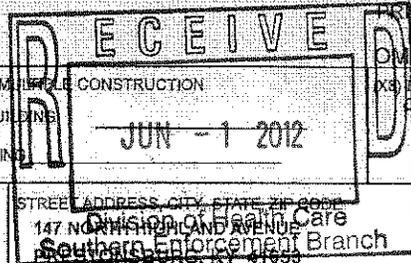


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 05/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/03/2012
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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTHSHORE AVENUE Prestonsburg, KY 41653 Southern Enforcement Branch
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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
F 000	INITIAL COMMENTS	F 000		
F 322 SS=D	<p>A standard health survey was conducted on 05/01-03/12. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interviews, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate treatment and services were provided to one of thirteen sampled residents (Resident #7) related to Gastrostomy tubes (G-tubes). Observation revealed staff failed to verify proper placement of the G-tube prior to administration of medications.</p> <p>The findings include:</p> <p>A review of the facility's Medication Administration-Gastric Tubes, Gastrostomy (G-tube) and Jejunostomy Tubes policy (dated December 2010) revealed staff was directed to check patency and placement of the tube prior to administering any solution. However, the policy failed to include the recommended steps for checking the patency or placement of the G-tube</p>	F 322	<p>Prestonsburg Health Care Center does not believe and does not admit that any deficiencies existed, either before, during or after the survey.</p> <p>The Facility reserves all rights to contest the survey findings through informal dispute resolution formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *CNHA* (X5) DATE: *6-1-12*

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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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
(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 000	INITIAL COMMENTS	F 000		
F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>A standard health survey was conducted on 05/01-03/12. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate treatment and services were provided to one of thirteen sampled residents (Resident #7) related to Gastrostomy tubes (G-tubes). Observation revealed staff failed to verify proper placement of the G-tube prior to administration of medications.</p> <p>The findings include: A review of the facility's Medication Administration-Gastric Tubes, Gastrostomy (G-tube) and Jejunostomy Tubes policy (dated December 2010) revealed staff was directed to check patency and placement of the tube prior to administering any solution. However, the policy failed to include the recommended steps for checking the patency or placement of the G-tube</p>	F 322	<p>F 322 483.25(g)(2) NG TREATMENT/SERVICES- RESTORE EATING SKILLS</p> <p>Corrective Action for Resident(s) Affected:</p> <p>Resident # 7 was checked for proper g-tube placement by DON on 5/3/12. G-tube was in place by listening for abdominal sounds by DON.</p> <p>How the Facility will act to Protect Residents in Similar Situation:</p> <p>All residents that have a g-tube were checked for proper placement by the DON on 5/3/12. All g-tubes were in proper place as evidenced by listening for abdominal sounds.</p> <p>Measures to Prevent Reoccurrence:</p> <p>All nurses will be inserviced and complete a competency check-off on policy of g-tube placement by DON and ADON on 5/22/12 and 5/29/12.</p>	

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

TITLE

(X6) DATE

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F 322	Continued From page 1 placement prior to administration of a solution, including medications. Observation of a medication pass for Resident #7 on 05/02/12, at 8:00 PM, revealed Licensed Practical Nurse (LPN) #1 failed to verify placement of the resident's G-tube prior to the administration of Xanax 0.25 milligrams (mg), Bethanechol 25 mg, Carafate 10 milliliters, Simvastatin 40 mg, and Trazodone 100 mg. An interview with LPN #1 on 05/03/12, at 9:00 AM, revealed the LPN had been trained to verify G-tube placement prior to the administration of medications by listening to abdominal sounds with a stethoscope after inserting air into the resident's G-tube and by aspirating for stomach content. LPN #1 stated she had received upsetting news earlier and just failed to verify the G-tube placement for Resident #7. LPN #1 confirmed she should have verified placement of the G-tube. Interview with the Director of Nursing (DON) on 05/03/12, at 2:30 PM, revealed nurses should verify the G-tube placement by listening for abdominal sounds using a stethoscope while inserting air into the tube and also should check for residual prior to any medication administration.	F 322	Monitoring of Corrective Action: The DON will audit three nurses checking for proper g-tube placement prior to administrating meds three times weekly for 1 month, then weekly for 1 month, then monthly for 3 months. If a nurse who has been checked off on how to verify placement on a g-tube fails to do so he/she will be disciplined by a write up. Findings will be discussed in QA meetings. Completion Date: 6/1/12	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364	F 364 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	

