STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING -- B. WING	03/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HANOVER NURSING CENTER	410 W LAGRANGE RD HANOVER, IN 47243

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	. An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/14/18 Facility Number: 000115 Provider Number: 155208 AIM Number: 100291080 At this Emergency Preparedness survey, Hanover Nursing Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 125 certified beds. At the time of the survey, the census was 55. Quality Review completed on 03/19/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0041 SS=C Bldg. --	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors.	E 0041	Deficiency ID: E0041 1. There was no load test documentation for the months of July and August 2017, and January and February 2018. Weekly Generator Inspection sheets lacked record of weekly storage battery tests and weekly	03/30/2018

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

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	Findings include: Based on review of Emergency Generator Monthly Test Log with the maintenance supervisor on 03/14/18 at 10:00 a.m., there was no load test documented for the months of July and August of the year 2017 and January and February for the year 2018 and the Weekly Generator Inspection sheets lacked a record of weekly storage battery tests and weekly inspections of the emergency generator set for the four weeks of July 2017, August 2017, and the first week of September 2017. Based on an interview during record review, the maintenance supervisor stated the facility was without a maintenance supervisor for the above listed months. This was confirmed by the maintenance supervisor at the time of record review.		inspections of the emergency generator for the four weeks of July, August 2017 and first week of September 2017. 2.All residents have the potential to be affected but no actual harm to any resident; Load test documentation for the month of March is up to date. Weekly generator inspections will continue to be ongoing and documented. 3.As a means to ensure ongoing compliance, the Administrator or designee will make sure that weekly and monthly inspections are completed per preventative maintenance schedule. Maintenance Director Educated 4.The audits and any corrective actions taken will be reviewed during the facility's monthly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5.Completion Date: 3/30/18 6.See attachment: A	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/14/18 Facility Number: 000115 Provider Number: 155208 AIM Number: 100291080	K 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The plan of corrections prepared and submitted because of requirement under federal and state laws. Please accept this plan of	

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	At this Life Safety Code survey, Hanover Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA)101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 125 and had a census of 55 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached wooden storage garage and a detached wooden building housing the emergency generator which were not sprinkled. Quality Review completed on 03/19/18 - DA		correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. The documentation serves to confirm the facility's allegation of compliance thus, the facility respectfully requests the granting of paper compliance or desk review. Should additional information be necessary to confirm said compliance, feel free to contact me.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review and interview, the facility failed to ensure 9 of 9 supplemental battery backup lights were provided with a complete written record of monthly tests for 7 of the past 12 months over the past year. LSC 19.2.9.1 requires	K 0291	Deficiency ID: K291 1.The battery backup light monthly/yearly test log lacked monthly tests for July, September, October, November, December	03/30/2018

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	emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on record review on 03/14/18 at 9:45 a.m. with the maintenance supervisor, the Battery Backup Light Monthly/Yearly Test Log for the years 2017 through 2018 listed nine battery backup supplemental lights located throughout the facility and lacked monthly test for July, September, October, November, and December for the year 2017 and January for the year 2018. The lack of a monthly tests on the nine battery backup supplemental lights for July through December of the year 2017 and January of the year 2018 was confirmed by the maintenance supervisor at the time of record review. 3.1-19(b)		2017 and January 2018. 2.All residents have the potential to be affected but no actual harm to any resident; Since February, battery backup light log up to date. 3.As a means to ensure ongoing compliance, the Administrator or designee will make sure that monthly battery backup light inspections are completed. Monthly battery backup light inspections will continue to be ongoing and documented. Maintenance Director Educated 4.The audits and any corrective actions taken will be reviewed during the facility's monthly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5.Completion Date: 3/30/18 6.See Attachment: B	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life			

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	Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of 72 of 72 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect 9 residents who reside on the Old Hall. Findings include: Based on review of the Battery and Smoke Detector Monthly Check sheets on 03/14/18 at 9:45 a.m. with the maintenance supervisor, there were no monthly battery operated smoke detector tests conducted on the seventy two resident room battery operated smoke detectors for June, July, August, September, October, November and December of the year 2017. This was confirmed by the maintenance supervisor at the time of record review. 3.1-19(b)	K 0300	Deficiency ID: K0300 1.The battery and smoke detector monthly checks were not conducted on seventy- two resident rooms for June, July, August, September, October, November and December 2017. 2.9 Residents have the potential to be affected but no actual harm to any resident; Battery and smoke detector monthly checks have been conducted in resident rooms and documented from January 2018 – current. 3.As a means to ensure ongoing compliance, the Administrator or designee will make sure that battery and smoke detector monthly checks are completed. Monthly battery and smoke detector checks will continue to be ongoing and documented. Maintenance Director Educated 4.The audits and any corrective actions taken will be reviewed during the facility's monthly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5.Completion Date: 3/30/18 6.See Attachment: C	03/30/2018
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including			

