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

11/8/12

PRINTED: 10/31/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345104	A. BUILDING ______ B. WING ______	C 10/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING & REHABILITATION-ZEBULON	509 W GANNON AVE ZEBULON, NC 27597

(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
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of maintenance records, the facility failed to clean the heating systems in resident rooms(101, 102, 106, 108,107,109, 111, 112, 113, 114, 115,116, 117, 202,204, 205,206,207, 203, 209, 211, 214, 216, 212). The facility failed to repair the damaged wheelchair for 1 of 1 resident (Resident #138). The findings included: During initial tour on 10/15/12 at10:00AM, observations in the following rooms(202,204, 205,206,207, 203, 209, 211, 214, 216, 212, 101, 102, 106, 108,107,109, 111, 112, 113, 114, 115,116, 117) had a large volume of heavy build of gray dirt/dust on the front panels of the heating systems The heat was on and gray dirt/dust blowing throughout the room. There were two housekeepers present on the halls, but neither staff cleaned the heating system in the rooms Follow- up observations was done of resident rooms heating systems on10/17/12 at 9:20AM through 9:31AM, the heating systems remained in the same conditon and the dirty/dusty continued to blow throughout the rooms. During an observation on 10/17/12 at 9:22AM, HK#1(housekeeper) indicated that the HK	F 253	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F253 1. The front panels of the heating vents in rooms 101, 102, 106, 108, 107, 109, 111, 112, 113, 114, 115, 116, 117, 202, 204, 205, 206, 207, 203, 209, 211, 214, 216 and 212 were cleaned removing any gray dirt/dust. Resident #138 was provided a wheelchair in good repair without missing tire material, functioning brakes and secured arm rests. 2. ED will conduct room to room observations to compile a list of heating vents in need of cleaning and wheel chairs in need of repair. 3. ED will in-service Housekeeping staff to include cleaning of vents when cleaning resident rooms. ED will in-service Maintenance Director regarding wiping down units weekly, cleaning filters monthly and quarterly cleaning with non-acid coil cleaner. ED will in-service staff if they note resident equipment is in need of repair to replace the equipment, if possible, and complete a work order form for repair of the wheelchair. ED will validate heating units, identified on initial audit, are cleaned. ED will	11/06/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Taslem Ahmd	Administrator	11/06/12

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 253	Continued From page 1 responsiblilities included wiping down the light fixtures, cleaning bathrooms, sink, sweeping mopping, maintenance department responsible for cleaning and changing the filters on the heating system. HK#1 did not clean or wipe down any of the heating system for the following rooms that were observed rooms 101, 102, 104. During an observation on 10/17/12 at 9:38AM, the Maintenace director toured resident rooms on both halls and swiped his fingers across the front panel of the heating system and acknowledged there was gray dirty/dusty matter in the groves of the panels. Maintenance director ackowledged that the dirty/dusty panels could be observed from the hall area of resident rooms. The maintenance director stated that housekeeping staff was responsible for cleaning the front panels/groves on a daily basis and maintenance did the deep cleaning of the entire system on a quarterly basis, which would include filters/coils. The weekley P-Tac cleaning and maintenance logs were reviewed revealed that the last cleaning and vacumed was done on 8/8/12. During an observation on 10/17/12 at 9:51AM, HK supervisor, HK#2 and maintenance director tour resident rooms . HK manager swiped fingers across the front panels and groves of the heating systems and acknowledge there was gray built up of dirt/dust present. The HK supervisor stated that the housekeeping staff was expected to clean the front panels of the heating systems on a daily basis when they were doing there general housecleaning. HK manager acknowledged that the system needed to be cleaned. During a a follow-up interview on 10/18/12 at	F 253	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* validate wheelchair in need of repair, identified on initial audit, are repaired or replaced. ED or designee will audit three heating units and three wheelchairs weekly to validate they are clean and in good repair. 4. Results of audits will be presented to center's Performance Improvement Committee monthly for a minimum of three months. Performance Improvement Committee will review and evaluate audit results making further recommendations as needed. Performance Improvement Committee will determine need for ongoing monitoring beyond the three month minimum to ensure ongoing compliance is maintained.	11/06/12

