STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155667	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 07/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE CHRISTIAN RETIREMENT VILLAGE	221 W DIVISION ST DEMOTTE, IN 46310

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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, State Licensure Survey and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/10/12 Facility Number: 010823 Provider Number: 155667 AIM Number: 200236630 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Oak Grove Christian Retirement Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building identified as the Shepard's Care and Skilled units was located on the southeast and southwest wings of the first floor,	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review on or shortly after, August 24, 2012.	

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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	built prior to March 1, 2003, and surveyed with Chapter 19, Existing Health Care Occupancies. The facility is located on the first floor of a two story fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has the capacity for 49 and had a census of 46 at the time of this survey. The facility was found not in compliance with state law in regard to sprinkler coverage, however, it was in compliance with state law in regard to smoke detector coverage. All areas where the residents have customary access were sprinklered with the exceptions noted in K-56, and all areas providing facility services were sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/16/12. The facility was found not in compliance with the			

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	aforementioned regulatory requirements as evidenced by the following:			

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K0021 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 8 doors to a hazardous area was held open only by a device which would allow the door to close upon activation of the fire alarm system. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. Furthermore, doors to hazardous areas are required to latch in the door frame when closed to keep the door tightly closed. This deficient practice could affect 10 staff and any visitor or resident accessing facilities in the service corridor.	K0021	Skilled and Shepherd's Care Units **K021 Closure of Doors to Hazardous Areas** The hinges on the self-closing door to the central supply storage room door have been changed to automatically close the door and latch properly in the door frame. Completed on 7/11/2012. The Plant Manager or Designee will monitor the door daily times 4 weeks and at random times each week for 4 weeks to ensure that the door closes and latches properly. **Compliance date: 7/11/2012**	07/11/2012

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	Findings include: Based on observation with the maintenance director on 07/10/12 at 1:25 p.m., the self closing door to the ten by twenty foot central supply storage room housing supplies including those wrapped in plastic, paper and cardboard cartons was held open by the door frame. The maintenance director acknowledged at the time of observation, the spring hinges designed to close the door were not able to pull the door into the door frame. 3.1-19(b)			

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K0025 SS=E	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 openings through ceiling and wall smoke barriers in 1 of 7 smoke compartments was maintained to provide the 1/2 hour smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, be protected so that the space between the penetrating item and the smoke barrier shall be filled with an approved 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 could affect visitors, 5 staff and any resident accessing the dining room adjacent to the kitchen.	K0025	**K025** The pipe in the walk in cooler that had been sealed with expandable foam has been properly sealed. Completed on 7/11/12. The Plant Manager will monitor contractors and vendors as work is completed to ensure smoke barriers are properly sealed. **Compliance date: 7/11/12.**	07/11/2012

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	Findings include: Based on observation with the maintenance director on 07/10/12 at 1:55 p.m., a pipe penetration in the walk in cooler was sealed with expandable foam. The maintenance director acknowledged at the time of observation, the penetration had not been properly sealed. 3.1-19(b)			

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K0048 SS=F	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 and interview, the facility failed to include the types of fire extinguishers available, or the use of the K-class fire extinguisher in conjunction with the overhead hood system in the written fire plan for the protection of 137 of 137 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that 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 The plan should include each type of fire extinguisher available and any special requirement for their usage. This deficient practice could affect	K0048	Oak Leaf Unit **K048** The fire safety plan located in the Disaster Manual is being revised to address the types of extinguishers available. The fire safety plan is being revised to include the availability of the K-class fire extinguisher located in the kitchen. The fire safety plan will also state the use of the K-class extinguisher in conjunction with the overhead extinguishing system. The Plant Manager will be responsible for the additions to the fire safety plan. The Plant Manager and/or designee will in-service facility staff on the fire safety plan changes by 8/9/12. **Compliance date: 8/9/12**	08/09/2012

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	all occupants. Findings include: Based on review of the Fire Alarm Policy with the maintenance director on 07/10/2012 at 3:40 p.m., the plan did not identify available fire extinguishers in the facility and address the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The maintenance director acknowledged at the time of record review, these elements were not addressed in the fire plan. 3.1-19(b)			

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to provide complete sprinkler coverage for 1 of 7 first floor smoke compartments in a two story building of Type V (111) construction. LSC 19.1.6.2 requires two story facilities of Type V (111) construction be provided with complete sprinkler protection. This deficient practice affects residents, staff, and 41 residents in the skilled and Shepards units. Findings include: Based on observation with the maintenance director on 07/10/12 between 12:30 p.m.	K0056	**K056** Sprinkler protection will be installed in the shower alcove in resident rooms 117, 122, 128, and the shower alcove in the Shepherd's Care unit shower room. This work was scheduled with Viking Fire Protection, Co. on 7/23/12, and is to be completed no later than 8/24/12. **Compliance date: 8/24/12**	08/24/2012

