

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/17/2014
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NAME OF PROVIDER OR SUPPLIER HANOVER NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE RD HANOVER, IN 47243
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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: 02/17/14</p> <p>Facility Number: 000115 Provider Number: 155208 AIM Number: 100291080</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hanover Nursing 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 V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors, and battery operated smoke</p>	K010000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to the low scope and severity of this survey findings, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, please feel free to contact me.</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>detectors in all resident sleeping rooms. The facility has a capacity of 125 and had a census of 65 at the time of this visit.</p> <p>All areas where residents have customary access were sprinkled. All areas providing facility services were sprinkled except a detached wooden storage garage and a detached wooden building housing the emergency generator.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/25/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K010017 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of 9 open use area were separated from the corridor, or met an Exception. LSC 19.3.6.1, Exception # 1, Spaces shall be permitted to be unlimited in area and open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick response sprinklers. (c) The open space is protected by an electrically</p>	K010017	<p>K17: Requires the facility to separate corridors from open use areas¹. The service hall employee lounge and service hall soda machine room doors with automatic closers have been replaced and rooms are now separated from the corridor.² All residents have the potential to be affected, thus, the following corrective actions have been taken: All doors that are opened to a corridor have been inspected and found to be in good working order. 3. As a means to ensure ongoing compliance, the Maintenance Director or designee will review corridors to ensure separation on a weekly basis as part of the preventative maintenance program compliance (See attachment A). All construction in the facility will be monitored by the Maintenance</p>	03/07/2014
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	<p>supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice affects 47 residents who use the main dining room, which is located adjacent to the Service Hall.</p> <p>Findings include:</p> <p>Based on observations on 02/17/14 during a tour of the Service Hall from 10:20 a.m. to 11:30 a.m. with the maintenance supervisor, the Service Hall employee lounge and the Service Hall soda machine room were open to the corridor. Furthermore, Exception # 1, requirement (c) of the Life Safety Code, Chapter 19.3.6.1 was not met as follows: the open Service Hall employee lounge and Service Hall soda machine room were not protected by an automatic smoke detection system or arranged to allow direct supervision by facility staff from a continuously staffed area such as a nurses' station. This was verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 02/17/14 at 2:20 p.m..</p>		<p>director or designee to ensure all corridors are appropriately secured. 4. The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5. Completion Date: March 7, 2014.</p>				

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K010025 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 47 residents who use the main dining room, located adjacent to the Service Hall, and 14 residents who reside on Wing 2.</p> <p>Findings include:</p> <p>Based on observations with the maintenance supervisor on 02/17/14 during a tour of the facility from 9:48 a.m. to 2:15 p.m., the following ceiling and wall smoke barriers had missing drywall or were not fire stopped;</p> <p>a. The Service Hall maintenance office</p>	K010025	<p>K25: The facility will ensure that all smoke barrier and wall penetrations will be secured with the appropriate fire retardant material to ensure at least a one half hour fire resistance rating.</p> <p>1. All ceiling and wall smoke barriers were repaired with appropriate fire retardant material to ensure at least a one half hour fire resistance rating. 2. All staff on service hall and staff and residents on wing 2 had the potential to be affected. The building has been inspected by maintenance personnel to identify other areas of concern pertaining to ceiling and wall smoke barrier. No other areas of concern have been identified. 3. The maintenance director was educated on the necessity of all smoke barrier and wall penetrations being secured with appropriate fire retardant material. (See Attachment</p>	03/07/2014			

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	<p>ceiling had a one inch gap around a computer cable penetration which was not fire stopped.</p> <p>b. The Service Hall supply room ceiling had seven, one quarter inch drywall seams with newly installed drywall which were not taped and covered with drywall compound.</p> <p>c. The Wing 2 corridor ceiling by the west set of smoke barrier doors had fourteen, one quarter inch drywall seams with newly installed drywall which were not taped and covered with drywall compound.</p> <p>d. The Wing 2 old minimum data set office ceiling had four, one quarter inch drywall seams with newly installed drywall which were not taped and covered with drywall compound.</p> <p>e. The Wing 2 west boiler room ceiling had a two inch gap around a water pipe penetration which was not fire stopped.</p> <p>f. The Wing 2 storage room ceiling had four, one quarter inch drywall seams with newly installed drywall which were not taped and covered with drywall compound.</p> <p>g. The Wing 2 restorative dining room ceiling had four, one quarter inch drywall seams with newly installed drywall which were not taped and covered with drywall compound.</p> <p>The Service Hall maintenance office ceiling, the Service Hall supply room</p>		<p>C).4. All wall and ceiling smoke barriers will be reviewed on a quarterly basis as part of the preventative maintenance program to ensure continued compliance. All construction in the facility will be monitored by the Maintenance director or designee to ensure all penetrations are appropriately secured. The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5. Completion date: March 7, 2014</p>				

