Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	55C0001059	04/10/2019
Name of Provider or Supplier	**Street Address, City, State**	
Fort Sutter Surgery Center, A Ca Limited Partnership	2801 K Street, Suite 525, Sacramento, CA	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
E0000	The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 416.54, Condition for Coverage for Ambulatory Surgical Centers (ASCs). Representing the California Department of Public Health: 32973 Census: 37
E0037	EP Training Program CFR(s): 416.54(d)(1) 403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 460.84(d)(1), 482.15(d)(1), 483.73(d)(1), 483.475(d)(1), 484.102(d)(1), 485.68(d)(1), 485.625(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1). *[For RNCHIs at 403.748, ASCs at 416.54, Hospitals at 482.15, ICF/IIDs at 483.475, HHAs at 484.102, "Organizations" under 485.727, OPOs at 486.360, RHC/FQHCs at 491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with

their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at 418.113 (d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at 441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at 460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at 483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at 485.68 (d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at 485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients,

	personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at 485. 920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain the emergency preparedness (EP) plan. This was evidenced by the failure to complete annual training in EP plan policies and procedures to all new and existing staff, service providers and volunteers consistent with their expected roles. This affected all patients, and could result in an ineffective Emergency Preparedness (EP) plan. Findings: During document review and interview with Administrative Staff on 4/10/19, the EP plan annual training was requested and reviewed. At 3:50 p.m., the EP plan provided failed to show that annual training for all staff, volunteers and providers had been completed. Upon interview, Administrative Staff 1 confirmed the finding stating that the facility had not completed and documented annual EP plan policy and procedure training, and staff competency evaluation.
K0000	K3 BUILDING: 01 K6 PLAN APPROVAL: 1986 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: FIVE STORY AND BASEMENT, CONSTRUCTION TYPE 1 (332), FULLY SPRINKLERED.

	The following reflects the findings of the California Department of Public Health, during a recertification Life Safety Code survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) §416.44(b)(c)(f), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. Representing the California Department of Public Health: 32973 Census: 37
K0343	Fire Alarm System - Notification CFR(s): NFPA 101 Fire Alarm - Notification 2012 EXISTING A positive alarm sequence in accordance with 9.6.3.4 is permitted. Occupant notification is provided automatically, without delay, in accordance with 9.6.3. Fire department notification is accomplished automatically per 9.6.4. Smoke detection devices or systems equipped with reconfirmation features shall not be required to automatically notify the fire department, unless the alarm condition is reconfirmed within 120 seconds (2 minutes). 21.3.4.3 through 21.3.4.3.2.2, 9.6.3, 9.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire alarm system components. This was evidenced by an alarm notification device that failed to provide an audible signal. This affected all patients, and could result in a delay in notification to occupants in the event of a fire. NFPA 101 Life Safety Code, 2012 edition 21.3.4 Detection, Alarm, and Communications Systems. 21.3.4.1 General. Ambulatory health care facilities shall be provided with fire alarm systems in accordance with Section 9.6, except as modified by 21.3.4.2 through 21.3.4.4. 21.3.4.2 Initiation. Initiation of the required fire alarm systems shall be by manual means in accordance with 9.6.2 and by means

of any detection devices or detection systems required.

21.3.4.3 Notification. Positive alarm sequence in accordance

with 9.6.3.4 shall be permitted.

21.3.4.3.1 Occupant Notification. Occupant notification

shall be accomplished automatically, without delay, in accordance

with 9.6.3 upon operation of any fire alarm activating

device.

9.6.3 Occupant Notification.

9.6.3.1 Occupant notification shall be provided to alert occupants of a fire or other emergency where required by other sections of this Code.

9.6.3.4 Where permitted by Chapters 11 through 43, a positive alarm sequence shall be permitted, provided that it is in accordance with NFPA 72, National Fire Alarm and Signaling Code.