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	exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure 3 of 7 corridors was provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice affects 32 residents who reside on the Wing 1 Hall and Wing 4 Hall. Findings include: Based on observations on 03/14/18 during a tour of the facility from 9:28 a.m. to 1:15 p.m., the corridor wall on the north side of the corridor next to the smoke barrier door set had a four foot by four foot section of drywall separating from the wall with visible broken drywall on the floor extending from the floor up to four feet on the corridor wall. Based on an interview at the time of observation, the maintenance supervisor indicated the drywall is on the repair list but has not been repaired yet. Furthermore, the Service Hall corridor walls, the Wing 1 Hall corridor walls, and the Wing 4 Hall corridor walls had carpeting installed on the corridor walls extending four feet up from the floor on both sides of the corridor. Based on an interview with the maintenance	K 0331	Deficiency ID: K0331 1.The facility failed to ensure 3 of 7 corridors was provided with a complete interior finish with a flame spread rating of Class A or B for a sprinklered facility. Facility wall near breakroom had broken up drywall along the bottom of wall. 2.32 Residents have the potential to be affected but no actual harm to any resident; Wall has been repaired with new drywall. All carpeted walls being torn down and discarded. Drywall being put into areas where there were carpeted corridors. Expected completion date: April 13, 2018. 3.As a means to ensure ongoing compliance, the Administrator or designee will inspect all walls for any type of wall breakage. Maintenance Director Educated 4.The audits and any corrective actions taken will be reviewed during the facility's monthly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5.Completion Date: 4/13/18 6.See Attachment: D	04/13/2018

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	supervisor at the time of observations, it was stated the facility does not have documentation of the flame spread rating of the corridor wall carpeting. This was confirmed by the maintenance supervisor at the time of observations. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 1 of 4 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated	K 0353	Deficiency ID: K0353 1.The facility failed to ensure 1 of 2 sprinklers in the kitchen dishwashing room which was covered in corrosion, Koorsen Fire Protection scheduled appointment on 4/4/18 for fire alarm inspections and sprinkler inspections. Sprinkler head to be replaced on 4/4/18.	04/04/2018

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	gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observations with the maintenance supervisor on 03/14/18 at 12:10 p.m., the Wing 1 Hall sprinkler riser room had one sprinkler gauge on the dry sprinkler riser with a date of 10/12/12, which is a period over the five year testing or replacement requirement. This was confirmed by the maintenance supervisor at the time of observation. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 sprinklers in the kitchen dishwashing room which was covered in corrosion was replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 37 residents who use the main dining room located adjacent to the kitchen. Findings include: Based on observation on 03/14/18 during a tour of the kitchen with the maintenance supervisor from		2.All residents have the potential to be affected but no actual harm to any resident; Sprinkler head will be replaced on 4/4/18 3.As a means to ensure ongoing compliance, the Administrator or designee will oversee inspection of element, leakage, foreign materials, paint, physical damage, and correct installation of sprinkler heads. Maintenance Director has been educated. 4.The audits and any corrective actions taken will be reviewed during the facility's monthly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5.Projected Completion Date: 4/4/18 6.See Attachment: E	

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	11:00 a.m. to 11:20 a.m., the dishwashing room sprinkler near the automatic dish washer was completely covered in green corrosion. This was confirmed by the maintenance supervisor at the time of observation. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 3 of 6 attic smoke barriers had a minimum of a 1/2 hour fire resistive rating and the penetrations caused by the passage of wire and/or conduit through the smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect 24 residents who reside on the Wing 2 Hall and 8 residents who reside on the Wing 4 Hall. Findings include:	K 0372	Deficiency ID: K0372 1.Facility failed to ensure 3 of 6 attic smoke barriers had a minimum of a ½ hour fire resistive rating and the penetrations caused by the passage of the wire and/or conduit through the smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. The administration hall attic smoke barrier wall had two, six-inch gaps with missing drywall around two flexible duct penetrations, two electrical conduit penetrations, and two	03/30/2018

