STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(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
K0000	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). Survey Date: 01/30/13 Facility Number: 000149 Provider Number: 155245 AIM Number: 100266840 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Castleton 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. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping	K0000	Submission of this Plan of Correction shall not constitute or be construed as an admission by Castleton Health Care Center that the allegations contained in the survey report are accurate or reflect accurately the provisions of Nursing Care and services to the residents of Castleton Health Care Center.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	rooms. The facility has a capacity of 109 and had a census of 52 at the time of this visit. All areas where the residents have customary access were sprinklered. The facility has one detached building providing facility laundry services and a maintenance shop which was sprinklered. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 1 Main Dining Room door sets to the corridor which close in the same direction latched into the door frame. LSC 19.3.6.3.2 states corridor doors shall be provided with a means suitable for keeping the door closed which is acceptable to the authority having jurisdiction. This deficient practice could affect 26 residents, staff, and visitors in the Main Dining Room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 3:55 p.m. on 01/30/13, the north door in the Main	K0018	1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? No resident was found to have been affected by the alleged deficient practice. 2. How other residents having potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? Any resident has the potential to be affected by the alleged deficient practice. Equipment to repair the fire doors in the Main Dining Room has been ordered and the door latch will be repaired by March 1, 2013. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director/designee	03/01/2013

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	Dining Room set of double doors, equipped with an astragal and closing in the same direction did not close and latch into the door frame, leaving a one inch gap between the door and the top of the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the north door in the Main Dining Room set of double doors to the corridor did not latch into the door frame leaving a one inch gap between the door and the top of the door frame. 3.1-19(b)		will audit fire doors during monthly fire drills to ensure proper function. Any door found to function improperly will be reported to the facility Administrator and repaired timely. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director/designee will report findings of audit to the QA Committee during monthly QA Meeting to ensure compliance.	

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K0025 SS=D	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			
	Based on observation and interview, the facility failed to ensure the passage of wire or pipe through 1 of 1 ceiling smoke barriers was protected to maintain the smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect two staff and visitors in the storage room by the Admissions Office. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 3:55 p.m. on	K0025	1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? No resident was found to be affected by the alleged deficient practice. 2. How other residents having potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. Approved caulking material was used to fill the opening surrounding the cables passing through the ceiling in the storage room by the Admissions Office on 2/12/13. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Ceilings will be observed during monthly maintenance rounds to ensure all openings through the ceiling are sealed appropriately. Any	03/01/2013

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	01/30/13, the two inch annular space surrounding fifteen cables passing through the ceiling in the storage room by the Admissions Office into the attic was not firestopped. The two inch opening did not maintain the one half hour fire resistance rating of the smoke barrier. Based on interview at the time of observation, the Maintenance Director acknowledged the two inch annular space surrounding fifteen cables passing through the ceiling into the attic in the storage room by the Admissions Office was not firestopped. 3.1-19(b)		unsealed opening will be sealed immediately by the Maintenance Director/designee. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? Results of Monthly Maintenance Rounds will be presented by the facility Maintenance Director/designee to the QA Committee during montly QA Meetings to ensure compliance.	

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K0029 SS=E	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 observation and interview, the facility failed to ensure 1 of 6 doors serving hazardous areas such as storage rooms greater than fifty square feet in size used to store combustible materials are provided with self closing devices to close and latch the door into the door frame. This deficient practice could affect 26 residents, staff and visitors in the vicinity of Physical Therapy Storage room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 3:55 p.m. on 01/30/13, the access door to the Physical Therapy Storage room is not equipped with a self closing device to close and latch the door into the door frame. The Physical Therapy Storage room measured	K0029	1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? No resident was found to be affected by the alleged deficient practice. 2. How other residents having potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. A self closing device was installed on the Physical Therapy Storage room door on 2/12/13. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Storage room doors will be monitored by the Maintenance Director/designee during monthly maintenance rounds to ensure self closing devices are installed on doors as appropriate. Any	03/01/2013

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	72 square feet in area and is used to store combustible boxes, padding and physical therapy supplies. Based on interview at the time of observation, the Maintenance Director acknowledged the Physical Therapy Storage room measures greater than fifty square feet, is used to store combustible boxes, padding, and physical therapy supplies and the access door is not equipped with a self closing device. 3.1-19(b)		door requiring a self closing device which does not have one, will be reported to the facility Administrator immediately and a self closing device will be installed timely. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? Results of the Monthly Maintenance Rounds will be presented to the QA Committee during monthly QA Meetings to ensure compliance.	