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	and 4:15 p.m., sprinkler protection was not provided for the shower alcove in resident rooms 117, 122 and 128 and the shower alcove in the Shepards unit shower room. The maintenance director acknowledged at the time of observation, these areas were not protected by the other sprinklers in the rooms. 3.1-19(b) 3.1-19(ff)			

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K0062 SS=E	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 Based on observation and interview, the facility failed to ensure 14 of 29 resident room showers had sprinkler heads which were free of obstructions to spray patterns. NFPA 25, 2-2.1.2 requires unacceptable obstructions to spray patterns shall be corrected. Further NFPA 13, Standard for the Installation of Sprinkler Systems, in 5-5.6 requires the clearance between sprinkler deflectors and the top of storage should be 18 inches or more. This deficient practice could affect visitors, staff and 21 residents on the skilled and Shephards units. Findings include: Based on observation with the maintenance director on 07/10/12 between 12:45 p.m. and 4:15 p.m., shower room curtains were installed 12 inches from the ceilings in the following	K0062	**K062** The shower curtains in rooms 106, 107, 109-114, 120, 123, 127, 132, 134, and 135 will be changed to have 18 inches of ½ inch or larger mesh to allow the sprinkler head spray to reach the enclosed space. New custom-made (due to size) shower curtains were ordered on 7/23/12 and are projected to take three to four weeks to be delivered. The curtains are planned to be installed no later than 8/24/12. **Compliance date: 8/24/12**	08/24/2012

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	resident room showers: 106, 107, 109, 110, 111, 112, 113, 114, 120, 123, 127, 132, 134 and 135. The maintenance director acknowledged at the time of observations, the shower curtains were closer than the minimum distance allowed between a sprinkler head and obstruction and could prevent sprinkler head spray from reaching the enclosed space. 3.1-19(b)			

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K0067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on record review and interview, the facility failed to ensure dampers in the ductwork serving 7 of 7 smoke compartments were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 19.5.2.1 refers to Section 9.2. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all occupants.	K0067	**K067** All smoke barrier fire dampers will be inspected and, where applicable, fusible links changed. All dampers will be operated to verify full closure and, where applicable the latch will be checked. All moving parts will be lubricated as necessary. A smoke barrier fire damper inspection is ordered, and is to be completed no later than 8/24/12. Smoke barrier fire damper inspections will be performed at least once every four years and documented. The fire damper inspection will be on file and readily available for verification. **Compliance date: 8/24/12**	08/24/2012

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	Findings include: Based on a review of preventive maintenance records with the maintenance director on 07/10/12 at 3:45 p.m., the last record of a smoke barrier fire damper inspection was dated 01/16/08. The maintenance director said at the time of record review, the dampers had not been reinspected since then. 3.1-19(b)			

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K0130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review, and interview; the facility failed to ensure 5 of 5 service water heaters (SWH) had unexpired certificates of inspection. LSC 19.1.1.3 requires all health facilities to be maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all occupants. Findings include: Based on observation with the maintenance director on 07/10/12 between 12:30 p.m. and 4:15 p.m., certificates of inspection were not posted for boilers #309494, #409496, #309493, #309497 and #309495. Certificates of inspection kept in a binder in the maintenance office were reviewed with the maintenance director on 07/10/12 at 3:50 p.m. Each had expired on 03/23/12. The maintenance director said at the time of record review, the boilers	K0130	**K130** Boilers #309494, #409496, #309493, #309497, #309495 have been inspected and certified by the state of Indiana technician, Rich Walton. Boilers were found in good working order and certification is in process – waiting on state of Indiana to return paperwork. This work was completed on 7/20/12. Boilers will be certified yearly and proper documentation will be kept with each boiler as well as on file for verification. **Completion date: 7/20/12**	07/20/2012

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	had not been reinspected. 3.1-19(b)			

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K0000	A Life Safety Code Recertification, State Licensure Survey and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/10/12 Facility Number: 010823 Provider Number: 155667 AIM Number: 200236630 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Oak Grove Christian Retirement Village 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), and 410 IAC 16.2. The Oakleaf unit was surveyed under Chapter 18, New Health Care Occupancies.	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review on or shortly after, August 24, 2012.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155667	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 07/10/2012
NAME OF PROVIDER OR SUPPLIER OAK GROVE CHRISTIAN RETIREMENT VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 221 W DIVISION ST DEMOTTE, IN 46310	