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	Based on observations on 03/14/18 during a tour of the attic smoke barriers from 12:50 p.m. to 1:15 p.m. with the maintenance supervisor, the following attic smoke barriers had missing drywall or penetrations not fire stopped: a. The Administration Hall attic smoke barrier wall had two, six inch gaps with missing drywall around two flexible duct penetrations, two electrical conduit penetrations, and two sprinkler pipe penetrations not fire stopped. b. The Wing 2 Hall attic smoke barrier wall near the nurses station had three, six inch areas around electrical conduit penetrations and sprinkler pipe penetrations filled with yellow expandable foam. Based on an interview at the time of observation, the maintenance supervisor stated there is no documentation available for review to indicate the flame spread rating of the expandable yellow foam. c. The Wing 4 Hall attic smoke barrier wall had a one quarter inch gap around a sprinkler pipe penetration not fire stopped. This was confirmed by the maintenance supervisor at the time of observations. 3.1-19(b)		sprinkler pip penetrations not fire stopped. Wing 2 had three, six-inch areas filled with yellow expandable foam that did not have flame spread rating. Wing 4 hall attic smoke barrier wall had a one quarter inch gap around a sprinkler pipe penetration not fire stopped. 2.24 Residents have the potential to be affected but no actual harm to any resident; all sprinkler pipe penetrations have been sealed. 3.As a means to ensure ongoing compliance, the Administrator or designee will oversee the inspection of all attic smoke barriers for any penetrations monthly x 3, then quarterly x3, and as needed. Maintenance Director Educated 4.The audits and any corrective actions taken will be reviewed during the facility's monthly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5.Completion Date: 3/30/18 6.See attachment F	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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			

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	routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills on 2 of 3 shifts and 2 of 4 quarters over the past year. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Fire Drill Reports on 03/14/18 at 9:35 a.m. with the maintenance supervisor, there was no record of a fire drill conducted on the second and third shift for the third quarter of the year 2017. Based on an interview with the maintenance supervisor at the time of record review, there are no other records to indicate the missing fire drills had been conducted. This was confirmed by the maintenance supervisor at the time of record review. 3.1-19(b)	K 0712	Deficiency ID: K0712 1.Facility failed to conduct quarterly fire drills on 2 of 3 shifts and 2 of 4 quarters over the past year. 2.All residents have the potential to be affected but no actual harm to any resident; From January 2018, all fire drills have been conducted and documented in maintenance logs. 3.As a means to ensure ongoing compliance, the Administrator or designee will oversee the continuance of fire drills quarterly on each shift, conducted at various times. Maintenance Director Educated. 4. The audits and any corrective actions taken will be reviewed during the facility's monthly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5.Completion Date: 3/30/18 6.See Attachment: G	03/30/2018
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing	K 0761	Deficiency ID: K0761 1.Facility failed to ensure annual inspection and testing of 1 of 1 fire door between wing 3 and 5 hall Assisted Living Suites. There was	03/19/2018

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	fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf.		no inspection and testing documentation within the most recent 12 month period. 2.12 residents have the potential to be affected but no actual harm to any resident; Annual inspection and testing of fire door between wing 3 and 5 has been conducted and documented in maintenance logs. 3.As a means to ensure ongoing compliance, the Administrator or designee will oversee the monthly fire door inspection and testing are conducted. Maintenance Director Educated. 4.The audits and any corrective actions taken will be reviewed during the facility's monthly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5.Completion Date: 3/19/18 6.See Attachment: H	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 01 B. WING	03/14/2018

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	(8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 12 residents who reside on the Wing 3 Hall. Findings include: Based on record review and interview with the maintenance supervisor on 03/14/18 at 10:20 a.m., the facility has one fire barrier door located between the wing 3 Hall and the wing 5 Hall Assisted Living Suites. Furthermore, the maintenance supervisor stated during record review there in no inspection and testing documentation for the Wing 3 Hall to Wing 5 Hall fire barrier door set door opening within the most recent twelve month period. This was confirmed by the maintenance supervisor at the time of record review. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance			

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	and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to exercise the generator for 4 of 12 months over the past year to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at	K 0918	Deficiency ID: K0918 1.Facility failed to exercise the generator for 4 of 12 months over the past year to meet the requirements of NFPA 110, 2010 Edition. There was no load test documented for the months of July and August of the year 2017 and January and February for the year 2018. 2.All residents have the potential to be affected but no actual harm to any resident; Weekly and	03/30/2018

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	not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Emergency Generator Monthly Test Log with the maintenance supervisor on 03/14/18 at 10:00 a.m., there was no load test documented for the months of July and August of the year 2017 and January and February for the year 2018. This was confirmed by the maintenance supervisor at the time of record review. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the emergency generator set was maintained for 9 of the past 52 weeks. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the maintenance supervisor on 03/14/18 at 10:00 a.m., the Weekly Generator Inspection sheets lacked a record of		monthly generator testing has been conducted and documented in maintenance logs for the month of March 2018 to current. 3.As a means to ensure ongoing compliance, the Administrator or designee will oversee weekly and monthly generator testing and document in maintenance log. Maintenance Director Educated. 4.The audits and any corrective actions taken will be reviewed during the facility's monthly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. 5.Completion Date: 3/30/18 6.See Attachment: I	

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	weekly storage battery tests and weekly inspections of the emergency generator set for the four weeks of July 2017, August 2017, and the first week of September 2017. Based on an interview during record review, the maintenance supervisor stated the facility was without a maintenance supervisor for the above listed months. This was confirmed by the maintenance supervisor at the time of record review. 3.1-19(b)			