DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/22/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPLI	(X3) DATE SURVEY COMPLETED	
		345533	B. WIN	G		11/1	7/2011
	ROVIDER OR SUPPLIER DARS OF CHAPEL HII	L L		101	ET ADDRESS, CITY, STATE, ZIP COD GREEN CEDAR LANE APEL HILL, NC 27517		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOU		SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	FO	000			
	The facility is in correquirements of 42 Long Term Care Fa Survey).	mpliance with the CFR Part 483, Subpart B for acilities (General Health		TO THE PERSON NAMED IN COLUMN TO THE			
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To the second se							
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		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.

are es an PRINTED: 12/19/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 01 - THE CEDARS OF CHAPEI A. BUILDING B, WING 12/13/2011 345533 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 101 GREEN CEDAR LANE THE CEDARS OF CHAPEL HILL CHAPEL HILL, NC 27517 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1/16/12 K 017 K 017 NFPA 101 LIFE SAFETY CODE STANDARD K 017 \$\$=E I. What corrective action will be put in Corridor walls form a barrier to limit the transfer of place for the resident(s) identified as having smoke. Such walls are permitted to terminate at been affected by this practice? the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is No actual harm resulted from this practice. required for the corridor walls. 18.3.6.1. 18.3,6.2, 18.3,6.5 The window in the Wellness Clinic will be modified to include side trim and center sweep to maintain appropriate smoke barrier. II. How other residents having the potential to be affected by this practice will be This STANDARD is not met as evidenced by: identified and what corrective action will Based on observation on Tuesday 12/13/2011 take place? between 11:15 AM and 3:30 PM the following was noted: This practice had the potential to affect all 1) The window in the Wellness Clinic that open Members. Corrective action is mentioned into the exit corridor does not close smoke tight. above. 42 CFR 483.70 K 018 NFPA 101 LIFE SAFETY CODE STANDARD K 018 III. What measures will be put in place to SS≃D ensure the practice does not recur? Doors protecting corridor openings are constructed to resist the passage of smoke. Inspection of sliding glass windows will be Doors are provided with positive latching added as part of the routine preventative hardware. Dutch doors meeting 18.3.6.3.6 are maintenance checks which occur on a monthly permitted. Roller latches are prohibited. basis. See Exhibit D. 18.3.6.3 IV. How will the corrective action be monitored? Director of Plant Services to review the PM This STANDARD is not met as evidenced by: checks once they are completed and perform Based on observation on Tuesday 12/13/2011 on-going spot checks of sliding glass between 11:15 AM and 3:30 PM the following windows.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

1) The corridor door to resident room 31 did not

2) The corridor door to the dinning room next to

TITLE

(X8) 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 other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the shove findings and plans of correction are disclosable 14 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.

close smoke tight.

		I AND HUMAN SERVICÉS & MEDICAID SERVICES				PRINTED: FORM A OMB NO.	\PPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION 01 - THE CEDARS OF CHAPE	(X3) DATE SU COMPLET	RVEY (ED
	•	345533	B. WIN	IG		12/13	/2011
	ROVIDER OR SUPPLIER DARS OF CHAPEL HI	LL		101	ET ADDRESS, CITY, STATE, ZIP CODE I GREEN CEDAR LANE IAPEL HILL, NC 27517		
(X4) ID PREFIX TAG	ARACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	COMPLETION DATE
K 017 SS=E	Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at		K 017)17	K 018 I. What corrective action will be place for the resident(s) identifiation affected by this practice?	ntified as having	
	the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is				No actual harm resulted from this practice.		
	required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following was noted:					oor for resident room 31 was adjusted paired to close properly on 12/15/11. Chibit A.	
					Install center astragal on corridor doors by resident room 12. Additionally, all corridor doors will be inspected and modified accordingly to ensure they resist the passage of smoke. II. How other residents having the potential to be affected by this practice will be		
	1) The window in the Wellness Clinic that open into the exit corridor does not close smoke tight. 42 CFR 483.70 NFPA 101 LIFE SAFETY CODE STANDARD	K 018	(018	identified and what corrective a take place? This practice had the potential to Members. Corrective action is me	nffect all	-	
SS≍D	Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching			above.			
				III. What measures will be put in ensure the practice does not rec			
	hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011			Inspection of resident room doors doors is part of the routine preven maintenance checks which occur and quarterly basis respectively. A will be made as needed. See Exhi	and corridor tative on a monthly Adjustments		
				IV. How will the corrective actimonitored?			
	between 11:15 AM and 3:30 PM the following was noted: 1) The corridor door to resident room 31 did not close smoke tight. 2) The corridor door to the dinning room next to				Director of Plant Services to revie checks once they are completed a on-going spot checks of resident a and corridor doors.	nd perform	No. of the latest states and the latest stat
LABORATOR	1	DERVSUPPLIER REPRESENTATIVE'S SIG	NATURE		TIYLE		(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.