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F 253	Continued From page 2 8:30AM, the HK supervisor, indcated that there was a 7 step cleaning process that the housekeeping staff was responsible for when cleaning resident rooms. HK supervisor indicated that all the housekeeping staff was in-serviced on the expecations of the daily cleaning of resident rooms and the heating systems. During an interview on 10/18/12 at 2:15PM, the administrator indicated that the housekeeping staff has been in-service on the expectation of cleaning resident rooms. Review of the weekly P-Tac cleaning and maintenance log identifies the room number work description, date and intitials. The bottom of the sheet revealed the units should be wiped down weekly, filters should be cleaned monthly and the units should be removed quarterly and cleaned with non-acid coil cleaner. Review of the log from 4/28/12 through 8/8/12 revealed that 8/8/12 was the last logged date the P-Tac were cleaned and vacuumed. 2. Resident #138 was admitted to the facility 9/25/12. Review of his minimum data set assessment dated 10/2/12 revealed he had no behaviors or cognitive impairments. During the initial tour of the facility on 10/15/12 at 9:30 AM resident #138 complained that his wheelchair was in poor repair and that he had told the rehab staff but no one had done anything. The wheelchair was noted to be missing large pieces of tire material in multiple locations on both tires. The left brake was loose when engaged and the right arm rest was not secured and easily lifted away from the chair.	F 253		

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F 253	Continued From page 3 On 10/17/12 at 10:45 AM the Rehab Director was interviewed and indicated she was not aware of any concerns with resident #138 ' s wheelchair. She said the rehab department was responsible for the assignment of wheelchairs but she was unaware of who assigned resident #138 his chair. The wheelchair was observed by the Rehab Director and she indicated the wheelchair should not have been assigned to a resident. She said it was the responsibility of all staff to report maintenance concerns to the Maintenance Director. On 10/17/12 at 10:50 AM the Maintenance Director indicated he was not aware of any concerns with the wheelchair assigned to resident #138. He said he routinely spot checked the chairs but he depended on staff to report concerns with the wheelchairs. On 10/17/12 at 10:55 AM the Director of Nursing observed the wheelchair and indicated she would not have expected the wheelchair to be assigned to any resident. She said it was the responsibility of all staff to report any maintenance concerns via a work order for needed repairs.	F 253	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F356 1. Posted Nurse Staffing Information posted on a daily basis currently includes: facility name, the current date, the total number and the actual hours worked by the categories of licensed and unlicensed nursing staff directly responsible for resident care per shift including Registered Nurses, Licensed Practical Nurses, Certified Nursing Aides and resident census. The current posting includes nurse staffing data specified on a daily basis at the beginning of each shift. The current posting is in a clear and readable format and located in a prominent place readily accessible to residents and visitors at the nurses station.	11/06/12
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356	2. The ED has designated the Licensed Nurse working the 11:00 p.m. – 7:00 a.m. shift as responsible for the posting Nurse Staffing Information. The ED will in-service the 11:00 p.m. – 7:00 a.m. Licensed Nurses that the posted Nurse Staffing Information is to posted on a daily basis includes:	

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F 356	Continued From page 4 - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to post the actual hours worked by licensed and unlicensed nursing staff for fours days of the recertification survey. Findings included: The posted staffing information was observed on 10/15/12 at 9:30 AM on the window of the nursing station. One sheet was observed for each of the three shifts. The sheet included the date, the shift and the facility census. The sheet also included an area for actual hours worked for both licensed	F 356	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* facility name, the current date, the total number and the actual hours worked by the categories of licensed and unlicensed nursing staff directly responsible for resident care per shift including Registered Nurses, Licensed Practical Nurses, Certified Nursing Aides and resident census. The current posting includes nurse staffing data specified on a daily basis at the beginning of each shift. The current posting is in a clear and readable format and located in a prominent place readily accessible to residents and visitors at the nurses station. Three times weekly the ED will conduct an audit to validate posted Nurse Staffing Information includes: facility name, the current date, the total number and the actual hours worked by the categories of licensed and unlicensed nursing staff directly responsible for resident care per shift including Registered Nurses, Licensed Practical Nurses, Certified Nursing Aides and resident census. The current posting includes nurse staffing data specified on a daily basis at the beginning of each shift.	11/06/12

