

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

AMENDED ACCEPT
FOC

PRINTED: 03/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345529	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/10/2011
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NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/NORTH RALEIGH	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616
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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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F 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff and physician interview, the facility failed to provide psychological services for 1 of 1 sampled resident needing psychological services. (Resident # 4)</p> <p>Findings include:</p> <p>Resident #4 was admitted to the facility on 2/10/10. Diagnoses included Depression Disorder, recurrent severe with psychotic features and history of Subarachnoid Hemorrhage/ motor vehicle accident 2003.</p> <p>Review of a NN (Nurses Notes) dated 2/9/11 9:00am revealed the resident had an episode of increased anxiety. Vital signs were temperature 98.4, pulse 102, blood pressure 128/82 and respirations were 24. The physician was notified and a new order received to give an extra dose of Zyprexa (antipsychotic medication) and to get a psychiatric consult.</p> <p>A review of the physician order revealed an order dated 2/9/11 that read; "give extra 5mg of Zyprexa now. Psychiatrist consult." This order was signed by the physician.</p>	F 250	<p>Resident #4 was seen by Paradigm on 03/08/11</p> <p>An audit of active charts was completed on 03/16/11 by Social Worker to ensure no New orders for psych services had been written and appropriately implemented. None were found.</p> <p>Orders will be reviewed by Director of Nursing, MDS coordinator, Dietary Manager, and Social Worker in morning meeting five days a week</p> <p>Resident Lason/Social Worker have been counseled by Administrator on 03/16/11 for failure to follow up on referral for Paradigm.</p> <p>Psych services audit will be conducted by Director of Nursing/ designee five times a week for 4 weeks and then three times a week for four weeks and then monthly times three months.</p> <p>Findings will be reported to the Quality Assurance Committee monthly times three months.</p>	3/21/11
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mabelle Baldwin</i>	TITLE Administrator	(X6) DATE 3/31/11
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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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F 250	<p>Continued From page 1</p> <p>A review of the social work progress notes revealed no documentation that the order for a psychiatric consult had been completed. An interview with the social worker on 3/10/11 at 2:30pm revealed she was unaware of the physician order for a referral on 2/9/11.</p> <p>A review of the NN dated 2/18/11 at 3:00pm documented the physician was notified of a conversation between the resident and the social worker where the resident stated she had thoughts of harming her self. The NN indicated that the physician did not feel the resident was a threat to self or others at this time and a new order was received. The new order was to increase Zyprexa to 5mg twice a day and Xanax 0.25mg by mouth every 6 hours as needed. A family member was notified of the residents thoughts; the physician order for medication change and referral for a psychiatric consults. A review of the MAR (medication administration record) for February 2011 revealed the resident was receiving Zyprexa 5mg dally from 2/1/11 through 2/17/11.</p> <p>A review of the physician orders revealed an order dated 2/18/11 that read 1. increase Zyprexa to 5mg by mouth twice a day, 2. Xanax 0.25mg by mouth every 6 hours as needed, 3. contact phychiatric services for follow up. This order was signed by the physician.</p> <p>A review of the social work progress notes revealed an entry dated 2/18/11(no time) that read; "resident is alert and oriented x2 with STM (short term memory) deficits AEB (as evidenced by) not being able to recall SW (social worker) name, not able to recall month/year and need cues on BIMS (brief interview for mental status).</p>	F 250		

