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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155754 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 02<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/01/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>HUBBARD HILL ESTATES INC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>28070 CR 24<br>ELKHART, IN 46517 |
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| K020000 | <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: 04/01/14</p> <p>Facility Number: 001131<br/>Provider Number: 155754<br/>AIM Number: 200823940</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hubbard Hill Estates, Inc. 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 located on the main level of a two story facility was determined to be of Type V (111) construction and was fully sprinklered except for the lower level elevator machine room. The facility has a fire alarm system with smoke detection in the corridor and in all areas</p> | K020000 | <p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by State and Federal law. Hubbard Hill Estates desires this Plan of Correction to be considered as the facility's Allegation of Compliance. Compliance is effective on May 1, 2014 except for K-Tag 56 and 160 which I'm filing an attached temporary waiver with justification.</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>open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 66 and had a census of 61 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the garage which was used for a maintenance shop and the lower level elevator machine room.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/08/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> |  |  |  |
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| K020029<br>SS=E  | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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 1 of 9 doors serving hazardous areas such as storage rooms greater than fifty square feet in size used to store combustible materials were provided with self closing devices to close and latch the door into the door frame. This deficient practice could affect 12 residents, staff and visitors in the vicinity of the medical supplies storage room by the warming kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Director of Building Services during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 04/01/14, the medical supplies storage room by the warming kitchen was utilized to store combustible boxes and diapers, measured 150 square feet in size, and the corridor access door was not</p> | K020029   | <p><b><u>K029</u></b><br/><b><u>What corrective action will be done by the facility?</u></b><br/>A new self-closing door device was ordered and the device was installed on April 17, 2014. The device will close and latch the door. A sign was posted on April 17, 2014 that states that the door must be kept closed at all times.<br/><b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b><br/>This deficient practice could affect 18 residents, staff and visitors in the vicinity of the medical supplies storage room by the warming kitchen.<br/><b><u>What measures will be put into place to ensure this practice does not recur?</u></b><br/>1. Staff will be in-serviced on April 21, 22, and 23 regarding the</p> | 04/17/2014  |  |   |  |

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|                    | <p>equipped with a self closing device to close and latch the door into the door frame. Based on interview at the time of observation, the Director of Building Services acknowledged the aforementioned hazardous areas access door was not equipped with a self closing device to close and latch the door into the door frame.</p> <p>3.1-19(b)</p> |               | <p>NFPA standard that doors serving hazardous areas such as storage rooms are provided with self-closing devices and must remain closed at all times.</p> <p>2.The nursing managers, housekeepers, administrator, and maintenance staff will monitor/audit compliance that the door is closed during walking rounds.</p> <p>3.An audit report will be completed if the door has been left open and submitted to the Dir. Of Nursing and or Administrator. Corrective action/discipline will be initiated if indicated.</p> <p><b><u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b></p> <p>Results of these audits of compliance will be reviewed at the Safety Committee monthly and reported to the Quality Assurance Performance Improvement committee quarterly X2. At that time the committee will review for continued need for auditing.</p> |                      |

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| K020038<br>SS=E | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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 the means of egress through 2 of 10 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 states door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect 18 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Director of Building Services during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 04/01/14, the exit by Room 2111 and the exit by Room 2117 were each marked as a facility exit. Each exit door was magnetically locked and could be opened by entering a four digit code, but the code</p> | K020038 | <p><b><u>K 038</u></b></p> <p><b><u>What corrective action will be done by the facility?</u></b></p> <p>A sign was posted at the exit doors by Room 2111 and 2117 on April 18, 2014 that identifies the numerical code to be used to exit. The posting will be added to the daily buildcheck list.</p> <p><b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b></p> <p>This deficient practice could affect all residents in the rehab area of health care and all staff and visitors.</p> <p><b><u>What measures will be put into place to ensure this practice does not recur?</u></b></p> <p>1. Staff will be in-serviced on April 21, 22, and 23 regarding the NFPA standard that exits are readily accessible at all times, and the need to have the code posted.</p> <p>2. Thenursing managers, housekeepers, administrator, and maintenance staff will monitor daily to ensure that the doors are properly posted.</p> <p><b><u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></b></p> <p>Results of these audits of compliance</p> | 04/18/2014 |
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|  | <p>was not posted. Based on interview at the time of the observations, the Director of Building Services stated not all residents have a clinical diagnosis to be in a secure building and acknowledged the four digit code was not posted at each of the aforementioned facility exits. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the code.</p> <p>3.1-19(b)</p> |   | <p>will be reviewed at the Safety Committee monthly and reported to the Quality Assurance Performance Improvement committee quarterly X2. At that time the committee will review for continued need for auditing.</p> |   |  |   |  |