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	The facility is located on the first floor of a two story fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with hard wired smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has the capacity for 49 and had a census of 46 at the time of this survey. The facility was found not in compliance with state law in regard to sprinkler coverage however, it was in compliance with state law in regard to smoke detector coverage. All areas where the residents have customary access were sprinklered with the exceptions noted in K-56, and all areas providing facility services were sprinklered. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0048 SS=F	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. 18.7.1.1 Based on record review and interview, the facility failed to include the types of fire extinguishers available, or the use of the K-class fire extinguisher in conjunction with the overhead hood system in the written fire plan for the protection of 137 of 137 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that 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 The plan should include each type of fire extinguisher available and any special requirement for their usage. This deficient practice could affect	K0048	Oak Leaf Unit **K048** The fire safety plan located in the Disaster Manual is being revised to address the types of extinguishers available. The fire safety plan is being revised to include the availability of the K-class fire extinguisher located in the kitchen. The fire safety plan will also state the use of the K-class extinguisher in conjunction with the overhead extinguishing system. The Plant Manager will be responsible for the additions to the fire safety plan. The Plant Manager and/or designee will in-service facility staff on the fire safety plan changes by 8/9/12. **Compliance date: 8/9/12**	08/09/2012

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	all occupants. Findings include: Based on review of the Fire Alarm Policy with the maintenance director on 07/10/2012 at 3:40 p.m., the plan did not identify available fire extinguishers in the facility and address the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The maintenance director acknowledged at the time of record review, these elements were not addressed in the fire plan. 3.1-19(b)			

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. Based on observation and interview, the facility failed to provide complete sprinkler coverage for 1 of 7 first floor smoke compartments in a two story building of Type V (111) construction. LSC 19.1.6.2 requires two story facilities of Type V (111) construction be provided with complete sprinkler protection. This deficient practice affects residents, staff, and 5 residents in the Oak Leaf unit. Findings include: Based on observation with the maintenance director on 07/10/12 between 12:30 p.m. and 4:15 p.m., sprinkler	K0056	**K056** Sprinkler protection will be installed in the shower alcove in resident rooms 117, 122, 128, and the shower alcove in the Shepherd's Care unit shower room. This work was scheduled with Viking Fire Protection, Co. on 7/23/12, and is to be completed no later than 8/24/12. **Compliance date: 8/24/12**	08/24/2012

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	protection was not provided for the bath tub and shower alcoves in the Oak Leaf shower room. The maintenance director agreed at the time of observation, these areas were not protected by the other sprinklers in the room. 3.1-19(b) 3.1-19(ff)			

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K0067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A Based on record review and interview, the facility failed to ensure dampers in the ductwork serving 7 of 7 smoke compartments were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 19.5.2.1 refers to Section 9.2. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all occupants.	K0067	**K067** All smoke barrier fire dampers will be inspected and, where applicable, fusible links changed. All dampers will be operated to verify full closure and, where applicable the latch will be checked. All moving parts will be lubricated as necessary. A smoke barrier fire damper inspection is ordered, and is to be completed no later than 8/24/12. Smoke barrier fire damper inspections will be performed at least once every four years and documented. The fire damper inspection will be on file and readily available for verification. **Compliance date: 8/24/12**	08/24/2012

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	Findings include: Based on a review of preventive maintenance records with the maintenance director on 07/10/12 at 3:45 p.m., the last record of a smoke barrier fire damper inspection was dated 01/16/08. The maintenance director said at the time of record review, the dampers had not been reinspected since then. 3.1-19(b)			

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K0130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review, and interview; the facility failed to ensure 5 of 5 service water heaters (SWH) had unexpired certificates of inspection. LSC 19.1.1.3 requires all health facilities to be maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all occupants. Findings include: Based on observation with the maintenance director on 07/10/12 between 12:30 p.m. and 4:15 p.m., certificates of inspection were not posted for boilers #309494, #409496, #309493, #309497 and #309495. Certificates of inspection kept in a binder in the maintenance office were reviewed with the maintenance director on 07/10/12 at 3:50 p.m. Each had expired on 03/23/12. The maintenance director said at the time of record review, the boilers	K0130	**K130** Boilers #309494, #409496, #309493, #309497, #309495 have been inspected and certified by the state of Indiana technician, Rich Walton. Boilers were found in good working order and certification is in process – waiting on state of Indiana to return paperwork. This work was completed on 7/20/12. Boilers will be certified yearly and proper documentation will be kept with each boiler as well as on file for verification. **Completion date: 7/20/12**	07/20/2012

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	had not been reinspected. 3.1-19(b)			