

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2014
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NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 RANDALLIA DR FORT WAYNE, IN 46805
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(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
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/29/14 and 04/30/14</p> <p>Facility Number: 000240 Provider Number: 155349 AIM Number: 100274960</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Saint Anne Home 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 National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building consisting of the three story building and the main entrance/dining room was surveyed with Chapter 19, Existing Health Care Occupancies.</p> <p>The nursing home is a fully sprinklered three story building with a basement of Type II (222) construction, the main entrance/dining room is a one story fully</p>	K010000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K010033 SS=E	<p>sprinklered building of Type V (111) construction and the Rehabilitation unit with a physical therapy gym is a one story fully sprinklered building of Type V (000) construction. The facility has a fire alarm system with smoke detection in the corridors, in areas open to the corridors with battery operated smoke detectors in the resident rooms of the existing building. The facility has a capacity of 168 and had a census of 148 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/05/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building.</p>			

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K010050 SS=C	<p>8.2.5.2, 19.3.1.1</p> <p>Based on observation and interview, the facility failed to maintain 2 of 2 exit stairways in accordance with LSC 7.7.1 and LSC 7.7.2. LSC 7.7.1 requires exits to discharge to the public way or an exterior exit discharge. LSC 7.7.2 allows no more than 50 percent of exits to discharge into an area on the level of exit discharge. This deficient practice could affect any of the 44 residents on the second floor and any of the 45 residents on the third floor in the event of an emergency evacuation.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 04/29/14 at 12:00 p.m. and then again at 12:30 p.m., the southwest stair and northeast stair discharged on to the first floor and not directly to the exterior of the building. This was confirmed by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p> <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</p>	K010033	FSES inspection was conducted by the fire engineer on 5/14/14. The completed FSES report will be done by 5/27/14.	05/27/2014			

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	<p>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>1. Based on record review and interview, the facility failed to include the fire drill location and type of fire for 12 of the last 12 calendar months. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the fire drill forms titled "Emergency Fire/Evacuation Drill" with the Maintenance Director on 04/29/14 at 10:50 a.m., the fire drill documentation did not include the location of the fire drill and the type of fire simulated. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of the last 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on review of the fire drill forms</p>	K010050	1. This was never a requirement in the past. We will start adding this with the next month's drill starting in May 2014.2. We will start varying the 3rd shift times of fire drills starting in June 2014.	05/14/2014

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K010056 SS=E	<p>titled "Emergency Fire/Evacuation Drill" with the Maintenance Director on 04/29/14 at 10:50 a.m., all third shift fire drills for four of the last four quarters took place between 4:00 a.m. and 5:02 a.m. This was confirmed by the Maintenance Director at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>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</p> <p>1. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 1 canopies in accordance with NFPA 13, Standard for Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13-1999 Edition, Section 5-13.8.1</p>	K010056	<p>1. We will replace the canvas canopy with one that is fire resistant. The new unit was ordered 5/14/14 and will be installed the week of June 30, 2014. The old cover will be removed by May 30, 2014.2. A fire sprinkler added to this area 5/8/14.</p>	05/30/2014

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	<p>requires sprinklers shall be installed under exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect any resident evacuated through main entrance.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/29/14 at 1:00 p.m., there was a unsprinklered canvas canopy extending out 10 feet from the building at the main entrance. During the record review process at 11:00 a.m., the Maintenance Director was unable to provided documentation to confirm the canvas canopy was inherently fire resistant.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was provided for 1 of 1 areas outside the office supply closet in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect residents and staff in the front reception area.</p> <p>Findings include:</p>			

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K010062 SS=F	<p>Based on an observation with the Maintenance Director on 04/29/14 at 1:00 p.m., the area outside the office supply closet near the main entrance reception/lounge area lacked sprinkler coverage. Based on an interview with the Maintenance Director at the time of observation, he agreed this area would not have sprinkler coverage.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected and the necessary corrective action shall be taken. This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K010062	<p>1 The sprinkler gauge was replaced and date marked on the gauge The private fire hydrant was inspected by Shambaugh & Sons2 - Maintenance Director or designee will conduct visual inspection of hydrant quarterly 3- Third party vendor will inspect and flow test the hydrant annually and following each use. 4- Results of all inspections will be forwarded to QA Committee for review and recommendation</p>	05/08/2014

