

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

PRINTED: 05/02/2006  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045267</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/03/2005</b>
NAME OF PROVIDER OR SUPPLIER  <b>LEGACY HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3310 NORTH 50 STREET</b> <b>FORT SMITH, AR 72904</b>	
(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 324 SS=J	<p>483.25(h)(2) ACCIDENTS</p> <p>The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #10433 is substantiated, all or in part, in these findings.</p> <p>Based on observation, record review and interview, the facility failed to ensure that nursing staff used for van transportation were competent in loading and unloading residents when using the mechanical lift for the van for 1 case-mix residents (Residents #1) who required the use of mechanical lift for van transportation. The facility failed to ensure that all nursing staff were competent in reporting any malfunctions/defects prior to using any mechanical lifts for 2 case-mix residents (Resident #1 and #3) who required the use of a mechanical lift for transfers within the facility and for transportation in the facility van. The facility also failed to ensure that Maintenance Staff were competent to provide preventative maintenance and repair of healthcare equipment used to assist in the transfer of residents to the facility van. The failed practices resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death for Resident #1 who fell from the mechanical lift used to</p>	F 324		8/31/05

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

TITLE

(X6) 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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F 324	<p>Continued From page 1</p> <p>transfer to the facility van and had the potential to affect 2 wheelchair bound residents routinely transferred by the facility's van and 50 residents occasionally transferred by the facility van, and had the potential to cause more than minimal harm to 12 residents who required the use of a mechanical lift within the facility according to the Director of Nursing on 8/4/05 at 9:35 a.m. The Immediate jeopardy was removed by the facility on 7/22/05 and the scope and severity reduced to "G" when the facility removed the defective mechanical lift and the van from use, however, the underlying deficient practice was not corrected. The findings are:</p> <p>1. Resident #3 had diagnoses of Congestive Heart Failure, Myocardial Infarction and Coronary Atherosclerosis. The Minimum Data Set dated 5/6/05 documented the resident had modified independence in cognitive skills for daily decision making and was totally dependent on the assistance of two staff persons for transfer and bed mobility.</p> <p>a. An Incident/Accident Report dated 7/18/05 at 4:30 p.m. documented: "Electric lift gave way c (with) res (resident) in air." Nurse's Notes dated 7/18/05 at 10:00 p.m. documented: "Res (resident) was dropped from lift during transfer from w/c (wheelchair) to bed. C/O (complains) r (right) lower leg pain, r hand has bruising, c/o back pain. [Physician] notified and was here this p.m.</p> <p>b. Physician Progress Notes dated 7/18/05 documented: "Apparently had fallen off Hoyer lift this evening while being transferred from chair to bed. Resident reports she fell on her back. C/O (complains) pain in the right knee and right leg.</p>	F 324			

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F 324	<p>Continued From page 2</p> <p>Right knee red. C/O pain in entire back, right knee and right lower leg when touched. Moaned and groaned when asked to move leg. No swelling, no deformities noted. Bilateral hand grasp equal."</p> <p>c. The Emergency Physician Record dated 7/19/05 at 10:50 a.m. documented a clinical impression of "fall". None of the X-rays taken during this Emergency Room Visit documented evidence of an acute fracture.</p> <p>d. The "Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property and Exploitation of Residents in Long Term Care" documented: "Complete description of incident: On July 19, 2005, two CNA [D.N.A. # 2 and NA #1] went into [Resident #3's] room to transfer her from her electric wheelchair to her bed via the electric Hoyer lift. The two D.N.A.'s hooked the lift up to the lift pad, which was already under [Resident #3]. They began lifting the resident up from her electric wheelchair when [D.N.A. # 2 and NA #1] and [Resident #3] heard a loud popping sound from the Hoyer lift and the Hoyer lift dropped [Resident #3] approximate wheelchair height to the floor as the resident landed on her right side of her body. The D.N.A.'s went outside [Resident #3's] room to get help from the nursing staff. The nursing staff did a complete assessment on Resident #3 for any signs and symptoms that would be associated with the fall and the assessment yielded no negative findings for any broken bones. The nursing staff then used a 4 man total lift from the floor to the bed.... [Facility] conducted a full investigation regarding the Hoyer lift incident as we feel like this was an equipment malfunction, since this is such a freak incident. Our maintenance man removed the</p>	F 324			