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K0046 SS=E	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. Based on observation and interview, the facility failed to provide exterior emergency lighting of at least 1½ hour duration for 1 of 9 exits. LSC Section 7.9.1.1 requires emergency lighting facilities for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect 26 residents, staff and visitors if required to evacuate the facility from the Main Dining Room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 3:55 p.m. on 01/30/13, the Main Dining Room exit discharge to the exterior of the facility was not provided with exterior lighting. Based on interview at the time of observation, the Maintenance Director acknowledged the Main Dining Room exit discharge to the exterior of the facility was not provided with emergency exterior lighting. 3.1-19(b)	K0046	1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? No resident was found to be affected by the alleged deficient practice. 2. How other residents having potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. Lighting was installed outside the Main Dining Room exterior exit door on 2/14/13. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Exterior exit door lighting will be audited by the Maitenance Diretor/designee during monthly maintenance rounds. Any exterior exit door for means of egress found not to have emergency lighting will be reported to the Administrator and will be added/replaced timely. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? Results of the Monthly Maintenance Rounds will be presented by the Maintenance	03/01/2013

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			Diretor to the QA Committee during montly QA Meetings to ensure compliance.	

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K0048 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review, observation and interview; the facility failed to develop a written fire safety plan for staff response to the activation of battery operated smoke detectors installed in 61 of 61 resident sleeping rooms. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Disaster & Fire Manual: Fire Emergency Procedure" documentation with the Maintenance Director during record review from 9:45 a.m. to 12:10 p.m. on 01/30/13, the facility's written fire safety plan did not	K0048	1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? No resident was found to affected by the alleged deficient practice. 2. How other residents having potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. The facility "Disaster & Fire Manual: Fire Emergency Procedure" has been update to indicate staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms. Staff were in-serviced on the new Fire Emergency Procedure on 2/12/13. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Staff will be in-srviced on the facility's Fire Emergency Procedure at least annually and upon hire. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? In-service training will be reviewed by the QA Committee	03/01/2013

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	include staff response to the activation of battery operated smoke detectors installed in each resident sleeping room. Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 3:55 p.m. on 01/30/13, battery operated smoke detectors were installed in each resident sleeping room. Based on interview at the time of record review, the Maintenance Director acknowledged the facility's written fire safety plan did not include staff response to the activation of battery operated smoke detectors installed in resident sleeping rooms. 3.1-19(a)		during monthly QA Meetings to ensure compliance.	

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K0062 SS=F	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 1. Based on record review, observation and interview; the facility failed to ensure 1 of 1 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director from 9:45 a.m. to 12:10 p.m. on 01/30/13, documentation of annual fire hydrant testing within the last twelve months was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 3:55 p.m. on 01/30/13, the facility has one fire hydrant in the parking lot near the Laundry	K0062	1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? No resident was found to be affected by the alleged deficient practice. 2. How other residents having potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. 1. The facility owned fire hydrant was tested and inspected on 2/3/13. 2. Sprinkler heads in the Daniel's Drive shower room were replaced. 3. Missing escutcheon plates were replaced. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? 1. The Maintenance Director/designee will track the annual inspection of the facility owned hydrant to ensure timely test and inspection is performed. 2. The Maintenance Director/designee will observe sprinkler heads during monthly maintenance rounds to ensure no sprinkler head has been painted, is corroded, damaged, loaded or in the improper orientation.	03/01/2013