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K010029 SS=E	<p>ceiling, the Wing 2 corridor ceiling, the Wing 2 old minimum data set office ceiling, the Wing 2 west boiler room ceiling, Wing 2 storage room ceiling, and Wing 2 restorative dining room ceiling drywall gaps and unfinished drywall seams were verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 02/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</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 Based on observations and interview, the facility failed to ensure 5 of 6 Service Hall corridor doors to combustible storage rooms over 50 square feet in size, a fuel fired equipment room, and a laundry room over 100 square feet in size were provided with self closing devices which</p>	K010029	K29: The regulation states that one hour fire rated construction or an approved automatic fire extinguishing system protects hazardous areas. The facility will ensure this requirement is met through the following corrective measures. 1. New self-closing devices were installed on 5 of 6 hazardous area room	03/07/2014
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	<p>would cause the doors to automatically close and latch into the door frames. This deficient practice could affect 47 residents who use the main dining room, located adjacent to the Service Hall.</p> <p>Findings include:</p> <p>Based on observations on 02/17/14 during a tour of the Service Hall with the maintenance supervisor from 10:20 a.m. to 11:30 a.m., self closing devices were not provided on the two doors leading into the Service Hall supply room which measured one hundred ninety square feet and had storage consisting of sixteen shelves of combustible toilet paper, plastic adult briefs, and thirty six cardboard boxes, and the Service Hall boiler room, which housed three natural gas boilers. Furthermore, the north door to the Service Hall laundry room, a two hundred and thirty square foot room, and the door to the Service Hall activity storage room which measured one hundred and twenty square feet and stored twelve shelves of combustible cardboard boxes and paper decorations failed to self close and latch into the door frames, leaving a two inch gap along the latching sides of the doors in the closed position. This was verified by the maintenance supervisor at the</p>		<p>doors (See Attachment D). The areas of concern do not occupy residents and no one was harmed. 2. All staff that use the service hall have the potential to be affected. An audit of all self closing doors has been completed and no other areas identified as a concern. (See Attachment B).3. As a means to ensure compliance, the Maintenance Director or designee will review self closing doors as a part of the preventative maintenance program (See Attachment A). 4. The Maintenance Director or designee will monitor all hazardous area doors self-closing devices through quarterly preventative maintenance to ensure they are in proper working order. The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5. Completion Date: March 7, 2014.</p>		

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K010038 SS=E	<p>time of observations and acknowledged by the administrator at the exit conference on 02/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 10 exit door electromagnetic locks unlocked and remained unlocked while the fire alarm was activated and silenced. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6.2 requires, where permitted in Chapters 11 through 42, doors in the means of egress shall be permitted to be equipped with an approved entrance and egress access control system, provided that the following criteria are met. (d) Activation of the building fire-protective signaling system, if provided, shall automatically unlock the doors in the direction of egress, and the doors shall remain unlocked until the fire-protective signaling system has been manually reset. This deficient practice affects 20 residents who reside on Wing 4.</p>	K010038	<p>K38: The regulation states exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.11. A service call was made to safe care; the door was fixed and is functioning properly (see attachment (See Attachment E). No residents on wing 4 were harmed. 2. All occupants on Wing 4 were at risk. 3.As a means to ensure compliance, the Maintenance Director or designee will monitor doors alarms on a monthly basis during the fire drills to ensure proper functioning (See Attachment L).4. As a means of quality assurance, the Maintenance Director or designee will monitor for compliance through quarterly preventative maintenance to ensure they are in proper working order. Should concerns be observed, corrective action shall be taken. The monitoring and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted</p>	03/07/2014

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K010046 SS=F	<p>Findings include:</p> <p>Based on observation during a test of the fire alarm system on 02/17/14 with the maintenance supervisor at 2:00 p.m., the electromagnetic lock on the Wing 4 exit door failed to release and unlock when the fire alarm was activated, and stayed locked when the fire alarm was silenced but not reset. This was verified by the maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 02/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 battery backup lights was tested monthly and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test</p>	K010046	<p>accordingly if warranted. 5. Completion Date: March 7, 2014</p> <p>K46: The regulations states that emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9 19.2.9. 1. No residents were harmed related to this deficient practice. 2. As all residents have the potential to be affected, the following corrective actions have been taken. The lights have been checked for proper functioning3. A log was created for the battery backup light monthly and yearly test (See Attachment F). The maintenance director was educated on the</p>	03/07/2014			

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	<p>shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility during a power outage.</p> <p>Findings include:</p> <p>Based on record review and interview on 02/17/14 at 9:50 a.m. with the maintenance supervisor, the Emergency Lighting Log was reviewed and indicated an annual ninety minute test and monthly tests were conducted for the year 2012 on the emergency battery backup light in the detached building which houses the emergency generator. Furthermore, the maintenance supervisor indicated there is no Emergency Lighting Log for the year 2013 through January of 2014. The lack of an Emergency Lighting Log for the monthly tests and annual 90 minute test for the year 2013 through January 2014 was verified by the maintenance supervisor at the 02/17/14 record review and interview, and acknowledged by the administrator at the exit conference on</p>		<p>necessity of emergency lighting and the need of monthly/yearly testing. (See Attachment C).4. The Maintenance Director or designee will monitor the lights proper functioning during weekly generator inspections (See Attachment G). As a means of quality assurance, all findings will be included in the facility's quarterly Assurance meetings and the plan of action adjusted accordingly. 5. Completion Date: March 7, 2014.</p>				