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F 324	<p>Continued From page 3</p> <p>Hoyer lift from the facility and lock it up in his shop until the Manufacturer came to do a complete evaluation of the Hoyer lift. DON called the Manufacturer Vanderlift to schedule an evaluation of the Hoyer lift and the Manufacturer scheduled [Company] to come to the facility on July 20, 2005 to do a through evaluation on the electric Hoyer lift. The facility also had a second opinion done by [Given Name] to evaluate why the lift would drop someone to the floor as both evaluation yielded no negative findings. An inservice was conducted by [Maintenance Staff] with [D.N.A. # 2 and NA #1] to evaluate the proper technique for setting up a Hoyer lift transfer with a resident for transfer. Both [D.N.A. # 2 and NA #1] did correctly hook someone up in the electric Hoyer for a transfer and from the wheelchair to the bed. Since the facility has several residents who used the Hoyer lift for transfer, we had the Physical Therapist to demonstrate the proper technique for a 4 man total transfer with all the D.N.A.'s on all shifts with return demonstration so the D.N.A.'s could get another up from their wheelchair or the bed. The facility also order a new Hoyer lift and it will be here on Monday, July 25, 2005. Both the [Maintenance Staff] and the [Physical Therapist] will inservice all staff on the proper technique and safety requirement for transferring anyone to and from the wheelchair to the bed."</p> <p>e. On 8/02/05 at 2:56 p.m. the Director of Nurses [DON] stated that on the night that Resident #5 fell, she told the staff to take the lift out of service. She ordered a new lift but it did not come in when it was supposed to. She stated she could not put the new lift into service until everyone had received appropriate inserviced on the relative operation of the device. The DON stated the</p>	F 324			

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F 324	<p>Continued From page 4</p> <p>facility did seek Physical Therapy consults on residents requiring lifting, did inservices with the staff and the staff has been doing manual lifts using however many people it might take. The DON stated she had a concern due to the mental status change in Resident #5 after the incident. The nurse called her and said Resident #5 would not wake up. The DON told the nurse to send her emergency room and make sure CT of the head was done.</p> <p>f. On 8/03/05 at 10:33 a.m. the Maintenance Staff stated prior to the lift malfunctioning during the transfer of Resident #3, he had not been made aware of any prior problems. After the lift malfunctioned, he was told there were prior problems. The aides said it would gradually go down and they would have to bring it back up. He stated there was no documentation that he had serviced the lift. The Maintenance Staff stated he lubricated and tested the lift on a monthly basis. After the incident with Resident #3, he stated that he told the DON there had been prior problems with the lift but he did not tell the Administrator. On 8/03/05 at 10:36 a.m., the DON denied knowing there were problems with the lift prior to the incident with Resident #3. On 8/03/05 at 10:49 a.m. the Administrator stated, that he was not aware there had been problems with the lift prior to the incident with Resident #3. He stated the DON told him the aides heard a "popping" after the lift was placed in the up position.</p> <p>g. On 8/03/05 at 11:30 a.m., CNA #3 stated she knew there was a problem with the lift prior to the incident with Resident #3. She stated she would raise Resident #3 up in the lift and it would go back down slow. D.N.A. #3 stated there had been problems several weeks before the incident</p>	F 324			

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F 324	<p>Continued From page 5</p> <p>but that she "did not report it. I'm very sorry I didn't."</p> <p>h. On 8/03/05 at 11:37 a.m., CNA #4 stated when using the lift on Resident #3 only, the lift would start lowering. CNA #4 stated, " I just thought that was how it was supposed to be. I assumed somebody was told."</p> <p>2. Resident #1 had diagnoses of Nephrotic Syndrome, Renal Failure, Insulin Dependent Diabetes Mellitus, Right Below Knee Amputation, Peripheral Vascular Disease, Hypertension, Anemia, Coronary Artery Disease, Congestive Heart Failure, Morbid Obesity and Peripheral Neuropathy. The Minimum Data Set dated 5/11/05 documented that she was independent in her cognitive skills for daily decision making, had total dependence on the staff for transfer, mobility, locomotion, dressing and personal hygiene, had limitation of both legs and feet and could not attempt a test for balance without physical assistance.</p> <p>a. An Incident Accident Report dated 7/22/05 at 5:00 p.m. documented: "When I [CNA#1] arrived to Dialysis Center, I proceeded to unload resident. I lowered the lift with resident on it and the safety flap turned out which holds the chair on it. So the wheelchair fell off causing resident to land on her shoulder and head causing skin tears to right hand and right elbow. She complained of back and light hip pains. Bruising to right arm instantly at the skin tear sights. We had to increase her O2 (oxygen) by 1 because she couldn't breathe-ER (Emergency Room) called-sent to ER." The witness statement of Certified Nursing Assistant #1 documented: "the flap laid out on lift causing her chair to fall off with her in it, landing</p>	F 324			