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F 356	Continued From page 5 and unlicensed nursing staff. Observations made on 10/15/12 at 9:30 AM, 10/16/12 at 12:00 PM, 10/17/12 at 10:30 AM and 10/18/12 at 1:20 PM did not include the total hours worked by licensed and unlicensed staff for any of the three shifts. The Director of Nursing was interviewed on 10/18/12 at 1:20 PM and indicated that the third shift nurse is responsible for the posted staffing. She said her expectation was for the actual hours worked by licensed and unlicensed nursing staff be completed on the staffing forms.	F 356	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* The current posting is in a clear and readable format and located in a prominent place readily accessible to residents and visitors at the nurses station. 3. Results of audits will be presented to center's Performance Improvement Committee monthly for a minimum of three months. Performance Improvement Committee will review and evaluate audit results making further recommendations as needed. Performance Improvement Committee will determine need for ongoing monitoring beyond the three month minimum to ensure ongoing compliance is maintained	11/06/12

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type II unprotected (2II) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared/and or executed solely because it is required by the provisions of federal and state law.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation on Friday 11/9/12 at	K 018	1. It is the practice of the center to ensure that doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 ¾ inch solid bonded core wood, or capable of resisting fire for at least 20 minutes. 2. The opening in the wall at the tray return between the dining room and kitchen will be sealed off with metal stud and 5/8 sheet rock to be able to closed smoke tight. 3. The Director of Plant Operation will assure this area remains smoke tight. 4. Findings would be discussed at monthly Performance Improvement Committee Meeting.	12/21/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Taslem Ahmd
TITLE: Administrator
(X6) DATE: 12/05/12

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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K 018	Continued From page 1 approximately 8:00 Am onward the following was noted: 1) The opening in the wall at the tray return between the dining room and kitchen is not equipped with a smoke control device or door. The dining room is open to the exit corridor and front lobby and all doors and openings between the kitchen and dining room are required to be able to be closed smoke tight. 42 CFR 483.70(a)	K 018	Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared/and or executed solely because it is required by the provisions of federal and state law.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation on Friday 11/9/12 at approximately 8:00 Am onward the following was noted: 1) The smoke barrier was observed as noncompliant; specific findings include the smoke walls on both hall have holes/penetrations that was not sealed in order to maintain the required fire resistance rating of the smoke barrier. (Location - walls in the rooms and hall	K 025	1. It is the practice of the center to assure all penetrations in the smoke walls are sealed in order to maintain the required fire resistance rating of the smoke barrier. 2. The Director of Plant Operation will seal all penetrations to maintain the required fire resistance rating of the smoke barrier through out the center. 3. The Director of Plant Operation will make weekly rounds to assure all penetrations are sealed in compliance with our preventive maintenance program. 4. Findings would be discussed at monthly Performance Improvement Committee Meeting.	12/21/12

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K 025	Continued From page 2 that are part of the smoke wall)	K 025	Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared/and or executed solely because it is required by the provisions of federal and state law.	
K 038 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation on Friday 11/9/12 at approximately 8:00 Am onward the following was noted: 1) When question staff were not familiar with the master override switch for the exit doors equipped with mag locks and it function.	K 038	1. The Director of Plant Operation had instructed all employees through an in service on 11/09/12 on the reason and operation of the master override switch for the exit doors equipped with mag locks. 2. The Director of Plant Operation will continue the same in service during each shift's fire drill. 3. All new hires will be orientated on the function of the master override switch during general orientation.	12/21/12
K 056 SS=F	42 CFR 483.70(a) 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	K 056	4. In service status and need will be discussed in center's monthly Performance Improvement Committee meeting.	