9.6.3.7 Audible alarm notification appliances shall be of such character and so distributed as to be effectively heard above the average ambient sound level that exists under normal conditions of occupancy.

9.6.3.8 Audible alarm notification appliances shall produce signals that are distinctive from audible signals used for other purposes in a given building.

NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition

18.2 Purpose. Notification appliances shall provide stimuli for initiating emergency action and provide information to users, emergency response personnel, and occupants.

Findings:

During fire alarm testing and interview with staff on 4/10/19, the facility fire alarm was tested.

At 12:20 p.m., the manual pull station located in the corridor area near the Conference

	Room was tested and the fire alarm system was activated. The chime/strobe alarm device located in the corridor area did not provide an audible alarm. Upon interview, Staff 1 confirmed the finding.
K0345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm Systems - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is not met as evidenced by: Based on observation, document review, and interview, the facility failed to maintain the smoke detection devices. This was evidenced by the absence of a smoke detector sensitivity testing report. This affected all patients, and could result in a smoke detector malfunction in the event of a fire. NFPA 101 Life Safety Code, 2012 Edition 21.3.4 Detection, Alarm, and Communications Systems. 21.3.4.1 General. Ambulatory health care facilities shall be provided with fire alarm systems in accordance with Section 9.6, except as modified by 21.3.4.2 through 21.3.4.4. 9.6.1.3 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and signaling Code, unless it is an approved existing installation, which shall be permitted to be continued in use. NFPA 72 National Fire Alarm, 2010 edition 14.4.5.3.1 Sensitivity shall be checked within 1 year after installation. 14.4.5.3.2 Sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3.

14.4.5.3.3 After the second required calibration test, if sensitivity tests indicate that the device has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years.

14.4.5.3.3.1 If the frequency is extended, records of nuisance alarms and subsequent trends of these alarms shall be maintained.

14.4.5.3.3.2 In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.

14.4.5.3.4 To ensure that each smoke detector or smoke alarm is within its listed and marked sensitivity range, it shall be tested using any of the following methods:

(1) Calibrated test method

(2) Manufacturer ' s calibrated sensitivity test instrument

(3) Listed control equipment arranged for the purpose

(4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the fire alarm control unit where its sensitivity is outside its listed sensitivity range

(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction.

Findings:

During a facility tour, document review, and interview with staff on 4/10/19, records for smoke detector sensitivity were requested.

At 12:00 p.m., smoke detection devices were observed throughout the facility, and at the two fire alarm panels. The facility was not able to provide a current smoke detector sensitivity testing report. The last smoke detector sensitivity testing was unknown. Upon interview, Staff 1 stated that they would be contacting the fire alarm system vendor regarding the report.

K0346	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Fire alarms that are out of service for 4 hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain interim fire measures. This was evidenced by the failure to provide written protocol to ensure that if the automatic fire alarm system was out of service for more than 4 hours in a 24 hour period, the authority having jurisdiction (AHJ) would be notified. This affected all patients, and could potentially result in the AHJ being unable to exercise oversight in a timely manner if the fire alarm system should become inoperable. Findings: During document review and interview with staff on 4/10/19, the interim fire measures and policy were reviewed. At 11:00 a.m., the approved Fire Watch policy, did not include guidance for notification to the Department of Public Health if the fire alarm system was out of service for more than 4 hours in a 24 hour period. Upon interview, Staff 1 confirmed the finding.

K0353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation, document review, and interview, the facility failed to maintain the integrity of the automatic fire sprinkler system. This was evidenced by failure to perform required monthly valve and gauge inspections. This affected all patients, and could result in the ineffective operation of the automatic fire sprinkler system in the event of a fire. NFPA 101 Life Safety Code, 2012 edition 21.7.6 Maintenance and Testing. See 4.6.12. 4.6.12 Maintenance, Inspection, and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system,condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. 4.3 Records 4.3.1* Records shall be made for all inspections, tests, and maintenance of the system

and its components and shall be made available to the authority having jurisdiction upon request.