Facility ID: 001203

If continuation sheet Page

PRINTED: 12/19/2011

		AND HUMAN SERVICES					APPROVED
		& MEDICAID SERVICES				OMB NO.	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE CEDARS OF CHAPE			(X3) DATE SU COMPLET	(ED
	•	345533	B. WI	1G	· · · · · · · · · · · · · · · · · · ·	12/13	3/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	•	
THE CED	ARS OF CHAPEL HI	.L			11 Green Cedar Lane Hapel Hill, NC. 27517		
		<u> </u>			PROVIDER'S PLAN OF CORRECT	TION	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
K 018	Continued From pa	-	K	018	<u>K 054</u>		1/16/12
	resident room 12 did not close smoke tight. 42 CFR 483.70		17.	025	I. What corrective action will be put in place for the resident(s) identified as having		
K 025	•	FETY CODE STANDARD	V.	J20	been affected by this practice?		
	least a one-hour fire	constructed to provide at e resistance rating in			No actual harm resulted from this p	practice.	
	accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3				The smoke duct detectors in the attic area will be cleaned and in good condition by the fire alarm vendor. Additionally, all smoke duct detectors in the attic will be inspected and cleaned, if necessary.		
					II. How other residents having the to be affected by this practice will identified and what corrective actake place?	ll be	
					This practice had the potential to a Members. Corrective action is men above.		:
	This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following				III. What measures will be put in ensure the practice does not recu		
	between North and penetrations in the order to maintain th	ocated in the attle area South unit has holes and wall that were not sealed in e required rating of the wall.	·		Fire alarm vendor will begin inspectioning the sampling tube for the detectors as part of the required an inspection.	smoke duct	
K 054 SS≂F	· ·	FETY CODE STANDARD	Ķ	054	IV. How will the corrective actio monitored?	n be	
	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3		·		Director of Plant Services will revi- results of the required annual inspe Additionally, a visual inspection by staff will be completed once the ve- completed their service. See Exhibit	ction. / facility ndor has	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** 01 - THE CEDARS OF CHAPEL A. BUILDING B. WING 12/13/2011 345533 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 101 GREEN CEDAR LANE THE CEDARS OF CHAPEL HILL CHAPEL HILL, NC 27517 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID. (X4) ID EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 056 116/12 I. What corrective action will be put in place K 054 K 054 Continued From page 2 for the resident(s) identified as having been affected by this practice? This STANDARD is not met as evidenced by: -No actual harm resulted from this practice. Based on observation on Tuesday 12/13/2011 -Inspection of all sprinkler heads in the SNF between 11:15 AM and 3:30 PM the following indicate that intermediate sprinkler heads are was noted: used when within 12-24 inches of a hot air 1) The smoke duct detectors in the attic area diffuser, NFPA 13 (Table 8.3.2.5(c)) indicates tocated in the HVAC units were not clean and that intermediate-temperature sprinkles are maintained in good condition. appropriate 12-24 inches from a hot air 42 CFR 483.70 diffuser (Exhibit M). The Cedars has K 056 NFPA 101 LIFE SAFETY CODE STANDARD K 056 contacted the NC Office of the State Fire Marshal for guidance on NFPA 13 and the use SS=F There is an automatic sprinkler system, installed of intermediate sprinkler heads. Additionally, In accordance with NFPA 13, Standard for the The Cedars has asked the general contractor Installation of Sprinkler Systems, with approved of the construction as well as the contractor components, devices, and equipment, to provide who installed the sprinklers to determine why complete coverage of all portions of the facility. GREEN sprinkler heads where use (i.e. The system is maintained in accordance with directive from fire marshal, Town of Chapel NFPA 25, Standard for the Inspection, Testing, Hill, etc.) and Maintenance of Water-Based Fire Protection -Once a determination has been made. The Systems. There is a reliable, adequate water Cedars will change all necessary sprinkler supply for the system. The system is equipped heads to be in compliance with NFPA 13. with waterflow and tamper switches which are II. How other residents having the potential connected to the fire alarm system. 18.3.5. to be affected by this practice will be identified and what corrective action will take place? This practice had the potential to affect all Members. Corrective action is mentioned III. What measures will be put in place to ensure the practice does not recur? This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 Once a determination has been made. between 11:15 AM and 3:30 PM the following sprinkler heads will be changed as necessary was noted: and no further measures will need to be taken. 1) Throughout the facility there are sprinkler IV. How will the corrective action be heads in the facility rated for Intermediate monitored? Temperature Classification, Glass Bulb Color of Once all necessary sprinkler heads have been Green temperature rating of (200°F) in place of changed, the Director of Plant Services will Ordinary Temperature Classification, Glass Bulb audit all sprinkler heads to verify appropriate