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F 324	<p>Continued From page 6</p> <p>on shoulder and hitting her head on the concrete." On 7/22/05, no time noted D.N.A. #1 documented, "I checked the lift before I left the premises with the resident. The lift was latched at the flap. I looked at it because it was off a little. When I got her to Dialysis the flap was latched and when I stepped on lift to get in van it was still latched. When I put resident on lift and lowered it is when the flap malfunctioned and broke". The Xray Report dated 7/24/05 documented, "fracture of the distal clavicle with smaller separate superior fragment. Main fragments are in near anatomical alignment. There is some AC spurring."</p> <p>b. The Conference Report dated 7/22/05 documented, "Nature of the violation: locking wheelchair while in van lift usage... Corrective action necessary: [D.N.A. #1] was informed she wouldn't be allowed until pending of investigation-duties of van transportation... Action taken: [D.N.A. #1] was suspended from her duties of transport driver pending investigation ...van is not in use at this time."</p> <p>c. The "Facility Investigation Report for Resident Abuse, Neglect Misappropriation of Property, and Exploitation of Resident in Long Term Care" dated 7/25/05 at 4:00 p.m. documented, "Complete Description of Incident: On Friday, July 22, 2005, our Transporter [D.N.A. #1] was unloading our resident [Resident #1] at the Dialysis Center for her 4:30 p.m. appointment. Transporter [D.N.A. #1] was standing to the side of the lift with one hand on the resident and the other on the control to lower the resident down to the ground. [D.N.A. #1] stated she took her hand off the wheelchair to reach for the O2 tank when the wheelchair rolled off the lift approx 3-4 feet off</p>	F 324			

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F 324	Continued From page 7 the ground and it dumped the resident onto the concrete pavement as the resident landed mainly on her right side... On the van it has a lift gate that is supposed to lift up when the lift is going up and down to prevent the wheelchair from rolling off the lift. Transporter [D.N.A. #1] stated that she checked the lift before she left the premise and it was working fine and it had worked fine all week. Transporter [D.N.A. #1] stated that the lift guard didn't close when lowering the resident down to the ground. Upon evaluation with [Maintenance Staff] and ADM [Administrator] when the lift was in the closed position in the van and then it was coming out of the van and then coming down to either unload/load a resident the lift guard is suppose to be up in the closed position, but we noticed that it would open up and stay open until it reached the ground. Upon evaluation, we noticed the foot plate, which is suppose to release the lift guard once it reaches the ground, was bent and on the side of the lift where the lift guard is connected to the release plate (foot plate) there was a bolt or pin missing and that is why the lift plate didn't stay closed until the foot plate touches the ground to release the lift plate... Findings and actions taken: Internal investigation was completed. The van was pulled around the facility to be locked up as it was locked out/tagged out. [Maintenance Staff] removed all the keys for the van from the facility and removed the battery from the van so that no one could use the van. [Maintenance Staff] took the van to [facility] during the week of July 25-29 for an evaluate of the lift and the report will be complete next week... As far as our transporting our resident to appointment, the facility will used [transportation services]. Management has purchased a new van with a lift and when it comes to the facility we will inservice all	F 324			

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F 324	<p>Continued From page 8</p> <p>Transport/D.N.A. over the proper way to load and unload a resident into and out of the van. This event will be QA for the QA Committee and our Regional QA person will review the monitors on a monthly basis."</p> <p>d. On 8/2/05 the [Equipment Company] documented regarding the wheelchair lift that "the roll stop latch has been bent so that it is not working. It is bent in an open position so that the outboard roll stop thinks the platform is on the ground. I am not sure what caused the problem. There could be several reasons. 1.) Platform could have been let down with weight on it and hit the corner on a curb. 2.) Platform could have been let down on uneven ground. 3.) Platform could have been down and someone moved the van and hit something with that edge of the platform."</p> <p>e. On 8/02/05 at 8:56 a.m. the Director of Nurses [DON] stated, "The lip on the lift gave way- the wheelchair was not locked and rolled off the lift." She stated she talked with CNA #1 about locking the wheelchair. The DON stated there had been problems with the lift prior to the accident and the Maintenance Man had applied WD 40 and it was working fine.</p> <p>f. On 8/02/05 at 9:13 a.m. the Maintenance Staff stated a couple of weeks before the incident, CNA #1 reported the lip on the lift was sticking. He stated he worked on it and lubricated it with "white lithium, grease and WD 40." He stated the "lip was bent " and he "straightened it up." The Maintenance Man denied any other problems with the lift. He stated that after the incident with Resident #1, " the lip was broke on the side. When you raised the lift up- the lip was at a 180</p>	F 324			

