

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/24/2013
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NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/24/13</p> <p>Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Wittenberg Lutheran 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>The original one story building with a partial basement identified as building 102 was determined to</p>	K0000	We are respectfully requesting an IDR for K-067. We are respectfully requesting an extension until March 30, 2013 for K-130-2(Fellow Ship Hall roll-top door)	

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>be to be of Type II (000) construction and was fully sprinklered. The Chapel/Fellowship Hall identified as building 202 was determined to be Type V (000) construction and occupies a 1990 wing addition to the facility. The facility is surveyed as two buildings due to different construction types.</p> <p>The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 155 and had a census of 143 at the time of this survey.</p> <p>All areas where residents have customary access are sprinklered. A detached grounds maintenance shed was unsprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/30/13.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>			

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	<p>be to be of Type II (000) construction and was fully sprinklered. The Chapel/Fellowship Hall identified as building 202 was determined to be Type V (000) construction and occupies a 1990 wing addition to the facility. The facility is surveyed as two buildings due to different construction types.</p> <p>The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 155 and had a census of 143 at the time of this survey.</p> <p>All areas where residents have customary access are sprinklered. A detached grounds maintenance shed was unsprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/30/13.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>			

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K0017 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 an open use area in 1 of 8 smoke compartments was separated from the corridor by smoke resistant walls extending from the floor to the roof above, or met an exception. LSC 19.3.6.1, Exception # 6: Spaces other than patient sleeping rooms, treatment rooms and hazardous areas may be open to the corridor and may be unlimited in area provided: (a) The space and corridors which the space opens into in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b)</p>	K0017	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the alleged deficient practice. Residents using the open use area in 1 of 8 compartments had the potential of being affected by the alleged deficient practice. No residents were affected by the alleged deficient practice. Residents using the open use area in 1 of 8 compartments had the potential of being affected by the alleged deficient practice. Deficiency remedied 1-25-132. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Residents using the open use area in 1 of 8 compartments had the potential</p>	02/25/2013

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	<p>Each space is protected by automatic sprinklers, or the furnishings and furniture within the area, in combination with all other combustibles within the area, are of such minimum quality and arrangement that a fully developed fire is unlikely to occur, and (c) The space does not obstruct access to required exits. This deficient practice affects visitors, staff and 8 or more residents in the 400 hall lounge.</p> <p>Findings include:</p> <p>Based on observation with the Facilities Director on 01/24/13 at 2:45 p.m., an ice machine was installed in the wall between the 400 lounge and utility room. The lounge is open to the area at the point where four exit corridors meet. A one inch by 24 inch gap was evident where the wall was not sealed between the top of the ice machine and wall. There was nothing to prevent the passage of smoke between the utility room and lounge, and from there into the corridor. The area was not protected by an electrically supervised automatic smoke</p>		<p>of being affected by the alleged deficient practice. An audit was completed on 1-25-13 and no other gaps in the walls were evident.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All equipment installations, and/or repairs to equipment regarding fire or smoke will penetration will be managed and coordinated to include the proper placement of approved fire caulk, and/or putty to any penetration created by equipment/or repair. Weekly audits conducted to include monitoring for fire wall penetration gaps and immediate resolution. Maintenance staff to be educated regarding this audit process by 2-23-13.Attachment A4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.Audits will be conducted weekly x 4 weeks, then monthly x 3 months, then quarterly x 3 quarters. Safety committee will monitor for trends and patterns.Attachment: Photocopy of five rated caulk material - attachment A-1Attachment: Photograph of remedial deficiency - attachment A-2</p>	

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	<p>detection system or located to permit direct supervision by the facility staff from a nurses' station or similar space.</p> <p>3.1-19(b)</p>			

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K0025 SS=D	<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 openings through a ceiling smoke barrier in 1 of 5 basement service areas 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, cable or wire to be protected so that 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 could affect any visitors and 2 staff in the laundry.</p> <p>Findings include:</p>	K0025	<p>POC Feb., 2013 K - 025</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>No visitors or laundry staffs were affected by the alleged deficient practice. Visitors or laundry staff using this 1 of 5 basement area had the potential of being affected by the alleged deficient practice. Resolution with approved fire caulk was facilitated on 01/25/13.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>Visitors or laundry staff using this 1 of 5 basement area had the potential to be affected by the</p>	02/23/2013	

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	<p>Based on observation with the Facilities Director on 01/24/13 at 1:30 p.m., there were unsealed ceiling penetrations by four ducts and a three inch pipe observed behind the dryers in the laundry. The Facilities Director agreed at the time of observation, the gaps should have been sealed.</p> <p>3.1-19(b)</p>		<p>alleged deficient practice. The unsealed ceiling penetrations by four ducts and a three inch pipe behind the laundry dryers were sealed by an approved fire caulk on 01/25/13. An audit was facilitated on 01/25/13 and no other unsealed ceiling penetrations by ductwork or piping were observed.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>All new ductwork and/or piping installations, and/or repairs will be coordinated and managed to repair any created or existing ceiling penetrations with approved fire caulk, and/or putty. Revised weekly audit facilitated, 02/09/13, to ensure ceiling penetrations are sealed with approved fire caulk, and/or putty. Attachment A</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <p>Audits to be put in place, 02/09/13, and completed weekly X 4 weeks, then monthly X 3 months, then quarterly X 3 quarters. Safety committee will monitor monthly for</p>		

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			trends and patterns. Attachments: A-1, B-1, B-2, B-3, B-4	

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K0038 SS=E	<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 2 of 12 exits were arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and 40 or more residents on the 110 hall and near Nurses' Station 3.</p> <p>Findings include:</p> <p>Based on observation with the Facilities Director on 01/24/13 at 1:30 p.m., the expansion joints across the concrete exit discharge surfaces outside the 100 hall and near Nurses' Station 3 each gapped one inch between the concrete pads and appeared to have shifted to create an uneven</p>	K0038	<p>POC Feb., 2013 K - 0381. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No visitors, staff or residents were affected by this alleged deficient practice. Visitors, staff or residents using the 2 of 12 exit discharges had the potential of being affected by this alleged deficient practice. Deficiency corrected 2-7-13 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Visitors, staff or residents using the 2 of 12 exit discharges associated with each the 100 hall and nurse station 3 had the potential of being affected by this alleged deficiency of one inch gap between sidewalk pads and uneven surface due to weather conditions associated with heavy frost raising the floating concrete pad. Audit facilitated on 01/25/13 for all other exits with no further deficiency noted. The "Crack Stix" product made by Dalton Industries was put in place on 02/07/13 to alleviate the gaps and make smooth 3. What measures will be put into place</p>	02/23/2013

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	<p>surface. The Facilities Director said at the time of observations, the changes were weather related.</p> <p>3.1-19(b)</p>		<p>or what systemic changes will be made to ensure that the deficient practice does not recur. Audit facilitated on 01/25/13 for all other exits with no further deficiency noted. The "Crack Rite - Crack Stix" product made by Dalton Industries was put in place on 02/07/13 to alleviate the gaps and make smooth. Weekly audits to be facilitated by 02/23/13 to ensure no further deficiency of this type exist. Maintenance staff to be trained about this audit process by 02/23/13. Attachment: A, A-4. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. Audits will be conducted weekly X 4 weeks, then monthly X 3 months, then quarterly X 3 quarters. Safety Committee will monitor for trends and patterns. Attachment D, D-1, D-2</p>		

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K0048 SS=C	<p>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 develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 143 of 143 residents. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (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 <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Fire Policy and Code Red procedures with the Facilities Director on 01/24/13 at</p>	K0048	<p>POC Feb., 2013 K - 0481. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No occupants were affected by the alleged deficient practice. Occupants had the potential to be affected by the alleged deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Occupants have the potential of being affected by the alleged deficient practice. Existing Fire plan & policy to be revised by 02/11/13 to include use of battery operated smoke detectors regarding location of, and special response required for battery smoke detectors providing local alarms versus those smoke detectors which activated the fire alarm system. This will also include staff training and drills by 02/23/13 to identify alarm and proper reaction/response to a battery operated smoke alarm. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p>	02/23/2013	

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	<p>4:30 p.m., the plan did not address the location of, and special response required, for battery powered smoke detectors providing local alarms versus those smoke detectors which activated the fire alarm system. The Facilities Director confirmed at the time of record review, there was no procedure for response to the local alarms of battery powered smoke detectors. He confirmed staff had no training to ensure they were familiar with the necessary procedures and the sound of battery smoke detector alarms to prepare them in the event of an emergency.</p> <p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 143 of</p>		<p>Existing fire plan & policy (attachment E) to be revised by 02/11/13 to include use of battery operated smoke detectors regarding location of, and special response required for battery smoke detectors providing local alarms versus those detectors which activated the fire alarm system. This will also include mandatory staff education and drills by 02/23/13 to identify alarm and proper reaction/response to a battery operated smoke alarm. Attachment: E, E-1 4.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. All new employee orientation for safety will have this revised fire plan and policy presented. The annual safety fair will include this newly revised policy on battery operated smoke detectors. Monthly fire drills will be revised to include the test and response to battery operated smoke detectors. Safety committee will monitor monthly for trends and patterns.</p>		

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	<p>143 residents. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (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 <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Fire Policy and Code Red procedures with the Facilities Director on 01/24/13 at 4:30 p.m., the plan did not address the location of, and special response required, for battery powered smoke detectors providing local alarms versus those smoke detectors which activated the fire alarm system. The Facilities Director confirmed at the time of record review, there was no procedure for response to</p>			

