes made to ensure the alleged defficient practice does not reoccur: The weekly generator inspection will be documented in the TELS system by the Maintenance Supervisor. The Administrator will audit the completion of this documentation weekly for four weeks, and then quarterly for months.</p> <p>How the correctve actons will be monitored and the QA system implemented to ensure the alleged</p>	06/03/2011	

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K0056 SS=E	<p>Based on an observation with the Administrator, Maintenance Supervisor and Housekeeping/Laundry Supervisor on 05/04/11 at 12:40 p.m., a battery operated emergency task light was observed at the emergency generator. Based on record review with the Maintenance Supervisor at 1:40 p.m., a monthly check was not conducted for the months of June and August, 2010. This was acknowledged by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b)</p> <p>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>1. Based on observation and</p>	K0056	<p>defficient practce does not reoccur : Mainttenance Supervisor reportt oft monittoring will be ftorwarded tto tthe Administrattorr ffor monthly QA review, response and compliance. Plan will be adjustted accordingly Correctons completed : June 3, 2011.</p> <p>1. This practtce has tthe pottenttal tto aftectt any residentt in tthe smoking</p>	06/03/2011			

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	<p>interview, the facility failed to ensure 2 of 3 sprinklers in the Medical Records office were separated by at least six feet as required by NFPA 13. NFPA 13, Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect any resident in the smoking room and the Center hall north in the event of an emergency.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator, Maintenance Supervisor and the Housekeeping/Laundry Supervisor on 05/04/11 at 11:26 a.m., in the Medical Records office the sprinkler head above the desk and the sprinkler head near the ceiling fan were located five feet apart. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler heads</p>		<p>room and the Center hall north in the event of an emergency. The sprinkler head that was unnecessary has been moved. This facility does not have a smoking room.</p> <p>2. This practice has the potential to affect any number of residents at the Oak Lane nurses' station in the event of an emergency 1 of 2 sprinkler heads has been moved.</p> <p>Identification of and corrective actions taken for other residents having the potential to be affected by the alleged practice : No other residents were identified as having the potential to be affected. All sprinkler heads have been inspected for proper spacing with no additional concerns noted.</p> <p>Measures taken to and systematic changes made to ensure the alleged deficient practice does not reoccur : The inspection of sprinkler heads has been added to the monthly preventative maintenance schedule. No other sprinkler heads will be installed within 6 feet of another. Any remodeling will be monitored for compliance in the area of the spacing of the sprinkler heads.</p> <p>How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not reoccur : Maintenance Supervisor report of monitoring will be forwarded to the Administrator for monthly QA review, response and compliance. Plan will be adjusted accordingly.</p>		

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	<p>installed at the Oak Lane nurses' station was at least four inches from the wall. NFPA 13, 5-6.3.3 requires upright and pendant sprinkler heads shall be installed at least four inches from the wall. This deficient practice could affect any number of residents at the Oak Lane nurses' station in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observation with the Administrator, Maintenance Supervisor and the Housekeeping/Laundry Supervisor on 05/04/11 at 12:53 p.m., one of two sprinkler head at the Oak Lane nurses' station was mounted one inch from the wall. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>Correctons completed : June 3, 2011</p>		

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K0062 SS=F	<p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained in proper working order. Once obstructive material is observed during an investigation as described in NFPA 25, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems at 10-2.1., NFPA 25, 10-2.3 requires a complete flushing program shall be conducted. The work shall be done by qualified personnel. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Administrator and the Maintenance Supervisor on 05/04/11 at 2:14 p.m., the "Report of Inspection and Testing of Fire Protection Systems - Report of Internal Condition of Sprinkler Piping" from VFP Fire Systems dated 07/23/10 stated</p>	K0062	<p>Corrective Actions :</p> <p>1. TLC's qualified personnel have been contacted to perform a full dry pipe sprinkler system flush at Rolling Meadows.</p> <p>2. 4 of 7 sprinkler heads have been replaced. 1 of 1 sprinkler head has been cleaned.</p> <p>Identfication of and corrective actions taken for other residents having the potential to be affected by the alleged practice :</p> <p>1. All occupants of the facility have the potential to be affected TLC's Vice President of Construction and Sprinkler Division and qualified personnel have been contacted to provide this service They will perform a flush of the dry pipe sprinkler system</p> <p>2. No resident were identified to be affected by the sprinkler heads due to the fact that the sprinkler heads were in the kitchen and residents do not have access to the kitchen</p> <p>Measures taken to and systematic changes made to ensure the alleged deficient practice does not reoccur :</p> <p>1. Due to the existing schedule of qualified personnel they are unable to perform the dry pipe sprinkler system flush at this time. A time has been scheduled to perform the system flush in the summer of</p>	06/03/2011			