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F 364	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of facility temperature logs, and review of facility policy it was determined the facility failed to ensure the nutritive value of food served to residents was not compromised as evidenced by prolonged holding on the steam table of foods for the noon meal on 05/01/12. The food was placed on the steam table approximately one hour and fifteen minutes prior to tray line service. In addition, the facility failed to obtain food temperatures prior to the noon meal service on 05/01/12 in accordance with facility policy. The findings include: Review of the facility policy/procedure, Food Temperatures, (no date provided) revealed heating food in the steam table was prohibited....and food would be transferred to the steam table not more than thirty minutes before meal service. Further review of the policy revealed the temperature of the food would be taken and recorded for all items at all meals. Observations of the kitchen on 05/01/12, at 10:50 AM, revealed food to be served for the noon meal was on the steam table awaiting tray line service. Further observations at 11:45 AM on 05/01/12 (55 minutes after the first observation), revealed the dietary staff began tray line service. In addition, staff did not obtain food temperatures to ensure the food was at the appropriate temperature. Review of the food temperature log dated	F 364	Corrective Action for Resident(s) Affected: Beginning next meal service, the food was not prepared until 30 minutes before meal service. How the Facility will act to Protect Residents in Similar Situation: Dietary manager overseen food was placed in steam table only 30 minutes before meal service on evening meal on 5-1-12. Measures to Prevent Reoccurrence: Dietician inserviced dietary manager on proper time of placement of food on steam table immediatiately on 5-1-12. The dietary manager inserviced all dietary staff on proper time of placement of food on steam table prior to serving on 5-2-12.	

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F 364	Continued From page 3 05/01/12, revealed food temperatures had been documented for the breakfast meal, however, no temperatures were documented for the noon meal. Interview with the facility cook on 05/01/12, at 11:30 AM, revealed she had placed the food for the noon meal onto the steam table at approximately 10:15 AM. Continued interview with the facility cook at 11:48 AM on 05/01/12, revealed the cook obtained the food temperatures when she placed the food onto the steam table but had not documented the temperatures. According to the cook, the temperatures were "in my head." The cook was unaware of the facility policy related to food temperatures. Interview with the Registered Dietitian (RD) on 05/01/12, at 11:58 AM, revealed food should not be placed onto the steam table more than 30 minutes prior to the meal service. According to the RD, staff was required to obtain temperatures of the food on the steam table prior to service. Interview with the Dietary Manager (DM) on 05/01/12, at 12:00 PM, revealed the DM was unaware the food had been placed on the steam table at 10:15 AM. The DM stated the food should be placed on the steam table no more than 30 minutes prior to tray line service. According to the DM, staff must obtain food temperatures and write them down prior to meal service.	F 364	Monitoring of Corrective Action: The cook will write the time the food is placed in steam table on temperature form for every meal. The RD will check form weekly for 3 months. The dietary manager will check temperature form three times a week for 1 month, then weekly for 1 month, then monthly for 3 months. Findings will be discussed in QA meetings. Completion Date: 6/1/12	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371	F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY	

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F 371	<p>Continued From page 4</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review it was determined the facility failed to store, distribute, prepare, and serve food under sanitary conditions. The splashboard between the deep fryer and the range had a buildup of grease and food particles.</p> <p>The findings include:</p> <p>The facility had no policy/procedure related to cleaning of the kitchen area and specifically the splash board.</p> <p>Observations on 05/03/12, at 9:15 AM, revealed the splash board between the range and the deep fryer had a buildup of grease and food particles covering approximately three feet by four feet of the surface facing the deep fryer.</p> <p>Review of the facility cleaning schedule for April 2012 revealed the facility's cleaning schedule did not include the frequency for cleaning the splash board and did not list the splash board as an item to be cleaned. Although the deep fryer was listed on the cleaning schedule to be cleaned weekly, there was documentation to indicate the deep</p>	F 371	<p>Corrective Action for Resident(s) Affected:</p> <p>No food was fixed in deep fryer until splash guard was cleaned. Dietary aide cleaned the splash board on 5-1-12</p> <p>How the Facility will act to Protect Residents in Similar Situation:</p> <p>All equipment in kitchen was checked for grease buildup. No other grease buildup was noted. Dietary aide cleaned the splash board on 5-1-12.</p> <p>Measures to Prevent Reoccurrence:</p> <p>Dietary aide cleaned splash board immediately. Dietary manager inserviced all dietary staff on cleaning schedule of splash board on 5-17-12 or 5-18-12. Splash board cleaning form was added to cleaning schedule for dietary staff to initial when cleaned.</p>	