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F 250	<p>Continued From page 2</p> <p>For the last 2 weeks resident expressed she feels down/depressed, tired, poor appetite, feel bad about herself and thought about better off being dead all related to wanting to go home. see her house, can't help family, granddaughter sick and wants to walk. Both SW's spoke with resident after comment and still no change in answer. Staff MD (medical doctor) notified. MD feels confident that resident will not harm herself, to contact psychiatric services and increase psychiatric medications. Resident continues resting in bed." No further entries in social worker progress notes.</p> <p>A review of the quarterly MDS (Minimum Data Set) dated 2/18/11 revealed Resident #4 was able to understand what others said to her and was able to make her self understood by others. The residents cognitive patterns were severely impaired. The MDS section titled Mood revealed the resident had thoughts of being better off dead, or of hurting herself nearly every day.</p> <p>On 3/9/11 at 3:32pm an interview with the resident liaison (social worker) revealed that she made a referral for a psychiatric referral after the physician ordered one on 2/18/11. She stated that "maybe last week the referral was returned because the wrong family member had signed the form." When asked if she followed up on the referral the SW responded "no" she (resident#4) is depressed and that will not change she will always be that way".</p> <p>3/10/11 8:50am an interview with the resident revealed that some one came in the other day and spoke with her. She indicated that she enjoyed the conversation and that the lady was</p>	F 250		
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F 250	<p>Continued From page 3</p> <p>going to come and talk with her again. "It is nice to have some one to talk to. The SW comes in occasionally but not very often. The resident was sitting in her wheel chair and was neatly groomed.</p> <p>On 3/10/11 at 11:00am an interview with the nurse practitioner from the psychiatric service revealed she had not seen the resident since she had the breakdown last year. When asked what the resident was like she responded that she had a traumatic brain injury from a MVA(motor vehicle accident) and that she was unpredictable. Further discussion revealed that she just received a referral to follow up with her again; she indicated she just manages the medication and the therapist is a different person.</p> <p>3/10/11 an interview with the physician at 2:00pm revealed he checked in on the resident when ever he was in the building to see how she was. He remembers how she looked when she had a major break down last year and had to be hospitalized in the behavior unit. She was delusional and hallucinating she kept seeing her dead husband in her room. She was not like that this time I keep watching her eyes for that look she had last year and it was not there. I increased her medications and ordered a consult for her. When asked if he was aware that the first consult on 2/9/11 had not been done he said "no". When discussing the consult ordered on 2/18/11 he was unaware that she had not been seen until 3/8/11. The doctor stated his expectations would be that the nurse's would follow his orders.</p> <p>3/10/11 at 2:30pm an interview with the DON revealed all physician orders are reviewed on the</p>	F 250		

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F 250	Continued From page 4 following day during daily staff meeting. Also the nurse taking a referral order contacts the appropriate person to follow up on the referrals. The social worker entered the room and stated "I did not know about that referral on the 9th."	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide measurable objectives to meet a residents psychosocial needs for 1 of 1 sampled resident with psychosocial needs. (Resident #4) Findings include: Findings include:	F 279	^{F 279} Resident #4 's care plan was updated on 03/16/11 to reflect current condition and interventions that are in place for her care. Measurable goals have been added to current care plan. Resident Liason/Social Worker were inserviced on writing care plans with measurable goals on 03/16/11 for current charts.. Ten charts will be audited on care plans weekly at Standards Of Care meeting by MDS and/or Social Worker to identify any other care plans that are needing to be updated with measurable goals by April 20, 2011. Ten audits will be completed by Director of Nursing and/or designee weekly times four weeks then monthly times three months to ensure compliance. Findings will be reported to the Quality Assurance Committee monthly times three months.	3/21/11

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F 279	<p>Continued From page 5</p> <p>Resident #4 was admitted to the facility on 2/10/10. Diagnoses included Depression Disorder, recurrent severe with psychotic features and history of Subarachnoid Hemorrhage/ motor vehicle accident 2003.</p> <p>A review of the social work progress notes revealed an entry dated 2/18/11(no time) that read; "resident is alert and oriented x2 with STM (short term memory) deficits AEB (as evidenced by) not being able to recall SW (social worker) name, not able to recall month/year and need cues on BIMS (brief interview for mental status). For the last 2 weeks resident expressed she feels down/depressed, tired, poor appetite, feel bad about herself and thought about better off being dead all related to wanting to go home. see her house, can't help family, granddaughter sick and wants to walk. Both SW's spoke with resident after comment and still no change in answer. Staff MD (medical doctor) notified. MD feels confident that resident will not harm herself, to contact psychiatric services and increase psychiatric medications. Resident continues resting in bed."</p> <p>A review of the quarterly MDS (Minimum Data Set) dated 2/18/11 revealed Resident #4 was able to understand what others said to her and was able to make her self understood by others. The residents cognitive patterns were severely impaired. The MDS section titled Mood revealed the resident had thoughts of being better off dead, or of hurting herself nearly every day.</p> <p>A review of a care plan dated 2/18/11 revealed a problem STM (short term memory) deficit AEB (as evidence by) forgetfulness and unsafe</p>	F 279		
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F 279	Continued From page 6 decision making, repetitive anxious complaints regarding family issues. Stated feelings of feeling better off dead, but would not harm self. There were 3 identified goals. The first goal was "Respond to question/statement with appropriate verbalization x 90 days." The second goal was "Display logical progression of thought by making safe decisions thru next review." The third goal was "Will be receptive to areas of compromise to address feelings of unhappiness and conflict thru next review." On 3/9/11 at 3:32pm an interview with the resident liaison (social worker) responsible for writing the care plan confirmed the goals written were not measurable.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview, the facility failed to implement interventions related to a problem for feeling of being better off dead for 1 of 1 sampled resident with these feelings. (Resident #4). Findings include: Findings include: Resident #4 was admitted to the facility on 2/10/10. Diagnoses included Depression Disorder, recurrent severe with psychotic features and history of Subarachnoid Hemorrhage/ motor	F 282		