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	<p>"Cross main in front area had a build up of scale and cross main east of riser wing 300 wing." Based on an interview with the Maintenance Supervisor at the time of record review, this problem has not been addressed.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 4 of 7 sprinklers in the kitchen which had been painted and 1 of 1 sprinklers which was soiled. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice was not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p>		<p>2011. A waiver has been requested and the appropriate paperwork has been sent to the Indiana State Department of Health</p> <p>2. All sprinkler heads have been inspected for paint and dust. The maintenance director and assistant have been re-inserviced on keeping paint and dust off of sprinkler heads as well as the appropriate timeline for ensuring an inspection and testing of the fire protection system. The maintenance supervisor/assistant will visually inspect all sprinkler heads in the facility on a quarterly basis for the presence of paint and/or soil.</p> <p>How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not reoccur:</p> <p>1. The dry pipe sprinkler system will be maintained continuously in a reliable operating condition. Inspection and testing will occur periodically. If an obstruction investigation identifies the presence of sufficient material in the pipes to obstruct sprinklers, TLC's qualified personnel will be contacted to flush the system. Maintenance Supervisor report of monitoring will be forwarded to the Administrator for monthly QA review response and compliance. Plan will be adjusted accordingly.</p> <p>2. Documentation of the results of the periodic inspections and testing of sprinklers will be taken to</p>				

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	<p>Based on observation with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor on 05/04/11 at 12:18 p.m., one of one sprinkler head in the walk in cooler was soiled and dusty. Two of two sprinkler heads in the dish room were coated with paint overspray and one of four sprinkler heads in the serving area of the kitchen had a large amount of paint on the sprinkler head frame. This was acknowledged by the Maintenance Supervisor at the time of the observation.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to provide a sprinkler wrench for 1 of 1 sprinkler systems. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires a sprinkler wrench shall be available for each type of sprinkler. This deficient practice could affect all</p>		<p>tthe QA committee tto ensure tmely correcton has been completed Mainttenance Supervisor reportt oft monittoring will be ftorwarded tto tthe Administratrator ffor monthly QA review, response and compliance. Plan will be adjustted accordingly</p> <p>Correctons completed : June 3, 2011 (See attached waiver requestt)</p>		

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K0064 SS=B	<p>occupants.</p> <p>Findings include:</p> <p>Based on observation of the spare sprinklers with the Maintenance Supervisor on 05/04/11 at 12:26 p.m., a sprinkler wrench was not available. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <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>Based on observation and interview, the facility failed to inspect 4 of 4 fire extinguishers in the kitchen, Oak Lane and Birch Lane each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines</p>	K0064	<p>Corrective Actons : This practtce could affect any residentt near tthe Birch lane and tthe Oak Lane nurses' statton and any oft tthe residents on Oak Lane in tthe eventt of an emergency. All portable fre exttnguishers have been properly serviced and appropriately ttagged</p> <p>Identffcaton off and correctve actons taken ffor other residents having the potential to be affected by the alleged practice : No other residentts were identtfted as having tthe pottential tto be affecttall portable fre exttnguishers have been auditted ffor proper service and</p>	06/03/2011	

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	<p>inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect any number of kitchen staff as well as any resident near the Birch Lane and the Oak Lane nurses' station and any of the 19 residents on Oak Lane in the event of an emergency.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor on 05/04/11 from 12:14 p.m. to 12:59 p.m., the monthly inspection tag on the following fire extinguishers lacked documentation of a monthly inspection for the month of January 2011:</p> <p>a) the K-class fire extinguisher in the kitchen</p>		<p>appropriate tagging</p> <p>Measures taken to and systematic changes made to ensure the alleged deficient practice does not reoccur :</p> <p>Maintenance Supervisor and Maintenance Assistant serviced regarding documentation of monthly fire extinguisher checks. All portable fire extinguishers have been audited and documented on our TELS system</p> <p>How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not reoccur :</p> <p>Maintenance Supervisor report of monitoring will be forwarded to the Administrator for monthly QA review, response and compliance. Plan will be adjusted accordingly</p> <p>Correctons completed : June 3, 2011</p>				

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K0070 SS=D	<p>b) Birch Lane nurses' station c) Oak Lane nurses' station d) Oak Lane corridor This was acknowledged by the Maintenance Supervisor at the time of observations.</p> <p>3.1 – 19(b)</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation and record review, the facility failed to provide a complete policy for the use of 1 of 1 portable space heaters in the facility in accordance with NFPA 101, Section 19.7.8. This deficient practice is not in a resident care area but could affect any number of staff.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor and the Housekeeping/Laundry Supervisor on 05/04/11 at 12:07 p.m., a portable space heater was plugged in but not in use in the employee break room. Based on record review with the Maintenance Supervisor at the time of</p>	K0070	<p>Corrective Actions: No residents have the potential to be affected due to not having access to the employee break room. Portable space heating policy and procedure has been revised in accordance with Life Safety Code NFPA 101. A policy and procedure was in place at the time of survey to ensure no space heaters were in resident sleeping areas. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged practice: A facility wide audit was conducted to ensure portable space heating devices are in appropriate areas. No other devices were noted. Measures taken to and systematic changes made to ensure the alleged deficient</p>	06/03/2011	