Chapter 5 Sprinkler Systems.

5.1.1 Minimum Requirements.

5.1.1.1 This chapter shall provide the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems.

5.2.1 Sprinklers.

5.2.4 Gauges.

5.2.4.1* Gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained.

13.3.2 Inspection.

13.3.2.1.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. 13.3.2.2* The valve inspection shall verify that the valves are in the following condition:

(1) In the normal open or closed position

(2)*Sealed, locked, or supervised

(3) Accessible

(4) Provided with correct wrenches

(5) Free from external leaks

(6) Provided with applicable identification

Findings:

During a facility tour, document review, and interview with staff on 4/10/19, the automatic fire sprinkler system was observed and records were requested.

At 3:40 p.m., the facility was observed fully sprinkler. No records were available for 8 of 12 (January, February, April, May, July, September, October and November, 2019-2018) monthly inspections of valves and gauges. Upon interview, Staff 1 confirmed the finding stating that the facility was not aware of the requirement for monthly

	visual inspections of the sprinkler valves and gauges.
K0354	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain interim fire measures. This was evidenced by failure to provide written protocol to ensure that if the automatic fire sprinkler system was out of service for more than 10 hours in a 24 hour period, the authority having jurisdiction (AHJ) would be notified. This affected all patients, and could potentially result in the AHJ being unable to exercise oversight in a timely manner if the fire sprinkler system should become inoperable. Findings: During document review and interview with staff on 4/10/19, the interim fire measures and policy were reviewed. At 11:00 a.m., the approved Fire Watch policy, did not include guidance for notification to the Department of Public Health if the fire sprinkler system was out of service for more than 10 hours in a 24 hour period. Upon interview, Staff 1 confirmed the finding.

K0355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 20.3.5.3, 21.3.5.3, 9.7.4.1, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the portable fire extinguishers. This was evidenced by an obstructed extinguisher. This affected all patients, and could result in the inability to locate and/or obtain the extinguisher in the event of a fire. NFPA 101 Life Safety Code, 2012 edition 21.3.5.3 Portable fire extinguishers shall be provided in ambulatory health care facilities in accordance with 9.7.4.1. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Extinguishers, 2010 Edition. 6.1.3.3.1 Fire extinguishers shall not be obstructed or obscured from view. Findings: During a tour of the facility and interview with staff on 4/10/19, the portable fire extinguishers were observed.

	At 12:50 p.m., the portable fire extinguisher located in Operating Room (OR) 5 was observed. The fire extinguisher was located inside a recessed wall cabinet, and was obstructed from view and access by wheeled medical equipment that were stored directly in front of the fire extinguisher. Upon interview, Staff 2 confirmed the finding.
K0521	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 20.5.2.1, 21.5.2.1, 9.2

This STANDARD is not met as evidenced by:
Based on document review and interview, the facility failed to maintain the Heating, Ventilating, and Air-Conditioning (HVAC) system. This was evidenced by the failure to provide a current smoke/fire damper testing and service report. This affected all patients, and could result in the spread of smoke and/or fire to other locations of the facility due to a malfunctioning damper.

NFPA 101, Life Safety Code, 2012 Edition

20.5 Building Services.

20.5.1 Utilities. Utilities shall comply with the provisions of

Section 9.1.

20.5.2 Heating, Ventilating, and Air-Conditioning.

20.5.2.1 Heating, ventilating, and air-conditioning shall comply

with the provisions of Section 9.2 and shall be installed in

accordance with the manufacturer ' s specifications, unless otherwise

modified by 20.5.2.2.

9.2 Heating, Ventilating, and Air-Conditioning.

9.2.1 Air-Conditioning, Heating, Ventilating Ductwork, and

Related Equipment. Air-conditioning, heating, ventilating

ductwork, and related equipment shall be in accordance with

NFPA 90A, Standard for the Installation of Air-Conditioning and

Ventilating Systems, or NFPA 90B, Standard for the Installation of

Warm Air Heating and Air-Conditioning Systems, as applicable, unless

such installations are approved existing installations,

which shall be permitted to be continued in service.

NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, 2012 edition.

5.4.8 Maintenance.

5.4.8.1 Fire dampers and ceiling dampers shall be maintained

in accordance with NFPA 80, Standard for Fire Doors and

Other Opening Protective's.

NFPA 80, Standard for Fire Doors and Other Opening Protective's, 2010 edition.

19.3.4 Documentation. All inspections and testing shall be

documented, indicating the location of the fire damper, date(s)

of inspection, name of inspector, and deficiencies discovered.

The documentation shall have a space to indicate when and how

the deficiencies were corrected.

19.4.1.1

19.4* Periodic Inspection and Testing.

19.4.1 Each damper shall be tested and inspected 1 year after

installation.

19.4.1.1 The test and inspection frequency shall then be every

4 years, except in hospitals, where the frequency shall be every

6 years.

19.4.4 If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in place if so equipped.

19.4.5 The operational test of the damper shall verify that there is no damper interference due to rusted, bent, misaligned, or damaged frame or blades, or defective hinges or other moving parts.

19.4.7 The damper shall not be blocked from closure in any way.

19.4.8 The fusible link shall be reinstalled after testing is complete.

19.4.8.1 If the link is damaged or painted, it shall be replaced with a link of the same size, temperature, and load rating.

19.4.9 All inspections and testing shall be documented, indicating the location of the fire damper or combination fire/smoke damper, date of inspection, name of inspector, and deficiencies discovered.

19.4.9.1 The documentation shall have a space to indicate when and how the deficiencies were corrected.

19.4.10 All documentation shall be maintained and made available for review by the AHJ.

19.4.11 Periodic inspections and testing of a combination fire/smoke damper shall also meet the inspection and testing requirements contained in Chapter 6 of NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.

Findings:

During document review and interview with staff on 4/10/19, the HVAC damper testing/service records were requested for review.

At 11:30 a.m., there were no records that indicated the facility inspected, tested, and maintained HVAC fire/smoke dampers. Upon interview, Staff 1 confirmed the finding.

K0918	Essential Electrical Systems Generator or Alternate Source CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for four continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on observation, document review, and interview, the facility failed to maintain the emergency power supply system (EPSS). This was evidenced by the failure to perform annual fuel quality testing, and monthly battery tests for two of two generators. This affected all patients, and could result in a loss of power due to a generator malfunction during an emergency power outage. NFPA 101 Life Safety Code, 2012 edition 21.5.1 Utilities. 21.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition. Chapter 8 Routine Maintenance and

Operational Testing

8.1* General.

8.1.1 The routine maintenance and operational testing program shall be based on all of the following:

(1) Manufacturer's recommendations

(2) Instruction manuals

(3) Minimum requirements of this chapter

(4) The authority having jurisdiction

8.3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established.

8.3.4 A permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available.

8.3.4.1 The permanent record shall include the following: (1)The date of the maintenance report (2)Identification of the servicing personnel (3)Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer

8.3.7.1 Maintenance of lead-acid batteries shall include the

monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted.

8.3.8 A fuel quality test shall be performed at least annually using tests approved by ASTM standards.

Findings:

During a facility tour, document review, and interview with staff on 4/10/19, the EPSS was observed and records were requested and reviewed.

1. At 11:45 a.m., the facility's Onan 125 kilowatt (kW) and Kohler 300 kW diesel generators were observed. Both generators were equipped with lead acid batteries.

	There were no documents that indicated the generator batteries were tested for electrolyte specific gravity or conductance monthly. Upon interview, Staff 1 confirmed the finding. 2. At 11:52 a.m., the facility was not able to provide an annual fuel quality testing record according to ASTM standards for the stored diesel fuel supply. Upon interview, Staff 1 confirmed the finding.