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	building. Based on interview at the time of observation, the Maintenance Director stated the aforementioned fire hydrant was owned by the facility and acknowledged documentation of annual fire hydrant testing within the last twelve months was not available for review. 3.1-19(b) 2. Based on observation and interview, the facility failed to replace 5 of 5 sprinklers in the Daniel's Drive shower room which had been painted. 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 two residents and staff in the Daniel's Drive shower room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 3:55 p.m. on 01/30/13, each of five automatic sprinklers in the Daniel's Drive shower		Sprinkler heads will be replaced as appropriate. 3. The Maintenance Director/designee will observe sprinkler heads during monthly maintenance rounds to ensure escutcheon plates are present with sprinkler heads. Missing escutcheon plates will be replaced as appropriate. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director/designee will report to QA Committee when annual test and inspection is completed to ensure compliance.The Maintenance Director/designee will present results of monthly Maintenance Rounds to QA Committee during monthly QA Meetings to ensure compliance.	

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	room had paint on the deflector. Based on interview at the time of the observations, the Maintenance Director acknowledged each of five automatic sprinklers in the Daniel's Drive shower room had paint on the deflector. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 3 of over 100 sprinkler heads in the facility were maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect ten residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:30 p.m. to 3:55 p.m. on 01/30/13, the following areas each had missing escutcheon plates which left a two inch opening in the ceiling into the attic from each area: a. in the closet in Room 134. b. in the Activities Room. c. in the east closet in the Physical Therapy Room. Based on interview at the time of the			

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	observations, the Maintenance Director acknowledged the sprinkler heads in the aforementioned locations each had missing escutcheon plates which left a two inch opening in the ceiling into the attic from each area. 3.1-19(b)			

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K0064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 20 portable fire extinguishers in the facility 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 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 it is in its designated place, it has not been actuated or tampered with and there is no obvious physical damage or condition to prevent its operation. This deficient practice could affect 26 residents, staff and visitors in the Main Dining Room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 3:55 p.m. on 01/30/13, the annual maintenance tag attached to the portable fire extinguisher located by the entry door to the kitchen	K0064	1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? No resident was found to be affected by the alleged deficient practice. 2. How other residents having potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. The fire extinguisher located by the entry door to the kitchen from the Main Dining Room was inspected and documentation was completed on 1/31/13. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Maintenance Director/designee will inspect each facility fire extinguisher monthly and document appropriately. The facility Administrator will conduct random audits of facility fire extinguishers to ensure inspections and appropriate documentation have been completed. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place?	03/01/2013

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	from the Main Dining Room indicated monthly inspections were not documented for November and December 2012. Based on interview at the time of observation, the Maintenance Director acknowledged monthly inspections for the portable fire extinguisher located by the entry door to the kitchen from the Main Dining Room were not documented for November and December 2012. 3.1-19(b)		The Maintenance Director/designee will present results from monthly audits of facilty fire extinguishers to the QA Committee during monthly QA Meetings.	

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K0144 SS=F	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. 1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 3 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: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. NFPA 99, 3-5.4.2 requires a written record of	K0144	1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? No resident was found to be affected by the alleged deficient practice. 2. How other residents having potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director/designee will complete a monthly generator load test including the duration of the load test. The transfer time will also be recorded. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The faciliy Maintenance Director was re-educated on requirements for the monthly generator load test by the facility Administrator. 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place? The Maintenance Director will present the results of the monthly generator load test to the QA Committee during the monthly	03/01/2013

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	inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator-Monthly Test Log" documentation with the Maintenance Director during record review from 9:45 a.m. to 12:10 p.m. on 01/30/13, monthly load test documentation for February and March 2012 was not available for review. In addition, monthly load test documentation for January 2013 did not include the duration of the monthly load test. Based on interview at the time of record review, the Maintenance Director acknowledged monthly load test documentation for February and March 2012 was not available for review and the duration of the January 2013 monthly load test was not recorded. 3.1-19(b) 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 1 of 12 months.		QA Meeting to ensure compliance.	

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	NFPA 99, 3-4.1.1.8 states 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. Findings include: Based on review of "Emergency Generator-Monthly Test Log" documentation with the Maintenance Director during record review from 9:45 a.m. to 12:10 p.m. on 01/30/13, documentation of emergency power transfer time for the January 2013 monthly load test was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged emergency power transfer time documentation for the January 2013 monthly load test was not available for review. 3.1-19(b)			

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