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	<p>the local alarms of battery powered smoke detectors. He confirmed staff had no training to ensure they were familiar with the necessary procedures and the sound of battery smoke detector alarms to prepare them in the event of an emergency.</p> <p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 143 of 143 residents. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (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 			

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	<p>building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Fire Policy and Code Red procedures with the Facilities Director on 01/24/13 at 4:30 p.m., the plan did not address the location of, and special response required, for battery powered smoke detectors providing local alarms versus those smoke detectors which activated the fire alarm system. The Facilities Director confirmed at the time of record review, there was no procedure for response to the local alarms of battery powered smoke detectors. He confirmed staff had no training to ensure they were familiar with the necessary procedures and the sound of battery smoke detector alarms to prepare them in the event of an emergency.</p> <p>3.1-19(b)</p>				

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	<p>Based on record review and interview, the facility failed to develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 143 of 143 residents. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (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 <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Fire Policy and Code Red procedures with the Facilities Director on 01/24/13 at 4:30 p.m., the plan did not address the location of, and special response required, for</p>			

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	<p>battery powered smoke detectors providing local alarms versus those smoke detectors which activated the fire alarm system. The Facilities Director confirmed at the time of record review, there was no procedure for response to the local alarms of battery powered smoke detectors. He confirmed staff had no training to ensure they were familiar with the necessary procedures and the sound of battery smoke detector alarms to prepare them in the event of an emergency.</p> <p>3.1-19(b)</p>			

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K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records and interview with the Facilities Director on 01/24/13 at 4:35 p.m., there was no record of a third shift fire drill for the third quarter during 2012. The Facilities Director acknowledged the fire drill was not included in the records.</p> <p>3.1-9(b) 3.1-51(c)</p>	K0050	<p>POC Feb., 2013 K - 0501. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents, staff or visitors were affected by this alleged deficient practice. Residents, staff and visitors had the potential of being affected by this alleged deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Residents, staff and visitors have the potential of being affected by this alleged deficient practice. Although our independent drill checklist indicated that this drill was facilitated, it was not placed in our life safety binder. The fire drills will be coordinated and managed as of 02/11/13 through the safety officer monthly to ensure compliance. Further review of these will be facilitated monthly by Safety Committee. 3.</p>	02/23/2013

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	<p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records and interview with the Facilities Director on 01/24/13 at 4:35 p.m., there was</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Facilitate the education (attachment F) of maintenance and security staff by 02/11/13 in the proper conducting, documentation and placement of documents in the Life Safety Review Binder. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <p>The Safety Officer and Safety Committee are to review and monitor fire drills monthly for compliance.</p>		

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	<p>no record of a third shift fire drill for the third quarter during 2012. The Facilities Director acknowledged the fire drill was not included in the records.</p> <p>3.1-9(b) 3.1-51(c)</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records and interview with the Facilities Director on 01/24/13 at 4:35 p.m., there was no record of a third shift fire drill for the third quarter during 2012. The Facilities Director acknowledged the fire drill was not included in the records.</p> <p>3.1-9(b)</p>			

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	<p>3.1-51(c)</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records and interview with the Facilities Director on 01/24/13 at 4:35 p.m., there was no record of a third shift fire drill for the third quarter during 2012. The Facilities Director acknowledged the fire drill was not included in the records.</p> <p>3.1-9(b) 3.1-51(c)</p>				

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K0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, observation and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 74 of 74 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a review of the monthly preventive maintenance records for 2012 provided by the Facilities Director on 01/24/13 at 4:15 p.m., inspection of battery powered smoke detectors were last done 11/15/12. An itemized listing of monthly battery operated smoke detector testing for each resident sleeping room location was not available for review. The Facilities Director said at the time of record review, the smoke detector checks had been done</p>	K0130	<p>POC Feb., 2013 K - 1301.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No occupants were affected by the alleged deficient practice. Occupants have the potential to be affected by the alleged deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>Occupants have the potential of being affected by the alleged deficient practice. An audit was facilitated on 01/28/13 with no deficiencies noted. Policy to be created by 02/11/13 to provide direction in inspecting and testing battery operated smoke detectors and their respective batteries. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A Policy (attachment H) and procedure will be created by 02/11/13 to give clear direction on testing and inspecting battery operated smoke detectors and their respective batteries. All</p>	03/30/2013			

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	<p>quarterly. Battery changes were documented in March and November 2012.</p> <p>3.1-19(a)</p>		<p>maintenance staff is to be educated by 02/23/13 in knowing how to test and inspect the battery operated smoke detectors and their respective batteries. A spreadsheet/weekly audit sheet (attachment H-1) will be created by 02/11/13 to document weekly testing of these. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. The Safety Officer will review the weekly audits weekly to ensure complete compliance. POC Feb., 2013 K – 130-2 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No staff, visitors or residents were affected by this alleged deficient practice. Staff, visitors or residents have the potential of being affected by this alleged deficient practice. This area is completely sprinklered. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Occupants using the</p>		