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K 056	Continued From page 3 building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Friday 11/9/12 at approximately 8:00 Am onward the following was noted: 1) There are sprinkler heads in the facility rated for Intermediate Temperature Classification, Glass Bulb Color of Yellow temperature rating of (175°F) and Green (200°F) in place of Ordinary Temperature Classification, Glass Bulb Color of Red temperature rating of (155°F). Locations (a) Front covered car port, walkway and vestibule. (b) Kitchen, kitchen dry storage room, storage/water heater room adjacent to kitchen. 2) The heat sensitive element on the sprinkler heads in the laundry room are cover in lint and not maintained clean in good condition. 3) The tamper alarm on the backflow device for the sprinkler riser when tested did not provide an alarm wen tested. 42 CFR 483.70(a)	K 056	Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared/and or executed solely because it is required by the provisions of federal and state law. 1. It is the practice of the center to assure that Sprinkler system are installed in accordance with NFPA standard. 2. An outside vendor has been contacted to replace yellow and green color glass bulbs with red temperature rating of (155 degree F) in locations (a) Front Covered car port, walkway and vestibule ; (b) kitchen, kitchen dry storage room, storage/water heater room adjacent to kitchen. The required replacement sprinkler heads for above (a) and (b) areas will be ordered and installed by an outside vendor and thereby will request for a 30-day extension.	01/23/13
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1	K 061	3. Sprinkler head in the laundry room covered in lint have been cleaned on 11/09/12 and in good condition 4. The tamper alarm on the backflow device for the sprinkler riser has been repaired by certified outside vendor and will provide alarm when tested.	12/21/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345104	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING & REHABILITATION-ZEBULON	509 W GANNON AVE ZEBULON, NC 27597

(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
K 061	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation on Friday 11/9/12 at approximately 8:00 Am onward the following was noted: 1) The gate valve for the anti-freeze charged sprinkler line does is not equipped with an electronically supervised tamper alarm. 2) 42 CFR 483.70(a)	K 061	5. The Director of Plant Operation will monitor and assure that all sprinkler heads are in compliance including color of bulbs, temperature rating as well as cleanliness of the heads. Also, the backflow device for the sprinkler riser will be tested quarterly by an outside certified vendor. 6. Findings would be discussed at monthly Performance Improvement Committee meeting.	12/21/12
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation on Friday 11/9/12 at approximately 8:00 Am onward the following was noted: 1) The kitchen hood at time of inspection was not operational. 42 CFR 483.70(a)	K 069	K 061 1. It is the practice of the center to assure that automatic sprinkler system have valves with an electronically supervised tamper alarm to be in compliance. 2. An outside vendor has been contacted for new gate valve equipped with an electronically supervised tamper alarm. The electronically supervised tamper alarm has been ordered by the outside vendor thereby will request for a 30 day extension.	01/23/13
K 144 SS=F	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:	K 144	3. Nowly installed tamper alarm will be tested quarterly by the contracted vendor to be in NFPA compliance. 4. The Director of Plant Operation will monitor all quarterly inspections by outside vendor and findings will be discussed in center's monthly Performance Improvement Committee meeting.	

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	345104	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING & REHABILITATION-ZEBULON	509 W GANNON AVE ZEBULON, NC 27597

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K 144	Continued From page 5 Based on observation on Friday 11/9/12 at approximately 8:00 Am onward the following was noted: 1) The generator when tested did not transfer load within 10 seconds. 42 CFR 483.70(a)	K 144	K 069 1. It is the practice of the center to assure that kitchen hood is operational at all times. 2. An outside vendor has been contacted to replace the motor of the kitchen hood, the hood is now fully operational. 3. The Director of Plant Operation will make weekly rounds to ensure the kitchen hood is fully operational. 4. Findings will be discussed in center's monthly Performance Improvement Committee meeting.	12/21/12
			K 144 1. An outside Vendor has been contacted to install new Transfer Switch for the generator. 2 The generator will be inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA. 3. An audit would be performed by Plant Operations Manager weekly to record the transfer time of the generator with allow time 10 seconds. 4. Findings of the audit would be presented to monthly Performance Improvement Committee meeting.	12/21/12