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F 324	<p>Continued From page 9</p> <p>degree angle." He stated that when facing the lift it was broke on the right hand side. The Maintenance Man stated CNA #1 told him she checked the lift before she left the nursing home and that she was lowering Resident #1 on the lift and the resident fell out. He stated it was his responsibility to inservice the staff on all lifts. He stated, "the lip would not have stood up prior to the accident if it was broken then. It is my opinion- but I ' m not an expert on lips." He further stated and documented, "I state on a monthly basis, used WD 40 to clean roll stop latch pivot and slide points and side entry roll stop hinge and used white lithium grease in the same areas."</p> <p>g. On 8/02/05 at 10:20 a.m. the Administrator stated, "We started the investigation on the Friday." The Administrator stated CNA #1 wrote out a statement, and she told him and [Maintenance Staff] she had had no problems with the lift before. The CNA reenacted what she did and "all it was, was a lift malfunction." The CNA told him the wheelchair was not locked. The Administrator stated he did not do anything with [CNA #1].</p> <p>h. On 8/03/05 at 8:54 a.m. CNA #1 stated she had been transporting residents in the facility for 2 ½ years. She stated the day of the incident she folded out the lift, climbed onto the lift, and unbuckled Resident #1. She pushed the resident out onto the lift, unstrapped the oxygen tank on the roller and had hold of the resident. The CNA stated she had hold of the resident and started to lower the lift. She turned around to make sure the oxygen tank was steady and "the resident fell off to the center straight down- wheelchair rolled off the end." CNA #1 stated she had checked</p>	F 324			

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F 324	Continued From page 10 the lift before leaving the nursing home and "underneath the lift a little hook thing [release latch foot] was bent, I checked to make sure the flap would let out." The CNA stated she filled out papers for the Maintenance Man before she left the facility but she did not tell anyone. She stated 1 week before that happened the flap would not release, she told [Maintenance Staff] and put it also in the "van log." The CNA stated she assumed it was repaired- had been used all week. The day of the incident with Resident #1 was the first time she had driven the van since then. CNA #1 stated "the flap laid out when she [Resident #1] was on the lift. Her weight made it lay out." The CNA stated the resident "slipped out" of her right hand. The CNA said the wheelchair was not locked when the resident was on the lift "because when on the lift you can't reach to unlock the wheelchair." CNA #1 stated the Maintenance Staff was not here so she did not have him inspect the lift before she left with Resident #1. She stated she was initially trained to lock the wheelchairs but can't physically release the lock" on Resident #1's chair. CNA #1 stated she could not find the cradle device to put on the back of Resident #1's wheelchair to hold the oxygen tank and she used a "Bungee cord" to hold the oxygen tank. She stated she has never read the lift "owners manual." The CNA stated she was not suspended over this incident. The day of the incident with Resident #1 she went back to work at the facility and at approximately 7:00 p.m. she met with the Administrator. She told the Administrator what happened and she told him she "refused to drive van anymore." When asked if she was counseled she replied, "No."  i. On 8/03/05 at 9:25 a.m. the Administrator	F 324			

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F 324	<p>Continued From page 11</p> <p>stated, he only covered the wheelchair brakes with the aide. When he was told the Maintenance Staff and the DON did not have documentation of the QA [Quality Assurance] weekly rounds to see if wheelchair brakes are locked, the Administrator stated, "Not yet, no. That's one of the things we're working on- failure to follow through. We haven't done it yet." He stated there had been not been inservices on wheelchair locks done as of yet.</p> <p>j. On 8/03/05 at 9:40 a.m. the Maintenance Staff stated 3 weeks before the incident with Resident #1 he used a ball peen hammer to tap the plate on the bottom- foot latch- sticking- lubricated it. He stated he was not aware there was a maintenance log in the van.</p> <p>k. On 8/03/05 at 9:42 a.m. the Administrator stated, he did not know the Maintenance Man had used a ball peen hammer on the van lift approximately 3 weeks ago. When asked about a maintenance log in the van he stated, " From my understanding they would just tell [Maintenance Staff]."</p> <p>l. On 8/03/05 at 9:52 a.m. the Administrator of Record stated that she was not aware prior to the incident that the foot latch was not operating, not aware the Maintenance Staff had used a ball peen hammer on the lift, and was not aware CNA #1 had used a bungee cord to secure the oxygen in the van or that the CNA #1 had changed the protocols she was taught in training for using the van lift.</p> <p>m. The Installation/Service Manual documented on page 4 "if installation, maintenance or repair procedures cannot be completed exactly as</p>	F 324			