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K010064 SS=E	<p>Based on record review and interview with the Maintenance Director on 04/29/14 at 11:09 a.m., he confirmed the last annual inspection of the private fire hydrant located on the north side of the building was conducted by Shambaugh & Sons on 04/15/13.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers near resident room 110 and 1 of 4 third floor fire extinguishers were readily accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, Section 1-6.3 requires fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice could affect 2 of 12 smoke compartments.</p> <p>Findings include:</p>	K010064	We removed the chair that was placed in front of the fire extinguisher and in-serviced staff that they cannot block the fire extinguisher.	05/14/2014
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K010076 SS=D	<p>Based on an observation with the Maintenance Director on 04/29/14 at 12:15 p.m., access to the fire extinguisher near resident room 110 was obstructed by a table and chair. On 04/30/14 at 10:30 a.m. access to the fire extinguisher near the third floor nurses' station was obstructed by wooden table chairs. This was acknowledged by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 5 oxygen cylinders in the oxygen storage/transfilling room was properly restrained. NFPA 99, Section 8-3.1.11.2(h) requires cylinder restraint to meet the requirements of Section 4-3.5.2.1(b)27 which requires</p>	K010076	The small oxygen tanks were put behind the containment chain. C.N.A.'s and nurses were in-serviced to ensure that they always put the tanks behind the containment chain.	05/14/2014

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K010130 SS=E	<p>freestanding cylinders to be chained or supported in a cylinder stand or cart. This deficient practice was not in a resident care area but could affect facility staff personnel.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/29/14 at 1:25 p.m., there was a small unsupported cylinder of compressed oxygen in the oxygen storage/transfilling room. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation, record review and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper</p>	K010130	<p>1. The rolling fire door will be duly inspected and certified by the door contractor. To be completed by 5/30/14.2. The two months of missing paperwork were found and filed with the other monthly check sheets. Completed 5/12/14.</p>	05/30/2014

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	<p>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 could affect approximately 8 residents in the second floor dining room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/29/14 at 2:00 p.m., there was a rolling fire door protecting the opening from the serving kitchen to the second floor dining room in the two hour fire wall. Based on interview with the Maintenance Director during the record review process at the 11:22 a.m. on 04/29/14, the rolling fire door had not been inspected since 07/26/12 by Overhead Door Company.</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review and interview, the facility failed to implement and maintain a preventive maintenance program for battery operated smoke detectors installed in 76 of 76 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by</p>			

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K030000	<p>the Code, shall be maintained. This deficient practice affects any of the 134 residents in the three story Healthcare building.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/29/14 during the tour from 12:00 p.m. to 2:00 p.m. and on 04/30/14 during the tour from 10:30 a.m. to 11:30 a.m., the resident rooms in the three story Healthcare building had battery operated smoke detectors. Based on an interview with the Maintenance Director during the record review process on 04/29/14 at 11:35 a.m., he was unable to provide documentation to confirm a monthly function test was conducted on the battery operated smoke detectors for August and November 2013.</p> <p>3.1-19(b)</p> <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>	K030000		

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	<p>Survey Date: 04/29/14 and 04/30/14</p> <p>Facility Number: 000240 Provider Number: 155349 AIM Number: 100274960</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Saint Anne Home 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 National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC16.2. The Rehabilitation unit and Therapy Gym were surveyed with Chapter 18, New Health Care Occupancies.</p> <p>The nursing home is a fully sprinklered three story building with a basement of Type II (222) construction, the main entrance/dining room is a one story fully sprinklered building of Type V (111) construction and the Rehabilitation unit with a physical therapy gym is a one story fully sprinklered building of Type V (000) construction. The facility has a fire alarm system with smoke detectors in the corridors and in areas open to the corridors with hard wired smoke</p>			
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K030039 SS=E	<p>detectors in the Rehabilitation hall resident rooms. The facility has a capacity of 168 and had a census of 148 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes is at least 8 feet. In limited care facilities and psychiatric hospitals, width of aisles or corridors is at least 6 feet. 18.2.3.3, 18.2.3.4</p> <p>Based on observation and interview, the facility failed to ensure the corridor width for 1 of 2 Rehabilitation Hall corridors was at least eight feet wide. This deficient practice affects any of the 14 residents on the Rehabilitation Hall.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 04/29/14 at 12:25 p.m., the corridor width measured six feet from resident suite E to resident</p>	K030039	FSES inspection was conducted by fire engineer on 5/14/14. The completed FSES report will be done by 5/27/14 to satisfy this deficiency.	05/27/2014