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			<p>fellowship hall area have the potential of being affected by this alleged deficient practice. Hours of operation for this food service area are Monday thru Friday only from 6:30 a.m. until 12:30 p.m. Culinary staff is always present during this open time frame. This area is always completely closed off and locked down during off-time hours. Corrective action is to replace existing door with door that meets all NFPA 101 life safety requirements for this area, inclusive of connection to the fire alarm system. 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 purchase and installation of a new door that meets all NFPA 101 Life Safety requirements for this area, inclusive of connection to fire alarm system. This work to be facilitated complete by 03-30-13. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. This will be monitored for compliance by safety officer and Safety Committee.Attachment: I, I-1,</p>		

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	<p>Based on record review, observation and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 74 of 74 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a review of the monthly preventive maintenance records for 2012 provided by the Facilities Director on 01/24/13 at 4:15 p.m., inspection of battery powered smoke detectors were last done 11/15/12. An itemized listing of monthly battery operated smoke detector testing for each resident sleeping room location was not available for review. The Facilities Director said at the time of record review, the smoke</p>		<p>I-2, I-3 Due to time required to order, receive and install new roll-top door, we are requesting a completion date of 3-30-13.</p>	
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	<p>detector checks had been done quarterly. Battery changes were documented in March and November 2012.</p> <p>3.1-19(a)</p> <p>Based on record review, observation and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 74 of 74 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a review of the monthly preventive maintenance records for 2012 provided by the Facilities Director on 01/24/13 at 4:15 p.m., inspection of battery powered smoke detectors were</p>						

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	<p>last done 11/15/12. An itemized listing of monthly battery operated smoke detector testing for each resident sleeping room location was not available for review. The Facilities Director said at the time of record review, the smoke detector checks had been done quarterly. Battery changes were documented in March and November 2012.</p> <p>3.1-19(a)</p> <p>Based on record review, observation and interview; the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 74 of 74 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all occupants.</p> <p>Findings include:</p>				

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	<p>Based on a review of the monthly preventive maintenance records for 2012 provided by the Facilities Director on 01/24/13 at 4:15 p.m., inspection of battery powered smoke detectors were last done 11/15/12. An itemized listing of monthly battery operated smoke detector testing for each resident sleeping room location was not available for review. The Facilities Director said at the time of record review, the smoke detector checks had been done quarterly. Battery changes were documented in March and November 2012.</p> <p>3.1-19(a)</p>				

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K0144 SS=F	<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 ensure documentation of monthly generator load tests were provided for 8 of the past 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</p>	K0144	<p>POC Feb., 2013 K - 144 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents, staff or visitors were affected by the alleged deficient practice. Residents, staff and visitors have the potential of being affected by the alleged deficient practice. Alleged deficient practice completed on 2-4-13 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Residents, staff and visitors have the potential of being affected by the alleged deficient practice. Maintenance will resume documenting the load capacity as of 02/04/13. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance staff was educated (attachment J) on 02/04/13 on proper documentation of emergency generator load testing and to resume this documentation. 4. How the corrective action(s) will be</p>	02/23/2013	

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	<p>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. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Emergency Generator Monthly Test Log for the past year with the Facilities Director on 01/24/13 at 4:45 p.m., complete generator load test documentation was recorded until April 2012. A new form was put in use in May 2012. No amperage readings to reflect the load testing was included in the documentation from May 2012 to date. The Facilities Director said at the time of record review, the generator was tested under load weekly but agreed the information required to calculate the load and the actual load percentage was not documented.</p>		<p>monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <p>Safety Officer and Safety Committee will monitor monthly for trends and patterns</p>		

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	<p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to ensure documentation of monthly generator load tests were provided for 8 of the past 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</p>				

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	<p>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. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Emergency Generator Monthly Test Log for the past year with the Facilities Director on 01/24/13 at 4:45 p.m., complete generator load test documentation was recorded until April 2012. A new form was put in use in May 2012. No amperage readings to reflect the load testing was included in the documentation from May 2012 to date. The Facilities Director said at the time of record review, the generator was tested under load weekly but agreed the information required to to calculate the load and the actual load percentage was not documented.</p>				

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	<p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to ensure documentation of monthly generator load tests were provided for 8 of the past 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>						

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	<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. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Emergency Generator Monthly Test Log for the past year with the Facilities Director on 01/24/13 at 4:45 p.m., complete generator load test documentation was recorded until April 2012. A new form was put in use in May 2012. No amperage readings to reflect the load testing was included in the documentation from May 2012 to date. The Facilities Director said at the time of record review, the generator was tested under load weekly but agreed the information required to to calculate the load and the actual load percentage was not documented.</p> <p>3.1-19(b)</p>						