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| K020050<br>SS=C  | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>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 document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m. on the first shift for 1 of 4 quarters. LSC 19.7.1.2 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Alarm Response Report" with the Director of Building Services during record review from 10:10 a.m. to 12:45 a.m. on</p> | K020050   | <p><b><u>K050</u></b><br/><b><u>What corrective action will be done by the facility?</u></b><br/>The current "Fire Alarm Response" form was modified and a signature of the Director of Building Services or designee was also added to ensure completion of the fire alarm process and documentation.<br/><b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b><br/>This deficient practice could affect all residents, visitors and staff.<br/><b><u>What measures will be put into place to ensure this practice does not recur?</u></b><br/>1. Staff will be in-serviced on April 21, 22, and 23 regarding the NFPA standard that the transmission of the fire alarm signal be verified and that the "Fire Alarm Response Report" be completed and signed by the person in charge at the time of the drill.</p> | 04/23/2014  |  |   |  |

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|  | <p>04/01/14, documentation for the first shift fire drill conducted on 05/09/13 at 8:30 a.m. did not include the transmission of the fire alarm signal. The aforementioned first shift fire drill report was left blank in the space as the response to, "10 minutes after fire alarm sounded-called to verify said alarm was received." Based on interview at the time of record review, the Director of Building Services acknowledged documentation for the aforementioned first shift fire drill conducted after 6:00 a.m. and before 9:00 p.m. did not include transmission of the fire alarm signal.</p> <p>3.1-19(b)</p> |   | <p>2.The Director of Building Services ordesignee will review the "Fire Alarm Response Report" to ensure compliance withnotification and and sign to ensure that the form is correctly documented.</p> <p><b><u>How will corrective action bemonitored to ensure the deficient practice does not recur and what QA will beput into place?</u></b></p> <p>"The FireAlarm Response Report" will be reviewed at the Safety Committee monthly andreported to the Quality Assurance Performance Improvement committee quarterly X2. At that time the committee will review for continued need for auditing.</p> |                      |   |

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| K020056<br>SS=D | <p><b>NFPA 101</b><br/><b>LIFE SAFETY CODE STANDARD</b><br/>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 elevator machine rooms. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be of ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect two residents, staff and visitors.</p> <p>Findings include:<br/><br/>Based on observation with the Director of</p> | K020056 | <p><b>K056</b><br/><b><u>What corrective action will be done by the facility?</u></b><br/>The facility contacted Otis Elevator and a fire suppression company on April 15, 2014 to discuss installation of the required equipment to comply with the standard that the elevator machine room is to be sprinkled or protected chemically.<br/><b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b><br/>This deficient practice could affect all residents, visitors and staff.<br/><b><u>What measures will be put into place to ensure this practice does not recur?</u></b><br/>1. The maintenance staff was in-serviced on April 21, 22, 23 and the NFPA standard related to the mandatory fire</p> | 07/31/2014 |
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|  | <p>Building Services during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 04/01/14, the elevator machine room on the lower level was not provided with automatic sprinklers. Based on interview at the time of observation, the Director of Building Services acknowledged comprehensive care residents have customary access to the elevator and acknowledged the aforementioned elevator machine room was not provided with automatic sprinklers.</p> <p>3.1-19(b)<br/>3.1-19(ff)</p> |   | <p>suppressionrequirement in the elevator machine room.<br/><b><u>How will corrective action bemonitored to ensure the deficient practice does not recur and what QA will beput into place</u></b><br/>Compliancewill be reported to the Quality Assurance Performance Improvement Committee.<br/><b><i>Please find an attachedTemporary Waiver Justification to give adequate time for this project to becompleted.</i></b></p> |                      |   |

