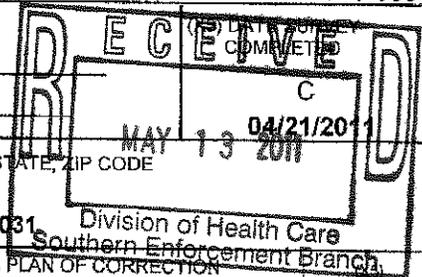


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	
NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031	
(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)	COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on April 19-21, 2011. Deficient practice was identified with the highest scope and severity being at "E" level. An abbreviated standard survey (KY15859) was also conducted at this time. The allegation was substantiated with deficient practice identified.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of the facility policies and records, it was determined the facility failed to ensure one of fourteen residents was allowed to make choices about aspects of his/her life in the facility that was significant to the resident. