



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER -- Governor
RUSSELL S. BARRON -- Director

TAMARA PRISOCK -- ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

July 27, 2018

Troy Thayne, Administrator
Desert View Care Center of Buhl
820 Sprague Avenue
Buhl, ID 83316-1827

Provider #: 135089

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Thayne:

On **July 18, 2018**, a Facility Fire Safety and Construction survey was conducted at **Desert View Care Center of Buhl** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 9, 2018**. Failure to submit an acceptable PoC by **August 9, 2018**, may result in the imposition of civil monetary penalties by **August 31, 2018**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **August 22, 2018**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **August 22, 2018**. A change in the seriousness of the deficiencies on **August 22, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **August 22, 2018**, includes the following:

Denial of payment for new admissions effective **October 18, 2018**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 18, 2019**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **July 18, 2018**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to Information Letters section and click on State and select the following:

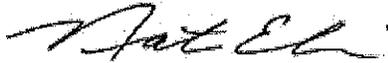
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **August 9, 2018**. If your request for informal dispute resolution is received after **August 9, 2018**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



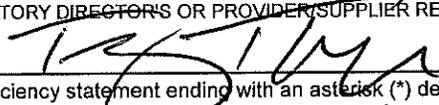
Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 07/26/2018
FORM APPROVED
OMB NO. 0938-0391

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|---|---|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135089 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 07/18/2018 |
| NAME OF PROVIDER OR SUPPLIER DESERT VIEW CARE CENTER OF BUHL | | STREET ADDRESS, CITY, STATE, ZIP CODE 820 SPRAGUE AVENUE BUHL, ID 83316 | | |
| (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 |
| E 000 | <p>Initial Comments</p> <p>The facility is a single story, type V (111) construction built in 1958. There is a partial, unfinished basement with a 1-hour separation. The building is fully sprinklered and has a complete fire alarm system with corridor smoke detection. The facility is separated into three smoke compartments and is equipped with a Type 1 EPSS with an annunciator. There are six exits to grade, with an additional service exit. The facility is currently licensed for 57 SNF/NF beds, and had a census of 37 on the date of the survey.</p> <p>The facility was found to be in substantial compliance during the initial Emergency Preparedness Survey conducted on July 18, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p> | E 000 | <p>RECEIVED AUG 10 2018 FACILITY STANDARDS</p> | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Administrator (X8) DATE 8-8-18

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 000 | <p>INITIAL COMMENTS</p> <p>The facility is a single story, type V (111) construction built in 1958. There is a partial, unfinished basement with a 1-hour separation. The building is fully sprinklered and has a complete fire alarm system with corridor smoke detection. The facility is separated into three smoke compartments and is equipped with a Type 1 EPSS with an annunciator. There are six exits to grade, with an additional service exit. The facility is currently licensed for 57 SNF/NF beds, and had a census of 37 on the date of the survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on July 18, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70, and 42 CFR 483.80.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction</p> | K 000 | <p>RECEIVED</p> <p>AUG 10 2018</p> <p>FACILITY STANDARDS</p> | |
| K 353 SS=F | <p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>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.</p> | K 353 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

[Signature] Administrator 8-8-18

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 353 | <p>Continued From page 1</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>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 REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure fire suppression system pendants were maintained according to NFPA 25. Failure to test or replace fire sprinkler pendants at required intervals, and keep them free of obstructions such as paint or corrosion, could hinder system performance during a fire event. This deficient practice affected 37 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on July 18, 2018, from approximately 1:00 PM to 3:00 PM, observation of the sprinkler pendants revealed two corroded sprinklers. One in the staff restroom and one in the hallway to the left of the nurse's station. When asked, the Maintenance Manager stated the facility was not aware of the corroded sprinkler heads.</p> <p>2.) During the review of facility inspection records conducted on July 18, 2018 from approximately 11:00 AM to 1:00 PM, fire suppression inspection reports revealed the facility suppression system is a dry system. However, no documentation could be produced for the testing of dry sprinkler</p> | K 353 | <p>K 353</p> <p>1-The sprinklers identified in the staff restroom and near the nurse's station were inspected and replaced. The rest of the sprinklers will receive a 10 year inspection to identify any additional problems and to meet the NFPA guidelines.</p> <p>2- All residents have the potential to be affected.</p> <p>3- The maintenance director will do quarterly inspections/audits of all sprinkler heads in the facility in order to identify and repair any that have obstructions on them. A 10 year inspection will be scheduled on the PM schedule</p> <p>4- The audits will be reviewed at least quarterly during the facility QAPI meeting.</p> <p>5- Compliance date: 08/22/18</p> | |

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| K 353 | Continued From page 2 pendants every 10 years. Further observation during the facility tour revealed sprinkler pendants dated 1978 and 1979. When asked, the Maintenance Manager stated the facility was not aware of the requirement to test or replace dry sprinkler heads every 10 years. Actual NFPA standard: NFPA 25 1.) 5.2.1 Sprinklers. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer 2.) 5.3 Testing. 5.3.1* Sprinklers. 5.3.1.1.1.6* Dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals. | K 353 | | | |
| K 363 SS=D | Corridor - Doors CFR(s): NFPA 101 Corridor - Doors | K 363 | | | |