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	<p>Based on record review and interview, the facility failed to ensure documentation of monthly generator load tests were provided for 8 of the past 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</p>			
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	<p>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. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Emergency Generator Monthly Test Log for the past year with the Facilities Director on 01/24/13 at 4:45 p.m., complete generator load test documentation was recorded until April 2012. A new form was put in use in May 2012. No amperage readings to reflect the load testing was included in the documentation from May 2012 to date. The Facilities Director said at the time of record review, the generator was tested under load weekly but agreed the information required to calculate the load and the actual load percentage was not documented.</p> <p>3.1-19(b)</p>				

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K0147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 9 of 9 flexible cords or unapproved multitap adapters were not used as a substitute for fixed wiring. NFPA 70, the National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 40 or more residents on the 100, 300 and 400 halls.</p> <p>Findings include:</p> <p>Based on observation with the Facilities Director on 01/24/13 between 12:00 p.m. and 4:00 p.m. extension cords or unapproved multitap outlet adapters were used to provide power to equipment in the following areas:</p> <p>a. Room 116, power strip under resident bed; b. Nursing supply storage room, a</p>	K0147	<p>POC Feb., 2013 K - 147</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>No staff, visitors or residents were affected by this alleged deficient practice. Staff, visitors or residents have the potential to be affected by this alleged deficient practice.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>Staff, visitors and residents on 100 hall, 300 hall and 400 hall have the potential to be affected by this alleged deficient practice. An audit was facilitated on 01/25/13 to correct 9 of 9 deficient flexible electrical cords. No other deficiencies were identified.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Weekly audits revised (attachment A) by 02/11/13 to include</p>	02/23/2013

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	<p>power strip piggy backed to a surge protector power strip;</p> <p>c. Room 409, two extension cords were plugged into a power strip;</p> <p>d. Room 302, two power strips under the resident bed to power a refrigerator and nebulizer;</p> <p>e. Room 301, a multitap adapter to power a refrigerator.</p> <p>The Facilities Director said at the time of observations, the use of these power sources were an ongoing problem.</p> <p>3.1-19(b)</p>		<p>monitoring of all resident rooms for improper use or placement of electrical cords. Noted deficiencies are to be corrected immediately. Letter to resident and family members to be mailed by 2-23-13 regarding information on Power Strips and Power Cords. (attachment K)</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <p>Safety Officer and Safety Committee to monitor for compliance and for trends and patterns.</p>	

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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 01/24/13</p> <p>Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Wittenberg Lutheran 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>The original one story building with a partial basement identified as building 102 was determined to</p>	K0000	We are respectfully requesting an IDR for K-067. We are respectfully requesting an extension until March 30, 2013 for K-130-2(Fellow Ship Hall roll-top door)		

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	<p>be to be of Type II (000) construction and was fully sprinklered. The Chapel/Fellowship Hall identified as building 202 was determined to be Type V (000) construction and occupies a 1990 wing addition to the facility. The facility is surveyed as two buildings due to different construction types.</p> <p>The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 155 and had a census of 143 at the time of this survey.</p> <p>All areas where residents have customary access are sprinklered. A detached grounds maintenance shed was unsprinklered.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>				

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	<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: 01/24/13</p> <p>Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Wittenberg Lutheran 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), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>The original one story building with a partial basement identified as building 102 was determined to be to be of Type II (000) construction and was fully</p>	K0000	We are respectfully requesting an IDR for K-067. We are respectfully requesting an extension until March 30, 2013 for K-130-2(Fellow Ship Hall roll-top door)	

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	<p>sprinklered. The Chapel/Fellowship Hall identified as building 202 was determined to be Type V (000) construction and occupies a 1990 wing addition to the facility. The facility is surveyed as two buildings due to different construction types.</p> <p>The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 155 and had a census of 143 at the time of this survey.</p> <p>All areas where residents have customary access are sprinklered. A detached grounds maintenance shed was unsprinklered.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>			

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K0029 SS=E	<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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 12 hazardous areas such as a kitchen was separated from other spaces by a smoke resistant partition. This practice affects 10 or more occupants of the adjacent Fellowship Hall.</p> <p>Findings include:</p> <p>Based on observation with the Facilities Director on 01/24/13 at 3:30 p.m., a six inch by twenty four inch opening between the Fellowship Hall and kitchen provided an opening for returning dirty dishes to the kitchen. The Facilities Director agreed at the time of observation, the opening had nothing to separate the</p>	K0029	<p>POC Feb., 2013 K - 029 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No occupants were affected by the alleged deficient practice. Occupants using the 1 of 12 hazardous areas had the potential of being affected by the alleged deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Occupants using the Fellowship Hall area had the potential to be affected by the alleged deficient practice. An audit was facilitated on 01/25/13 with no other deficiencies noted. The six inch by twenty four inch opening was closed off and sealed with existing wall construction on 01/28/13. 3. What measures</p>	02/23/2013

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NAME OF PROVIDER OR SUPPLIER WITTENBERG LUTHERAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307		
(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	
	kitchen from the Fellowship Hall. 3.1-19(b)		will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. The alleged deficient six inch by twenty four inch opening was closed off and sealed with existing wall construction on 01/28/13. Weekly audit revised, 02/09/13, to monitor area for potential openings. Maintenance to be educated with this auditing process by 02/23/13. Attachment A, A-3 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. Audits to be conducted weekly X 4 weeks, then monthly X 3 months, then quarterly X 3 quarters. Safety Committee will monitor for trends and patterns. Attachment C		

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K0048 SS=C	<p>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 develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 143 of 143 residents. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (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 <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Fire Policy and Code Red procedures with the Facilities Director on 01/24/13 at</p>	K0048	<p>POC Feb., 2013 K - 0481. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No occupants were affected by the alleged deficient practice. Occupants had the potential to be affected by the alleged deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Occupants have the potential of being affected by the alleged deficient practice. Existing Fire plan & policy to be revised by 02/11/13 to include use of battery operated smoke detectors regarding location of, and special response required for battery smoke detectors providing local alarms versus those smoke detectors which activated the fire alarm system. This will also include staff training and drills by 02/23/13 to identify alarm and proper reaction/response to a battery operated smoke alarm. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p>	02/23/2013

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	<p>4:30 p.m., the plan did not address the location of, and special response required for battery smoke detectors providing local alarms versus those smoke detectors which activated the fire alarm system. The Facilities Director confirmed at the time of record review, there was no procedure for response to the local alarms of battery powered smoke detectors. He confirmed staff had no training to ensure they were familiar with the necessary procedures and the sound of battery smoke detector alarms to prepare them in the event of an emergency.</p> <p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 143 of</p>		<p>Existing fire plan & policy (attachment E) to be revised by 02/11/13 to include use of battery operated smoke detectors regarding location of, and special response required for battery smoke detectors providing local alarms versus those detectors which activated the fire alarm system. This will also include mandatory staff education and drills by 02/23/13 to identify alarm and proper reaction/response to a battery operated smoke alarm. Attachment: E, E-1 4.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. All new employee orientation for safety will have this revised fire plan and policy presented. The annual safety fair will include this newly revised policy on battery operated smoke detectors. Monthly fire drills will be revised to include the test and response to battery operated smoke detectors. Safety committee will monitor monthly for trends and patterns.</p>		

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	<p>143 residents. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ul style="list-style-type: none"> (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 <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Fire Policy and Code Red procedures with the Facilities Director on 01/24/13 at 4:30 p.m., the plan did not address the location of, and special response required for battery smoke detectors providing local alarms versus those smoke detectors which activated the fire alarm system. The Facilities Director confirmed at the time of record review, there was no procedure for response to the</p>				

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	<p>local alarms of battery powered smoke detectors. He confirmed staff had no training to ensure they were familiar with the necessary procedures and the sound of battery smoke detector alarms to prepare them in the event of an emergency.</p> <p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 143 of 143 residents. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (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 			

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	<p>(8) Extinguishment of fire</p> <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Fire Policy and Code Red procedures with the Facilities Director on 01/24/13 at 4:30 p.m., the plan did not address the location of, and special response required for battery smoke detectors providing local alarms versus those smoke detectors which activated the fire alarm system. The Facilities Director confirmed at the time of record review, there was no procedure for response to the local alarms of battery powered smoke detectors. He confirmed staff had no training to ensure they were familiar with the necessary procedures and the sound of battery smoke detector alarms to prepare them in the event of an emergency.</p> <p>3.1-19(b)</p> <p>Based on record review and</p>			

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	<p>interview, the facility failed to develop a written plan and train staff to implement the plan for staff response to resident room smoke detectors to protect 143 of 143 residents. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> (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 <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Fire Policy and Code Red procedures with the Facilities Director on 01/24/13 at 4:30 p.m., the plan did not address the location of, and special response required for battery smoke detectors providing local alarms versus those smoke</p>			
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	<p>detectors which activated the fire alarm system. The Facilities Director confirmed at the time of record review, there was no procedure for response to the local alarms of battery powered smoke detectors. He confirmed staff had no training to ensure they were familiar with the necessary procedures and the sound of battery smoke detector alarms to prepare them in the event of an emergency.</p> <p>3.1-19(b)</p>			

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K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records and interview with the Facilities Director on 01/24/13 at 4:35 p.m., there was no record of a third shift fire drill for the third quarter during 2012. The Facilities Director acknowledged the fire drill was not included in the records.</p> <p>3.1-9(b) 3.1-51(c)</p>	K0050	<p>POC Feb., 2013 K - 0501. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents, staff or visitors were affected by this alleged deficient practice. Residents, staff and visitors had the potential of being affected by this alleged deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Residents, staff and visitors have the potential of being affected by this alleged deficient practice. Although our independent drill checklist indicated that this drill was facilitated, it was not placed in our life safety binder. The fire drills will be coordinated and managed as of 02/11/13 through the safety officer monthly to ensure compliance. Further review of these will be facilitated monthly by Safety Committee. 3.</p>	02/23/2013			