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K0076 SS=E	<p>observation, the policy did not address portable space heating devices shall not exceed two hundred twelve degrees Farenheit.</p> <p>3.1-19(b)</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 oxygen "B" cylinders</p>	K0076	<p>practice does not reoccur: The policy and procedure on portable space heaters has been revised in accordance with NFPA 101, Section 19.7.8. Existing policy and procedure has been reviewed and updated to include checking for integrity of space heating cords and that the temperature does not exceed 212 degrees Fahrenheit . Portable space heaters will be monitored on our TELS system monthly to ensure they are not in resident sleeping areas. How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not reoccur: Maintenance Supervisor report of monitoring will be forwarded to the Administrator for monthly QA review, response and compliance. Plan will be adjusted accordinglyCorrections completed: June 3, 2011</p> <p>Correctve Actons : Any of tthd8 residentts on Willow Lane had tthe pottential tto be affected by tthis</p>	06/03/2011	

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K0144 SS=C	<p>were properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b) 27 which requires freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice could affect any of the 18 resident on Willow Lane.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator, Maintenance Supervisor and the Housekeeping/Laundry Supervisor on 05/04/11 at 11:40 a.m., there were two unsupported small cylinders of compressed oxygen in the oxygen storage room. According to a tag on the cylinder these were "B" cylinders. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p>		<p>practtce. 2 of 2oxygen cylinders have been appropriately restrained</p> <p>Identffcaton off and correctve actons taken ffor other residents having the potential to be affected by the alleged practce : No other residents were identtfted as having tthe pottential tto be affectttd</p> <p>medical gas sttorage areas have been inspectted tto ensure medical gas and/or gases are appropriattely restrained</p> <p>Measures taken to and systematc changes made to ensure the alleged defficient practce does not reoccur: Inspectton oft tthe Oxygen rooms will be monittored for unrestrained gases and recorded on our TELS system weekly</p> <p>How the correctve actons will be monittored and the QA system implemented to ensure the alleged defficient practce does not reoccur : Mainttenance Supervisor reportt oft monittoring will be fforwarded tto tthe Administrattor ffor monthly QA review, response and compliance. Plan will be adjustted accordngly</p> <p>Correctons completed : June 3, 2011</p>		

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	1. Based on record review and interview, the facility failed to ensure the load testing for the past 3 of 12 months indicated a load test was conducted under operating conditions or not less than 30 percent of the nameplate rating for the diesel powered emergency generator set. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.	K0144	Corrective Actions : All residents have the potential to be affected by the practices. The weekly generator inspection is currently being completed as scheduled. Identificaton off and corrective actions taken ffor other residents having the potential to be affected by the alleged practice : No other residents were identified as having the potential to be affected. A load bank test will be completed by Safetecare. Measures taken to and systematic changes made to ensure the alleged defficient practice does not reoccur : A load bank test will be completed. Then after, the maintenance director and corporate electrician will add circuits to ensure the generator is operating at 30 percent. The generator will be tested under load, and monitored on our TELS system weekly. The Administrator will audit the completion of this documentatton weekly for four weeks, every other week for four weeks, then monthly thereafter. How the corrective actions will be monitored and the QA system implemented to ensure the alleged defficient practice does not reoccur : Maintenance Supervisor report of monitoring will be forwarded to the Administrator for monthly QA review, response and compliance. Plan will be adjusted accordingly. Correctcons completed : June 3, 2011	06/03/2011	

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	<p>Findings include:</p> <p>Based on review of the generator log titled "Weekly Emergency Generator Record" with the Maintenance Supervisor on 05/04/11 at 1:40 p.m., the generator log showed a monthly load test for the past twelve months for a thirty minute duration but did not indicate if the generator set ran under operating conditions or a thirty percent nameplate rating load test for the months of July and November 2010 and March 2011. Based on an interview with the Maintenance Supervisor, no other documentation was available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity</p>				

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	<p>to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice affects all occupants</p> <p>Findings include:</p> <p>Based on review of the generator log titled "Weekly Emergency Generator Record" with the Maintenance Supervisor on 05/04/11 at 1:44 p.m., the generator log showed a monthly load test for the past twelve months for a thirty minute duration but the monthly load test record did not include the time for the transfer of power from the main source to the generator for the months July and November of 2010 and the month of March 2011. Based on an interview with the Maintenance Supervisor, no other documentation was available for review.</p> <p>3.1-19(b)</p>				