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K030040 SS=E	<p>suite O in the Rehabilitation Hall. This was confirmed based on an interview with the Maintenance Director at the time of the observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type with openings of at least 41.5 inches wide. Doors in exit stairway enclosures are no less than 32 inches in clear width. In ICFs/MR, doors are at least 32 inches wide. 18.2.3.5 Based on observation and interview, the facility failed to ensure 1 of 13 exit doors had a clear width no less than 41.5 inches wide. LSC 18.2.3.5 requires the clear width of doors in the means of egress from nursing homes shall be no less than 41.5 inches. This deficient practice could affect any of the 14 residents on the Rehabilitation Hall in the event of an emergency evacuation.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 04/29/14 at 12:36 p.m., exit door #12 in the path of egress from the Rehabilitation Hall measured thirty six inches. This measurement was provided and confirmed by the Maintenance Director at</p>	K030040	FSES inspection was conducted by the fire engineer on 5/14/14. The report will be done by 5/27/14 to satisfy this deficiency.	05/27/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2014
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NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 RANDALLIA DR FORT WAYNE, IN 46805
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K030050 SS=C	<p>the time of observation.</p> <p>3.1-19(b)</p> <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. 18.7.1.2</p> <p>1. Based on record review and interview, the facility failed to include the fire drill location and type of fire for 12 of the last 12 calendar months. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the fire drill forms titled "Emergency Fire/Evacuation Drill" with the Maintenance Director on 04/29/14 at 10:50 a.m., the fire drill documentation did not include the location of the fire drill and the type of fire simulated. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p>	K030050	<p>1. This was never a requirement in the past. We will start adding this with the next month's drill starting in May 2014.2. We will start varying the 3rd shift times of fire drills starting in June 2014.</p>	05/30/2014
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K030062 SS=F	<p>2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 4 of the last 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review of the fire drill forms titled "Emergency Fire/Evacuation Drill" with the Maintenance Director on 04/29/14 at 10:50 a.m., all third shift fire drills for four of the last four quarters took place between 4:00 a.m. and 5:02 a.m. This was confirmed by the Maintenance Director at the time of record review.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for</p>	K030062	<p>1 The sprinkler gauge was replaced and date marked on the gauge The private fire hydrant was inspected by Shambaugh & Sons2 - Maintenance Director or designee will conduct visual inspection of hydrant quarterly 3-Third party vendor will inspect</p>	05/08/2014

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	<p>the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected and the necessary corrective action shall be taken. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review and interview with the Maintenance Director on 04/29/14 at 11:09 a.m., he confirmed the last annual inspection of the private fire hydrant located on the north side of the building was conducted by Shambaugh & Sons on 04/15/13.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler gauges in the Phase 1 boiler room was tested every five years. NFPA 25, Section 2-3.2 states gauges shall be replaced every five years or tested every five years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect 14 residents in the Rehabilitation Hall.</p>		<p>and flow test the hydrant annually and following each use. 4- Results of all inspections will be forwarded to QA Committee for review and recommendation</p>				

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	<p>Findings include:</p> <p>Based on an observation with the Maintenance Director on 04/29/14 at 12:36 a.m., the sprinkler gauge of the sprinkler riser in the Phase 1 boiler room lacked a calibration or replacement date. Based on an interview with Maintenance Director at the time of observation, he was unable to verify if the sprinkler gauge had been calibrated.</p> <p>3.1-19(b)</p>			