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	<p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records and interview with the Facilities Director on 01/24/13 at 4:35 p.m., there was</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</p> <p>Facilitate the education (attachment F) of maintenance and security staff by 02/11/13 in the proper conducting, documentation and placement of documents in the Life Safety Review Binder. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <p>The Safety Officer and Safety Committee are to review and monitor fire drills monthly for compliance.</p>		

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	<p>no record of a third shift fire drill for the third quarter during 2012. The Facilities Director acknowledged the fire drill was not included in the records.</p> <p>3.1-9(b) 3.1-51(c)</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records and interview with the Facilities Director on 01/24/13 at 4:35 p.m., there was no record of a third shift fire drill for the third quarter during 2012. The Facilities Director acknowledged the fire drill was not included in the records.</p> <p>3.1-9(b) 3.1-51(c)</p> <p>Based on record review and</p>				

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	<p>interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill records and interview with the Facilities Director on 01/24/13 at 4:35 p.m., there was no record of a third shift fire drill for the third quarter during 2012. The Facilities Director acknowledged the fire drill was not included in the records.</p> <p>3.1-9(b) 3.1-51(c)</p>				

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K0130 SS=E	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, observation and interview; the facility failed to maintain 1 of 1 rolling fire doors in accordance with NFPA 80, 1999 Edition, Standard for Fire Doors and Fire Windows, 15-2.4.3 which requires all horizontal or vertical sliding and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice affects staff, visitors and and 30 or more residents in the Fellowship hall.</p> <p>Findings include:</p> <p>Based on observation with the Facilities Director on 01/24/13 at 3:25 p.m., a rolling fire door protected the service window between the Fellowship Hall kitchen and adjacent Fellowship Hall. A review of fire equipment</p>	K0130	<p>POC Feb., 2013 K - 1301.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No occupants were affected by the alleged deficient practice. Occupants have the potential to be affected by the alleged deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>Occupants have the potential of being affected by the alleged deficient practice. An audit was facilitated on 01/28/13 with no deficiencies noted. Policy to be created by 02/11/13 to provide direction in inspecting and testing battery operated smoke detectors and their respective batteries. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. A Policy (attachment H) and procedure will be created by 02/11/13 to give clear direction on testing and inspecting battery operated smoke detectors and their respective batteries. All</p>	03/30/2013			

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	<p>inspection and testing reports on 01/24/13 at 4:10 p.m. did not include a report of testing for the rolling fire doors. The Facilities Director said at the time of record review, he could find no documentation of an inspection of the door.</p> <p>3.1-19(b)</p>		<p>maintenance staff is to be educated by 02/23/13 in knowing how to test and inspect the battery operated smoke detectors and their respective batteries. A spreadsheet/weekly audit sheet (attachment H-1) will be created by 02/11/13 to document weekly testing of these. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. The Safety Officer will review the weekly audits weekly to ensure complete compliance. POC Feb., 2013 K – 130-2 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No staff, visitors or residents were affected by this alleged deficient practice. Staff, visitors or residents have the potential of being affected by this alleged deficient practice. This area is completely sprinklered. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Occupants using the</p>		

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			<p>fellowship hall area have the potential of being affected by this alleged deficient practice. Hours of operation for this food service area are Monday thru Friday only from 6:30 a.m. until 12:30 p.m. Culinary staff is always present during this open time frame. This area is always completely closed off and locked down during off-time hours. Corrective action is to replace existing door with door that meets all NFPA 101 life safety requirements for this area, inclusive of connection to the fire alarm system. 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 purchase and installation of a new door that meets all NFPA 101 Life Safety requirements for this area, inclusive of connection to fire alarm system. This work to be facilitated complete by 03-30-13. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed. This will be monitored for compliance by safety officer and Safety Committee.Attachment: I, I-1,</p>		

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	<p>Based on record review, observation and interview; the facility failed to maintain 1 of 1 rolling fire doors in accordance with NFPA 80, 1999 Edition, Standard for Fire Doors and Fire Windows, 15-2.4.3 which requires all horizontal or vertical sliding and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice affects staff, visitors and and 30 or more residents in the Fellowship hall.</p> <p>Findings include:</p> <p>Based on observation with the Facilities Director on 01/24/13 at 3:25 p.m., a rolling fire door protected the service window between the Fellowship Hall kitchen and adjacent Fellowship</p>		<p>I-2, I-3 Due to time required to order, receive and install new roll-top door, we are requesting a completion date of 3-30-13.</p>	