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F 324	Continued From page 12 provided in this manual or if the instructions are not fully understood contact [Company] immediately. Failure to do so may result in serious bodily injury and/or property damage." The 'lubrication diagram and chart' on page 34 documented that the "roll stop latch pivot and slide points" should be lubricated with a light penetrating oil with the specified (recommended lubricant being "LPS2, general purpose penetrating oil". On page 35 the "maintenance and lubrication schedule" documented that the lubrication should be repeated "at 4 week or 100 cycle intervals". On page 35 the warning notation documented "maintenance and lubrication procedures must be performed as specified by an authorized service technician. Failure to do so may result in serious bodily injury and/or property damage". The "Troubleshooting Diagnosis Chart" documented "roll stop latch faulty unlatching" with "possible cause" and "remedy" as "platform not fully lowered-lower platform, obstruction under platform preventing latch foot from contacting surface-remove obstruction or lower platform in different location (level surface), roll stop damaged (bent, deformed or misaligned)-correct or replace, latch bent, deformed or misaligned-correct or replace, latch pivot pin adapters damaged or missing-correct or replace and lack of lubrication-lubricate".  n. The Braun L955SE Millennium Series Lift Manual documented on page 9 the "lift operation safety" as "warning: whenever a wheelchair passenger (or standee) is on the platform, the passenger must be positioned fully inside yellow boundaries, wheelchair brakes must be locked, roll stops must be up (vertical), roll stop latch must be fully engaged, and passenger should grip both handrails (if able)." The "Lift Operation	F 324			

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F 324	Continued From page 13 Safety" on page 10 documented "warning-if the lift operating instructions, manual operating /or lift operation safety precautions are not fully understood, contact [Company] immediately. Failure to do so may result in serious bodily injury and/or property damage." Page 10 also documented "do not use platform roll stops as a barrier (brake). Stop and brake wheelchair when loading onto the platform (manually stop and brake manual wheelchairs)." The "Pre-Lift Operation Notes and Details" on page 16 documented "warning-discontinue lift use immediately if any lift component does not operate properly. Failure to do so may result in serious bodily injury and/or property damage." Page 16 further documented "the L955SE platform is equipped with an outboard roll stop and a side entry roll stop....the two roll stops function in unison. Discontinue lift operation immediately if either roll stop does not operate properly". Page 20 of the manual included the documentation that "the passenger must be positioned in the center of the platform to prevent side-to-side load imbalance. Other persons should not ride on the platform with the wheelchair passenger. The wheelchair brakes must be locked, the roll stops must be in the fully-up (vertical) position and the outboard roll stop latch must be fully engaged whenever a wheelchair passenger is on the platform. Do not use the outboard roll stop as a barrier (brake). Stop and brake the wheelchair when fully loaded on the platform. Manually stop and brake manual wheelchairs.....If the roll stops, bridge plate, handrails or any other lift component does not operate as outlined in this manual, discontinue lift use immediately and contact your sales representative. One of our national Product Support representatives will direct you to an	F 324			

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F 324	<p>Continued From page 14</p> <p>authorized service technician who will inspect your lift". On page 24 the "lift operating instructions" documented "whenever a passenger is on the platform, the: passenger must face outward, wheelchair brakes must be locked and roll stops must be up. Failure to do so may result in serious bodily injury and/or property damage."</p> <p>3. As of 8/3/05 at 12:00 noon, the facility administration had not ensured that nursing staff had been inserviced regarding the necessity to follow facility protocols for reporting the malfunction of resident care equipment (wheelchair brakes, lifts, etc). The facility administration had not ensured that the Maintenance Staff was technically competent to provide preventative maintenance and repair to healthcare equipment or outsource the preventative maintenance and repair of healthcare equipment to a technical support agency.</p> <p>The "Repair Requisition" Policy documented the "Purpose" as "to assist in the prompt repair of equipment, or facility physical plant features, that may be broken or have failed." Under the "standard" the policy documented "requests for repairs to equipment, or the building, should be communicated in writing to the maintenance department, using form PM.II-12a. The Maintenance Supervisor should check requisition requests each day and plan work accordingly. Equipment that is broken, or not working properly, should be pulled from use until returned to safe working condition."</p>	F 324			