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| K020144<br>SS=F | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on record review, observation and interview; the facility failed to ensure a monthly load test for the emergency generator was conducted for 12 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators 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,</p> | K020144 | <p><b><u>K144</u></b><br/><b><u>What corrective action will be done by the facility?</u></b><br/>The Facility has updated both the annual and monthly generator testing to comply with NFPA standard that generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, to include minimum exhaust gas temperature, operating temperature conditions recommended by the manufacturer or under load at not less than 30 percent of EPS nameplate rating. The annual test will also comply with the two hour load test standard.<br/>A monthly testing form has been developed to document the testing of the generator to ensure that the emergency power will transfer within 10 seconds.</p> <p><b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b><br/>All residents, staff and visitors can be affected.</p> <p><b><u>What measures will be put into place to ensure this practice does not recur?</u></b></p> | 04/30/2014 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION             |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155754 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 02<br>B. WING _____              |  | X3) DATE SURVEY COMPLETED<br><br>04/01/2014 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>HUBBARD HILL ESTATES INC |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>28070 CR 24<br>ELKHART, IN 46517 |  |   |  |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5) COMPLETION DATE  |  |   |  |
|  | <p>based on facility operations. 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. Chapter 6-4.2.2 states diesel powered EPS installations that do not meet the requirement of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes for a total of two continuous hours. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Generator-West Wing Weekly Test/Monthly Load/Annual 90 Minute Load" documentation with the Director of Building Services during record review from 10:10 a.m. to 12:45 p.m. on 04/01/14, documentation for monthly load tests performed during the twelve month period of 04/18/13 through 03/20/14 did not state minimum exhaust gas temperature, operating temperature conditions recommended by the manufacturer or under load at not less than 30 percent of the EPS nameplate</p> |   | <p>1. The Director of Building Services will review the documentation at the time of generator testing to ensure that the documentation includes the minimum exhaust gas temperature, operating temperature conditions recommended by the manufacturer or under load at not less than 30 per of EPS nameplate rating.</p> <p>2. The Director of Building Services will also review the documentation to ensure that the testing of the generator will transfer in 10 seconds.</p> <p><u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>The generator testing documentation will be reviewed at the Safety Committee monthly and reported to the Quality Assurance Performance Improvement committee quarterly</p> <p>2. At that time the committee will review for continued need for auditing</p> |   |  |   |  |

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|  | <p>rating. Documentation for the 04/25/13 load test stated a "90 Minute Annual Load Test" was performed. The most recent documented load test performed per NFPA 110, Chapter 6-4.2.2 available for review was conducted by Cummins Power Generation on 07/02/12. Based on interview at the time of record review, the Director of Building Services stated the 4/25/13 ninety minute annual load test was not conducted per NFPA 110 requirements and acknowledged monthly load test documentation for the most recent twelve month period did not state minimum exhaust gas temperature, operating temperature conditions recommended by the manufacturer or under load at not less than 30 percent of the EPS nameplate rating. Based on observation with the Director of Building Services during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 04/01/14, the fuel source for the 400 kW West Wing generator which services the facility is diesel.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 12 of 12 months. NFPA 99, 3-4.1.1.8 states</p> |   |   |   |  |   |  |

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|  | <p>generator set(s) shall have sufficient capacity 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. 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 by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Generator-West Wing Weekly Test/Monthly Load/Annual 90 Minute Load" documentation with the Director of Building Services during record review from 10:10 a.m. to 12:45 p.m. on 04/01/14, documentation for emergency power transfer time for the twelve month period of April 2013 through March 2014 was not available for review. Based on interview at the time of record review, the Director of Building Services stated additional generator transfer time documentation for emergency power transfer time was not available for review and acknowledged emergency power transfer time was not documented for the twelve month period of April 2013 through March 2014.</p> |  |  |  |
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| K020160<br>SS=D  | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>All existing elevators, having a travel distance of 25 ft. or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.3.2</p> <p>Based on observation and interview, the facility failed to ensure the elevator equipment in 1 of 1 elevator equipment rooms was provided with a shunt trip. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. This deficient practice could affect two residents, staff and visitors in the facility elevator if the sprinkler system was activated in the lower level elevator machine room.</p> <p>Findings include:</p> <p>Based on observation with the Director of Building Services during a tour of the facility from 1:30 p.m. to 4:15 p.m. on 04/01/14, the lower level elevator machine room was not provided with automatic sprinklers and no evidence of shunt trip installation was noted. Based</p> | K020160   | <p><b><u>K160 What corrective action will be done by the facility?</u></b><br/>Otis Elevator, the fire prevention company and an electrician will ensure that the proper shunt trip is also installed if a water sprinkling system is used. <b><u>How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></b><br/>All residents, staff and visitors can be affected. <b><u>What measures will be put into place to ensure this practice does not recur?</u></b><br/>Fire suppression and shunt trip will be evaluated at least annually and or per manufacturer's recommendations. <b><u>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place</u></b><br/>Compliance will be reported to the Quality Assurance Performance Improvement Committee <b><i>Please find an attached Temporary Waiver Justification to give adequate time for this project to be completed.</i></b></p> | 07/31/2014  |  |   |  |

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|  | <p>on interview at the time of observation, the Director of Building Services acknowledged comprehensive care residents have customary access to the elevator and acknowledged the aforementioned elevator machine room was not provided with a shunt trip.</p> <p>3.1-19(b)</p> |  |  |  |
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