

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

PRINTED: 03/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/15/2013
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NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 291 SOUTH WARREN STREET MORGANTOWN, KY 42261
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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
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F 000 INITIAL COMMENTS

F 000

A Recertification Survey was initiated on 03/12/13 and concluded on 03/15/13. No deficiencies were identified.

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4/12/13
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1972</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) story, Type II (000)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Two (2) Type II generators. Fuel source is natural gas and propane.</p> <p>A standard Life Safety Code survey was conducted on 03/13/13. Morgantown Care and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred twenty two (122) beds with a census of one hundred twelve (110) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. Life Safety from</p>	K 000	<p>Morgantown Care and Rehab Center does not believe and does not admit that any deficiencies existed, before, during, or after the survey. The Facility reserves the right to contest 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 right 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 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 or compliance and plan of correction as part of its ongoing efforts to provide quality care to residents.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 4/16/13
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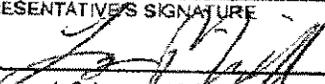
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<p>F 000 INITIAL COMMENTS</p> <p>A Recertification Survey was initiated on 03/12/13 and concluded on 03/15/13. No deficiencies were identified.</p>	<p>F 000</p>		
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BY: _____

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K 000	Continued From page 1 (Fire)	K 000		
K 029 SS-D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</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 that a hazardous area door was equipped with a self-closing device. This deficient practice affected one (1) of eight (8) smoke compartments, staff and approximately twenty sixteen (16) residents. The facility has the capacity for 122 beds with a census of 110 the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour, on 03/13/13 at 09:30 AM, with the Director of Maintenance (DOM) a corridor door to the Medical Records</p>	K 029	<ol style="list-style-type: none"> The identified door was equipped with a coordinator to ensure the doors close properly on 4/5/13. All fire doors have been observed by the Maintenance Director on 4/5/13 to ensure that they are closing properly. No further concerns were identified. The Maintenance Director was re-educated on K029 related to proper closing of fire doors by the Administrator on 4/12/13 The Maintenance Director will conduct monthly audits for three (3) months to ensure fire doors are closing properly. The audit results will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly. 	4/12/13

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K 029 Continued From page 2

room was observed not to have a door closing device. Door closing devices are required on corridor doors to rooms deemed to be a hazardous area.

An interview with the DOM, on 03/13/13, at 09:30 AM, revealed he was not aware this room would require a door closing device.

Reference: NFPA 101 2000 edition

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:

- (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

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K 029 Continued From page 3
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 than 48 in. (122 cm) above the bottom of the door.

K 029

19.3.8.3.4
Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous areas.

K 038 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

K 038

Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure exits were readily accessible in accordance with NFPA standards. This deficient practice affected seven (7) of eight (8) smoke compartments, staff and approximately ninety (90) residents. The facility has the capacity for 122 beds with a census of 110 the day of survey.

The findings include:

1. The combination that is required to operate the doors was posted next to the key lock on all exit doors by the Maintenance Director on April 12, 2013.
2. The combination that is required to operate the doors was posted next to the key lock on all exit doors by the Maintenance Director on April 12, 2013.
3. The Maintenance Director was re-educated on K038 related to locking arrangement requires combination to be posted by the Administrator on April 12, 2013.

4/12/13

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K 038 Continued From page 4

During the Life Safety Code tour, on 03/13/13 at 09:00 AM, with the Director of Maintenance (DOM) an exit door from the east hall was observed to have a magnetic locking device with no obvious method of operation. This type of locking arrangement would require the combination to be posted, however, other suitable locking arrangements were provided in the Life Safety Code if the facility felt it would make the exits safer for the residents.

An interview with the DOM on 03/13/13 at 09:00 AM revealed he was not aware he could not lock the exit doors in this manner. During the survey many exit doors throughout the facility were observed to be locked in this same unapproved manner.

Reference: NFPA 101 2000 edition

7.2.1.5.1

Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.

7.2.1.5.4*

A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.

19.2.2.2.5

K 038

4. The Maintenance Director will conduct weekly audits to ensure signage remains in place by the key lock for three (3) months. The audit results will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.

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K 038	Continued From page 5 Doors located in the means of egress that are permitted to be locked under other provisions of this chapter shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to keys carried by staff at all times, or other such reliable means available to the staff at all times. Only one such locking device shall be permitted on each door. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lb ² (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device,	K 038			

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K 038	Continued From page 6 relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler requirements were maintained. This deficient practice affected two (2) of eight (8) smoke compartments, staff and approximately thirty (30) residents. The facility has the capacity for 122 beds with a census of 110 the day of survey. The findings include: During the Life Safety Code survey, on 03/13/13 at 10:00 AM, inadequate sprinkler coverage was observed in the IC1 shower room. Further observation revealed the walls in the shower room would prevent the sprinkler from reaching all areas in this room.	K 062	1. Additional sprinkler heads will be placed in IC1 shower room by 4/26/13. 2. A 100% audit was completed by the Maintenance Director on 4/11/13 to ensure adequate sprinkler coverage was present. No other concerns were identified. 3. The Maintenance Director was re-educated on K062 by the Administrator on April 12, 2013. 4. The Maintenance Director will conduct monthly audits for three (3) months to ensure continued compliance. The audit results will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The	4/26/13

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K 062	Continued From page 7 An interview with the DOM, on 03/03/13 at 10:00 AM, revealed he was not aware of the improper sprinkler coverage. Reference: NFPA 13 1999 edition 5-5.5.1* Performance Objective. Sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-5.5.2 and 5-5.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard.	K 062	Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the kitchen had signage in place for the proper use of the Class-K portable fire extinguisher. This deficient practice affected one (1) of eight (8) smoke compartments and staff. The facility has the capacity for 122 beds with a census of 110 the day of survey. The findings include:	K 064	1. Signage was placed near the Class-K portable fire extinguisher in the kitchen to identify it as a secondary measure to the range hood extinguishing system on April 12, 2013. 2. There are no other Class-K portable fire extinguishers in the building. 3. The Maintenance Director was re-educated by	4/12/13