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F 371	Continued From page 5 fryer had only been cleaned once during the month of April 2012. Interview with the Dietary Manager (DM) on 05/03/12, at 9:20 AM, confirmed the splash board was not on the facility cleaning schedule. According to the DM, staff should be cleaning the splash board when they clean the deep fryer. The DM stated she did not know when the splash board was last cleaned.	F 371	Monitoring of Corrective Action: Dietician will monitoring cleaning splash board schedule and visually monitor weekly for 3 months. Dietary manager will monitor cleaning splash board schedule and visually monitor 3 times weekly for 1 month, then weekly for 1 month, then monthly for 3 months. All findings will be discussed in QA meetings. Completion Date: 6/1/12	

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
(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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 1</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1967, 1974</p> <p>Facility type: SNF</p> <p>Type of structure: Type II unprotected</p> <p>Smoke Compartments: Three</p> <p>Fire Alarm: Complete fire alarm with smoke detectors installed in corridors and resident rooms. Heat detectors in mechanical rooms/therapy and kitchen. System upgraded in June 2003.</p> <p>Sprinkler System: Complete sprinkler system (wet) installed in 2008</p> <p>Generator: Type 2 generator powered by Natural Gas installed in 1995</p> <p>A standard Life Safety Code survey was conducted on 05/02/12. Prestonsburg Health Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 51. The facility is licensed for 56 beds.</p> <p>The highest scope and severity was at "F" level.</p>	K 000	<p>Prestonsburg Health Care Center does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p> <p>K 029 NFPA 101 LIFE SAFETY CODE STANDARD</p>	
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

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

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 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 029 SS=D	<p>Continued From page 1</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were protected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of three smoke compartments and staff in the kitchen area.</p> <p>The findings include:</p> <p>Observation on 05/02/12, at 10:45 AM, revealed the dry goods storage room was used to store combustible materials. The door to the dry goods storage room had been removed. Rooms used to store large amounts of combustible materials must have a door that resists the passage of smoke and be equipped with a self-closer. The observation was confirmed with the Director of Plant Operations.</p>	K 029	<p>Corrective Action for Resident(s) Affected:</p> <p>No residents were affected by not having door on dry goods storage room.</p> <p>How the Facility will act to Protect Residents in Similar Situation:</p> <p>90 minute fire proof metal door will be hung by 6/1/12.</p> <p>Measures to Prevent Reoccurrence:</p> <p>Fire proof metal door was ordered on 5/9/12 by maintenance director. Door will be installed by 6/1/12.</p> <p>Monitoring of Corrective Action:</p> <p>Maintenance director will monitor proper functioning of door weekly for 3 months. Findings will be discussed in QA meetings.</p> <p>Completion Date:</p> <p>6/1/12</p>	

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K 029	<p>Continued From page 2</p> <p>Interview on 05/02/12, at 10:45 AM, with the Director of Plant Operations, revealed he had never known of the dry goods storage room having a door.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more 	K 029		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
(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 029	Continued From page 3 than 48 in. (122 cm) above the bottom of the door.	K 029		
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: Based on observation and interview, it was determined the facility failed to ensure the emergency generator was maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three of three smoke barriers, fifty-six residents, staff, and visitors. The findings include: Record review of the emergency generator maintenance log on 05/02/12, at 11:15 AM, revealed the emergency generator had not been run for 30 minutes under load as required. The documentation for the hour meter reflected a run time between 12 and 24 minutes. This had occurred for 6 of the 12 previous months. The observation was confirmed with the Director of Plant Operations. Emergency generators must be run under load monthly to ensure their reliability.	K 144	K 144 NFPA 101 LIFE SAFETY CODE STANDARD Corrective Action for Resident(s) Affected: No residents had been affected by the emergency generator not running for 30 minutes. How the Facility will act to Protect Residents in Similar Situation: All residents had the potential to be affected by emergency generator not running for 30 minutes. Measures to Prevent Reoccurrence: Nixon power company was notified immediately of emergency generator not working properly by maintenance director. Nixon power company came to facility on 5/8/12 and replaced the auto timer and had to order the hourly meter. Hourly meter will be replaced on 5-17-12.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 144	Continued From page 4 Interview on 05/02/12, at 11:15 AM, with the Director of Plant Operations, revealed he ran the generator under load for the required 30 minutes as required and was unsure why the hour meter did not reflect a run time of 30 minutes. Reference: NFPA 110 (1999 Edition). 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded.	K 144	Monitoring of Corrective Action: Maintenance director will monitor weekly auto test of hourly meter and weekly timer weekly. Findings will be discussed in QA meetings. Completion Date: 6/1/12	