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F 282	<p>Continued From page 7 vehicle accident 2003.</p> <p>A review of a care plan dated 2/18/11 revealed a problem STM (short term memory) deficit AEB (as evidenced by) forgetfulness and unsafe decision making, repetitive anxious complaints regarding family issues. Stated feelings of feeling better off dead, but would not harm self. Interventions listed included; brief visits for interaction, consult with ----- (name of phycological services on changes. and socialization and provide social support and reassurance. These interventions were to be provided by social services department.</p> <p>A review of the social work progress notes revealed an entry dated 2/18/11(no time) that read; "resident is alert and oriented x2 with STM (short term memory) deficits AEB (as evidenced by) not being able to recall SW (social worker) name, not able to recall month/year and need cues on BIMS (brief interview for mental status). For the last 2 weeks resident expressed she feels down/depressed, tired, poor appetite, feel bad about herself and thought about better off being dead all related to wanting to go home. see her house, can't help family, granddaughter sick and wants to walk. Both.SW's spoke with resident after comment and still no change in answer. Staff MD (medical doctor) notified. MD fells confident that resident will not harm herself, to contact psychiatric services and increase psychiatric medications. Resident continues resting in bed." No further entries in social worker progress notes.</p> <p>A review of the quarterly MDS (Minimum Data Set) dated 2/18/11 revealed Resident #4 was able to understand what others said to her and</p>	F 282	<p>F-282</p> <p>Resident #4 was seen by Paradigm on 03/08/11</p> <p>An audit of active charts was completed on 03/16/11 by Social Worker to ensure no New orders for psych services had been written and appropriately implemented. None were found.</p> <p>Orders will be reviewed by Director of Nursing, MDS coordinator, Dietary Manager, and Social Worker in morning meeting five days a week</p> <p>Resident Liason/Social Worker have been counseled by Administrator on 03/16/11 for failure to follow up on referral for Paradigm.</p> <p>Psych services audit will be conducted by Director of Nursing/ designee five times a week for 4 weeks and then three times a week for four weeks and then monthly times three months.</p> <p>Findings will be reported to the Quality Assurance Committee monthly times three months.</p>	3/21/11
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NAME OF PROVIDER OR SUPPLIER

UNIVERSAL HEALTH CARE/NORTH RALEIGH

STREET ADDRESS, CITY, STATE, ZIP CODE

5201 CLARKS FORK DRIVE

RALEIGH, NC 27616

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F 282	<p>Continued From page 8</p> <p>was able to make her self understood by others. The residents cognitive patterns were severely impaired. The MDS section titled Mood revealed the resident had thoughts of being better off dead, or of hurting herself nearly every day.</p> <p>On 3/9/11 at 3:32pm an interview with the resident liaison (social worker) revealed that she made a referral for a psychiatric referral after the physician ordered one on 2/18/11. She stated that "maybe last week the referral was returned because the wrong family member had signed the form." When asked if she followed up on the referral the SW responded "no" she (resident#4) is depressed and that will not change she will always be that way".</p> <p>3/10/11 8:50am an interview with the resident revealed that some one came in the other day and spoke with her. She indicated that she enjoyed the conversation and that the lady was going to come and talk with her again. "It is nice to have some one to talk to. The SW comes in occasionally but not not very often. The resident was sitting in her wheel chair and was neatly groomed.</p> <p>On 3/10/11 at 11:00am an interview with the nurse practitioner from the psychiatric service revealed she had not seen the resident since she had the breakdown last year. When asked what the resident was like she responded that she had a traumatic brain injury from a MVA(motor vehicle accident) and that she was unpredictable. Further discussion revealed that she just received a referral to follow up with her again; she indicated she just manages the medication and the therapist is a different person.</p>	F 282		