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| K 363 | <p>Continued From page 3</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, operational testing, and</p> | K 363 | <p>K- 363</p> <p>1-Doors on W-2, N-9, N-14, & E-4 were repaired to remove the identified gaps.</p> <p>2- All residents have the potential to be affected.</p> <p>3- An inspection of all doors to be completed by the maintenance director/designee at least quarterly beginning 8/15/18 in perpetuity to maintain compliance. Any door identified to not be in compliance will be fixed and maintained to NFPA standards.</p> <p>4- Inspection results to be reviewed at least quarterly during the facility QAPI meeting.</p> <p>5- Compliance Date: 8/22/18 9/24/18 <i>sc</i></p> | |
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| K 363 | <p>Continued From page 4</p> <p>interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely, preventing defend in place. This deficient practice has the potential to affect 4 residents, staff, and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During the facility tour on July 18, 2018, from approximately 1:00 PM to 3:00 PM, observation and operational testing of the resident room doors revealed resident rooms W-2, N-9, and N-14 had an approximately 5/8" gap between the face of the door and the frame of the door when fully closed. Resident room E-4 had an approximately 3/4" gap. When asked, the Maintenance Manager stated the facility was not aware the maximum distance between the face of the door and frame is 1/2" when fully closed.</p> <p>Actual NFPA Standards:</p> <p>NFPA 101 19.3.6.3* Corridor Doors. 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 1-3/4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes</p> <p>Additional Reference:</p> | K 363 | | |

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| K 363 | Continued From page 5 | K 363 | | |
| K 911 SS=F | Centers for Medicare/Medicaid Services S&C Letter 07-18. Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567, Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the Essential Electrical System (EES) generator was equipped with a remote manual stop station. Failure to provide a remote stop, potentially hinders the ability of staff to shut down the generator if required. This deficient practice affected 37 residents, staff and visitors on the date of the survey. Findings include: During the facility tour conducted on July 18, 2018 from approximately 1:00 PM to 3:00 PM, a remote manual stop station for the EES generator could not be located. When asked, the Maintenance Manager stated the facility was not equipped with a remote stop station. Actual NFPA standard: NFPA 110 5.6.5.6* All installations shall have a remote | K 911 | K- 911 1- A remote manual stop station has been installed per the NFPA standard. 2- All residents have the potential to be affected. 3- The remote manual stop station will be labeled and inspected monthly by the Maintenance director or designee to ensure compliance. 4- The manual stop station inspections will be reviewed at the quarterly QAPI meeting in perpetuity to maintain compliance. 5- Compliance date 8/22/18 | |

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| K 911 | Continued From page 6 manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. 5.6.5.6.1 The remote manual stop station shall be labeled. | K 911 | | | |
| K 918 SS=F | NFPA 99 6.4.1.1.16.2 Safety indications and shutdowns shall be in accordance with Table 6.4.1.1.16.2. (SEE TABLE) Electrical Systems - Essential Electric System 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 4 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 | K 918 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135089 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____ | | (X3) DATE SURVEY COMPLETED 07/18/2018 |
| NAME OF PROVIDER OR SUPPLIER DESERT VIEW CARE CENTER OF BUHL | | | STREET ADDRESS, CITY, STATE, ZIP CODE 820 SPRAGUE AVENUE BUHL, ID 83316 | | |
| (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 918 | <p>Continued From page 7</p> <p>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, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure Emergency Power Supply Systems (EPSS) were maintained in accordance to NFPA 110. Failure to inspect and test EPSS under load could result in a lack of system reliability during a power loss. This deficient practice affected 37 residents, staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>During review of the EPSS inspection and load testing documentation provided on July 18, 2018 from approximately 11:00 AM to 1:00 PM, no documentation could be produced for a three-year, four-hour load test. When asked about the four-hour load bank being performed tri-annually, the Maintenance Manager stated the facility was not aware of this standard.</p> <p>Actual NFPA standard:</p> <p>NFPA 110</p> <p>8.4 Operational Inspection and Testing. 8.4.9* Level 1 EPSS shall be tested at least once</p> | K 918 | <p>K- 918</p> <ol style="list-style-type: none"> 1- A four (4) hour load bank was performed to meet the NFPA standard. 2- All residents have the potential to be affected. 3- The three year load bank test will be auto-scheduled with the facility generator contractor to maintain compliance with the standard. The maintenance director will keep the service records, and will follow up with the service provider prior to the 3 year intervals. 4- The service records will be reviewed in the quarterly QAPI meeting in perpetuity to maintain compliance. 5- Compliance date: 8/22/18 | | |

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

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| K 918 | Continued From page 8 within every 36 months. 8.4.9.1 Level 1 EPSS shall be tested continuously for the duration of its assigned class (see Section 4.2). 8.4.9.2 Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. 8.4.9.3 The test shall be initiated by operating at least one transfer switch test function and then by operating the test function of all remaining ATs, or initiated by opening all switches or breakers supplying normal power to all ATs that are part of the EPSS being tested. 8.4.9.4 A power interruption to non-EPSS loads shall not be required. 8.4.9.5 The minimum load for this test shall be as specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. 8.4.9.5.1 For a diesel-powered EPS, loading shall be not less than 30 percent of the nameplate kW rating of the EPS. A supplemental load bank shall be permitted to be used to meet or exceed the 30 percent requirement. 8.4.9.5.2 For a diesel-powered EPS, loading shall be that which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. 8.4.9.5.3 For spark-ignited EPSSs, loading shall be the available EPSS load. 8.4.9.6 The test required in 8.4.9 shall be permitted to be combined with one of the monthly tests required by 8.4.2 and one of the annual tests required by 8.4.2.3 as a single test. 8.4.9.7 Where the test required in 8.4.9 is combined with the annual load bank test, the first 3 hours shall be at not less than the minimum loading required by 8.4.9.5 and the remaining hour shall be at not less than 75 percent of the nameplate kW rating of the EPS. | K 918 | | |