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K010062 SS=E	<p>02/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 4 of over 300 sprinklers were maintained. 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 could affect 14 residents who reside on Wing 2 and use the Wing 2 dining room.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility on 02/17/14 from 9:48 a.m. to 2:15 p.m. with the maintenance supervisor, the sprinkler above the desk in the director of nursing office and</p>	K010062	<p>K62: This regulation requires automatic sprinkler systems are continuously maintained in reliable operating conditions and are inspected and tested periodically. 1. The sprinkler head above the DON's desk, wing 2 dining room were cleaned and all paint has been removed. The laundry room sprinkler and service hall electric room sprinkler escutcheons have been secured to the ceiling. 2. All residents, staff and visitors on Wing 2 had the potential to be affected. A walk thru of the building has been completed to identify any other sprinklers with paint on them. No other concerns identified. 3. As a means to ensure ongoing compliance to ensure sprinkler heads are clean and free of paint, the Maintenance Director or designee will do a weekly walk through assessing the sprinkler heads for foreign materials such as paint or corrosion. (See Attachment A). 4. As a means of quality assurance, the</p>	03/07/2014			

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K010130 SS=F	<p>Wing 2 dining room sprinkler by the north wall were completely covered in white paint. Furthermore, the laundry room sprinkler above the dryers and the Service Hall electric room sprinkler both had escutcheons which were not tight fitting to the ceiling with one inch gaps. The director of nursing office sprinkler and Wing 2 sprinkler covered in white paint and the laundry room sprinkler and Service Hall sprinkler escutcheons not being tight fitting to the ceiling were verified by the maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 02/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 55 of 55 health care resident rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice affects all residents in the health care portion of the facility.</p>	K010130	<p>aforementioned audits/monitoring and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5. Completion Date: March 7, 2014.</p> <p>K130: Requires the facility to implement and maintain a preventive maintenance program for battery operated smoke detectors. 1. All 55 rooms' battery operated smoke detectors have a 10 Year Sealed Battery Alarm and are in good working order. (See Attachment H).2. All residents were at risk to be affected by the deficient practice. All rooms have been inspected and no concerns noted. (See</p>	03/07/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155208		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/17/2014	
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K010144 SS=F	<p>Findings include:</p> <p>Based on an interview on 02/17/14 at 10:10 a.m. with the maintenance supervisor, the facility has fifty five resident rooms with battery operated smoke detectors located in each of the resident room. Furthermore, there was no preventive maintenance program to document monthly testing and annual battery replacement for each battery operated smoke detector. The lack of a written maintenance program to provide monthly testing and annual battery replacement for the fifty five resident room battery operated smoke detectors was verified by the maintenance supervisor at the time of interview and acknowledged by the administrator at the exit conference on 02/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p> <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, the facility failed to document monthly load tests for 12 of the past 12 months to meet the requirements of NFPA 110, the</p>	K010144	<p>Attachment I).3. A preventative maintenance program has been put into place to document monthly testing. (See Attachment J).4. As a means of quality assurance, the Maintenance Director will provide a copy of attachment J to the administrator monthly for 3 months. The results of the audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly if warranted. 5. Completion Date: March 7, 2014</p> <p>K144: The regulation states that generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.1. Safe Care was</p>	03/07/2014			

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	<p>Standard for Emergency and Standby Powers Systems, chapter 6-4.2. 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. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Weekly Generator Weekly Inspection Checklist and Monthly Load Test Checklist with the maintenance supervisor on 02/17/14 at 10:15 a.m., the load tests were documented over the past year on a monthly basis by recording fifty seven amps as the result of the load test.</p> <p>Based on an interview with the</p>		<p>contacted and scheduled to complete a four hour load test and educate the Maintenance director on converting amps to percentage. Scheduled visit is March 7, 2014. (See Attachment K). No residents were harmed related to the deficient practice.</p> <p>2. All facility occupants are at risk.3. As a means to ensure ongoing compliance to ensure compliance, the Maintenance Director or designee will do a weekly inspection on the generator. (See Attachment G).4. As a means to ensure quality assurance, the Maintenance director or designee will monitor the system through quarterly preventative maintenance program. Should non-compliance be observed, corrective action shall be taken, the observations and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly if warranted. 5. Completion Date: March 7, 2014.</p>				

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	<p>maintenance supervisor on 02/17/14 at 10:20 a.m., when asked how the fifty seven amps is calculated to indicate a thirty percent load test was conducted monthly, the maintenance supervisor indicated he did not know how the fifty seven amp number equated to a thirty percent load. The lack of a documented load test monthly by either documenting a calculated method of the listed thirty percent of the emergency power system's name plate rating or the load being maintained at exhaust gas temperatures was verified by the maintenance supervisor at the time of interview and acknowledged by the administrator at the exit conference on 02/17/14 at 2:20 p.m.</p> <p>3.1-19(b)</p>			