heads were used

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upon activation of fire alarm.

1) Two of the smoke dampers located in the attic

between North and South Units dld not close

was noted:

monitored?

the smoke dampers.

Director of Plant Services will review the results of the required annual inspection and

the annual inspection of access locations for

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345533		IDENTIFICATION NUMBER:	A, BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE CEDARS OF CHAPE		(X3) DATE SURVEY COMPLETED	
		B. WIN			12/1	13/2011	
	PROVIDER OR SUPPLIER DARS OF CHAPEL HI	.L		10	EET ADDRESS, CITY, STATE, ZIP CODE D1 GREEN CEDAR LANE HAPEL HILL, NC 27517		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 056	Color of Red (155°F). 42 CFR 483.70		K 056 K 067		I. What corrective action will be put in place for the resident(s) identified as		1/16/12
K 067 SS≖D	NFPA 101 LIFE SAFETY CODE STANDARD			10 /			
	Based on observation between 11:15 AM was noted: 1) One of three HVA dampers located in South Unit was not that would allow for 2) HVAC unit 5 for tupon activation on the second secon	s not met as evidenced by: on on Tuesday 12/13/2011 and 3:30 PM the following AC units containing smoke the attic between North and provided with an access door inspection and maintenance, he kitchen did not shut down he fire alarm.	·		thermostats will be replaced. Se J. II. How other residents having potential to be affected by this will be identified and what con action will take place? This practice had the potential to Members. Corrective action is mabove.	e Exhibit ; the practice rective	·
K 104 SS=F		FETY CODE STANDARD ke barriers by ducts are unce with 8.3.6.	K 1		III. What measures will be put to ensure the practice does not The fire alarm vendor will inspe smoke dampers as part of the recannual inspection.	recur? ct the	
	Based on observati between 11:15 AM a was noted: 1) Two of the smoke	not met as evidenced by; on on Tuesday 12/13/2011 and 3:30 PM the following dampers located in the attic South Units did not close e alarm.			IV. How will the corrective ac monitored? Director of Plant Services will re results of the required annual ins	view the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-0391					
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING 01 - THE CEDARS OF CHAP			COMPLETED				
		·. 345533	B. WI	ИG		12/13	3/2011		
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE				
THE CEL	DARS OF CHAPEL HI	L4L		101 GREEN CEDAR LANE CHAPEL HILL, NC 27517					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		ULD BE	(X5) COMPLETION DATE		
K 104		ge 4	K.	104	<u>K 144</u>		1/16/12		
K 144 SS=D	NFPA 101 LIFE SA	12 CFR 483.70 NFPA 101 LIFE SAFETY CODE STANDARD		144	I. What corrective action will place for the resident(s) iden- having been affected by this				
	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/13/2011 between 11:15 AM and 3:30 PM the following was noted: 1) An annual generator load bank test has not been conducted on the facility. Facility at the time of the survey could not provide documentation indication that an annual load bank is not required. 42 CFR 483.70				No actual harm resulted from this practice. The annual generator load bank test was performed on 11/3/2011 for both generators. See Exhibits K & L.				
				-					
					A. How other residents havin potential to be affected by thi will be identified and what co action will take place?	s practice			
· · · · · · · · · · · · · · · · · · ·					This practice had the potential to Members. Corrective action is a above.				
•					III. What measures will be puto ensure the practice does no				
					The annual generator load bank tests were completed as necessary and are scheduled yearly to ensure compliance.				
					IV. How will the corrective as monitored?	ction be			
					Director of Plant Services will r results of the required annual in				
	. 4 A - 1								