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K 029 SS=D	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 This STANDARD is not met as evidenced by: Surveyor: 08661 42 CFR 483.70(a) By observation on 4/1/11 at approximately noon the hazardous area was non-compliant, specific findings include wedge under the door to the central supply storage room.	K 029	K 029 A magnetic door holder device that will release upon activation of the fire alarm will be installed on the central supply door. The maintenance director will in-service all staff having an office with a self closing device concerning blocking open the door or restricting its closure in any way. All storage room doors will be monitored as part of the maintenance directors daily morning rounds. Door inspection findings have been added To the monthly safety committee agenda for compliance. A magnetic door holder for the central supply door will be installed by May 2 nd 2011. The in-service for staff concerning the restriction of doors will be completed April 15 th 2011.	5/2/11
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Surveyor: 08661 42 CFR 483.70(a) By observation on 4/1/11 at approximately noon the following exit discharge illumination was	K 045	K 045 A two bulb light fixture was installed at the Exit near the laundry. All exits will be checked for proper two bulb Fixtures. All exit fixtures will be checked monthly, and the findings will be recorded on the monthly generator test form.	5/2/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Michele Baedert TITLE Administrator (X6) DATE 4/11/11

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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NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/NORTH RALEIGH	STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27616
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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)	(X6) COMPLETION DATE
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K 045	Continued From page 1 observed as noncompliant: specific findings include a single bulb fixture at the exit near laundry. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.	K 045	<i>cont.</i> The monthly generator test inspection sheet will be included for approval by the safety committee, and added to the safety committee agenda minutes. The light fixture near the laundry room exit was replaced April 6 th 2011. To the correct two bulb fixture.	5/2/11
K 050 SS=D	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 This STANDARD is not met as evidenced by: Surveyor: 08661 42 CFR 483.70(a) By document review on 4/1/11 at approximately noon the following fire drills were noncompliant, specific findings include the last four fire drills on third shift for 2010 were held between 11:00 PM and 12:15 AM only. Fire drills are to be held at unexpected times.	K 050	K 050 Fire drills for third shift will be held at a wider range of unexpected times. An annual fire grid will be planned out in advance to include all shifts. Drills will be scheduled at unexpected times on all shifts. The third shift supervisor will be inserviced on conducting fire drills and utilized on the scheduled dates. The annual fire drill grid of scheduled dates, shifts and times will be given to the safety committee for approval and added to the safety committee minutes. The safety committee meets on April 18 th 2011. the third shift supervisor will be in-serviced before the safety committee meeting concerning conducting the scheduled drills.	5/2/11
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard	K 056		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345529	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2011
NAME OF PROVIDER OR SUPPLIER UNIVERSAL HEALTH CARE/NORTH RALEIGH			STREET ADDRESS, CITY, STATE, ZIP CODE 5201 CLARKS FORK DRIVE RALEIGH, NC 27816	
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K 056	Continued From page 2 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	K 056	K 056 The correct distance of clearance to the sprinkler heads will be Maintained. The top shelf has been removed from under the sprinkler head in the freezer. A wire Barrier will be mounted inside the freezer 20" Away from the sprinkler head as a reminder And a barrier not to cross. All storage areas will be inspected For any other sprinkler head clearance Violations.	5/2/11
K 144 SS=D	This STANDARD is not met as evidenced by: Surveyor: 08661 42 CFR 483.70(a) By observation on 4/1/11 at approximately noon the automatic sprinkler system was non-compliant, specific findings include storage within 18" of the sprinkler head in the freezer area. 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. This STANDARD is not met as evidenced by: Surveyor: 08661	K 144	The dietary staff will be in-serviced by the Kitchen manager on the sprinkler head clearance standards. All storage areas will be inspected monthly By the maintenance director and findings Of the inspection will be added to the Safety committee Agenda and minutes. The dietary staff will be in-serviced by April 15 th 2011. The post will be mounted To the Inside of the freezer by April 15 th 2011.	

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K 144	<p>Continued From page 3 42 CFR 483.70(a) By observation on 4/1/11 at approximately noon the following operational inspection and testing was non-compliant. Specific findings include: documentation for monthly load test was conducted without recording percent rated load or temperature rise. A load bank test had not been completed within the past year.</p> <p>NFPA 99 3-4.4.2 Recordkeeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p> <p>NFPA 110 6-4.2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>NFPA 110 6-4.2.2 (1999 edition) Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPPS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. (load bank testing)</p>	K 144	<p>K 144</p> <p>The emergency generator was load Tested to meet the requirements of NFPA 110 6-4.2.2 (1999) edition.</p> <p>A new monthly and weekly generator Test form has been implemented to Include a more extensive check list,</p> <p>A contract has been signed with a licensed Generator maintenance company to Include a 2 hour load bank test annually:</p> <p>The date of the load bank test will be entered Into the minutes of the safety committee Agenda and followed up with on the month Following the testing. The load bank test Results will be kept in the maintenance Directors maintenance log.</p> <p>The load bank test was performed April 6th 2011 By National Power Corporation.</p>	5/2/11