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	<p>Hall. A review of fire equipment inspection and testing reports on 01/24/13 at 4:10 p.m. did not include a report of testing for the rolling fire doors. The Facilities Director said at the time of record review, he could find no documentation of an inspection of the door.</p> <p>3.1-19(b)</p> <p>Based on record review, observation and interview; the facility failed to maintain 1 of 1 rolling fire doors in accordance with NFPA 80, 1999 Edition, Standard for Fire Doors and Fire Windows, 15-2.4.3 which requires all horizontal or vertical sliding and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice affects staff,</p>				

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	<p>visitors and and 30 or more residents in the Fellowship hall.</p> <p>Findings include:</p> <p>Based on observation with the Facilities Director on 01/24/13 at 3:25 p.m., a rolling fire door protected the service window between the Fellowship Hall kitchen and adjacent Fellowship Hall. A review of fire equipment inspection and testing reports on 01/24/13 at 4:10 p.m. did not include a report of testing for the rolling fire doors. The Facilities Director said at the time of record review, he could find no documentation of an inspection of the door.</p> <p>3.1-19(b)</p> <p>Based on record review, observation and interview; the facility failed to maintain 1 of 1 rolling fire doors in accordance with NFPA 80, 1999 Edition, Standard for Fire Doors and Fire Windows, 15-2.4.3 which requires all horizontal or vertical sliding</p>				

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	<p>and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice affects staff, visitors and and 30 or more residents in the Fellowship hall.</p> <p>Findings include:</p> <p>Based on observation with the Facilities Director on 01/24/13 at 3:25 p.m., a rolling fire door protected the service window between the Fellowship Hall kitchen and adjacent Fellowship Hall. A review of fire equipment inspection and testing reports on 01/24/13 at 4:10 p.m. did not include a report of testing for the rolling fire doors. The Facilities Director said at the time of record review, he could find no documentation of an inspection of the door.</p> <p>3.1-19(b)</p>			

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K0144 SS=F	<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 ensure documentation of monthly generator load tests were provided for 8 of the past 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</p>	K0144	<p>POC Feb., 2013 K - 144 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents, staff or visitors were affected by the alleged deficient practice. Residents, staff and visitors have the potential of being affected by the alleged deficient practice. Alleged deficient practice completed on 2-4-13 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. Residents, staff and visitors have the potential of being affected by the alleged deficient practice. Maintenance will resume documenting the load capacity as of 02/04/13. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Maintenance staff was educated (attachment J) on 02/04/13 on proper documentation of emergency generator load testing and to resume this documentation. 4. How the corrective action(s) will be</p>	02/23/2013

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	<p>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. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Emergency Generator Monthly Test Log for the past year with the Facilities Director on 01/24/13 at 4:45 p.m., complete generator load test documentation was recorded until April 2012. A new form was put in use in May 2012. No amperage readings to reflect the load testing was included in the documentation from May 2012 to date. The Facilities Director said at the time of record review, the generator was tested under load weekly but agreed the information required to calculate the load and the actual load percentage was not documented.</p>		<p>monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes will be completed.</p> <p>Safety Officer and Safety Committee will monitor monthly for trends and patterns</p>		

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	<p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to ensure documentation of monthly generator load tests were provided for 8 of the past 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</p>			

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	<p>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. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Emergency Generator Monthly Test Log for the past year with the Facilities Director on 01/24/13 at 4:45 p.m., complete generator load test documentation was recorded until April 2012. A new form was put in use in May 2012. No amperage readings to reflect the load testing was included in the documentation from May 2012 to date. The Facilities Director said at the time of record review, the generator was tested under load weekly but agreed the information required to calculate the load and the actual load percentage was not documented.</p>			

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	<p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to ensure documentation of monthly generator load tests were provided for 8 of the past 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</p>						

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	<p>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. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Emergency Generator Monthly Test Log for the past year with the Facilities Director on 01/24/13 at 4:45 p.m., complete generator load test documentation was recorded until April 2012. A new form was put in use in May 2012. No amperage readings to reflect the load testing was included in the documentation from May 2012 to date. The Facilities Director said at the time of record review, the generator was tested under load weekly but agreed the information required to to calculate the load and the actual load percentage was not documented.</p>			

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	<p>3.1-19(b)</p> <p>Based on record review and interview, the facility failed to ensure documentation of monthly generator load tests were provided for 8 of the past 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</p>			

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	<p>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. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the Emergency Generator Monthly Test Log for the past year with the Facilities Director on 01/24/13 at 4:45 p.m., complete generator load test documentation was recorded until April 2012. A new form was put in use in May 2012. No amperage readings to reflect the load testing was included in the documentation from May 2012 to date. The Facilities Director said at the time of record review, the generator was tested under load weekly but agreed the information required to to calculate the load and the actual load percentage was not documented.</p>			

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