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NAME OF PROVIDER OR SUPPLIER MORGANTOWN CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH WARREN STREET MORGANTOWN, KY 42261		
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K 064	Continued From page 8 During the Life Safety Code tour, on 03/13/13 at 11:00 AM, observation revealed a Class-K portable fire extinguisher located in the kitchen area did not to have signage near the extinguisher for the proper use of this type of extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system. An interview, on 03/13/13 at 11:00 AM with the DOM, revealed he was not aware the extinguisher was required to have the proper signage in place. Reference: NFPA 10 1998 edition 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.	K 064	the Administrator on April 12, 2013 regarding F064. 4. The Maintenance Director will complete monthly audits to ensure the signage remains near the Class-K portable fire extinguisher in the kitchen for three (3) months to ensure continued compliance. The audit results will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 95 This STANDARD is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure the kitchen hood fire suppression system was maintained according to NFPA standards. This deficient practice affected one (1) of eight (8) smoke compartments and staff. The facility has the capacity for 122 beds with a census of 110 the day of survey. The findings include:	K 069			

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K 069	<p>Continued From page 9</p> <p>During the Life Safety Code tour, on 03/13/13 at 11:00 AM, it was revealed the cooking range was observed to be pulled out approximately six (6) inches from the range hood. The range must be in the proper location for the range hood fire suppression system to operate properly.</p> <p>An interview with the DOM, on 03/13/13 at 11:00 AM, revealed he was unaware the range was pulled out too far from the range hood.</p> <p>At 01:50 PM, an interview and record review with the DOM revealed the range hood suppression system was not connected to the fire alarm system. The record revealed it was not applicable for the range hood to be connected to the fire alarm system. Interview with the DOM, at that time, revealed he was not aware the range hood should be connected to the fire alarm system.</p> <p>Reference: NFPA 96 1998 edition</p> <p>7-6.2 Where a fire alarm signaling system is serving the occupancy where the extinguishing system is located, the activation of the automatic fire-extinguishing system shall activate the fire alarm signaling system.</p> <p>9-1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior reevaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the</p>	K 069	<ol style="list-style-type: none"> 1. The cooking range will be relocated to the proper location for the range hood fire suppression system to operate properly by April 17, 2013. 2. A complete facility audit revealed that there were no other areas of the facility affected by this practice as observed by the Maintenance Director on April 12, 2013. 3. The Maintenance Director will be re-educated by the Administrator by April 12, 2013 on the requirements of K069 involving that the range must be in proper location for the range hood fire suppression system to operate properly. 4. The Maintenance Director will complete monthly audits to ensure the cooking range is in the proper location for three (3) months. The audit results will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly. 	4/17/13

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K 069	Continued From page 10 fire-extinguishing system. Exception: Cooking appliances moved to perform maintenance and cleaning provided the appliances are returned to their original positioning prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. A-9-1.2.2 The effectiveness of an automatic extinguishing system is affected by the placement of the nozzles. For this reason, it is essential that cooking appliances be situated in the area in which they were when the extinguishing equipment was designed and installed. If an appliance is moved from under the equipment for cleaning or any other reason, it should be replaced to its original position prior to initiating a cooking operation.	K 069		
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, interview and record	K 144	1. A vendor will be brought in to ensure that battery chargers are not wired directly to the battery by April 23, 2013. The Maintenance Director will begin recording transfer times when testing the generator by April 12, 2013. 2. The center has two	4/23/13

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K 144	<p>Continued From page 11</p> <p>review it was determined the facility failed to maintain the generator set by NFPA standards. This deficient practice affected eight (8) of eight (8) smoke compartments, staff and all the residents. The facility has the capacity for 122 beds with a census of 110 the day of survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey, on 03/13/13, at 10:15 AM, wiring was observed to be connected to the battery at the generator set.</p> <p>An interview with the DOM, on 03/13/13, at 10:15 AM, revealed the wiring was connected to a battery charger. Battery chargers were not to be wired directly to the battery for safety and operational reasons. The DOM stated he was not aware the battery charger wiring should not be connected directly to the battery.</p> <p>At 01:45 PM, an interview and record review with the (DOM) revealed he was not recording the transfer times when testing the generators. This type of testing ensures the generator is transferring power in a timely manner as required. Run times were not being recorded as well.</p> <p>Reference: NFPA 99 199 edition</p> <p>3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>a. Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of</p>	K 144	<p>(2) generators. The vendor will be brought in to ensure that battery chargers are not wired directly to the battery by April 23, 2013. The Maintenance Director will begin recording transfer times when testing the generators by April 12, 2013.</p> <p>3. The Maintenance Director will be re-educated by the Administrator on ensuring the generator's battery charger is not hooked directly to the generator battery by April 12, 2013.</p> <p>4. The Maintenance Director will check the generator on a monthly basis for three (3) months to ensure continued compliance. The audit results will be reviewed by the Quality Assurance Committee monthly for three (3) months for further recommendations. If at anytime concerns are identified, the Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.</p>	

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K 144 Continued From page 12
supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1.
b. Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b).

b. Inspection and Testing.
1.* Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.
2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.
3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.

Reference: NFPA 110 1999 edition

5-12.6
The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturer's recommendations and accepted engineering practices.
Battery charger output wiring shall be permanently connected. Connections shall not be

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K 144	Continued From page 13 made at the battery terminals. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations.	K 144		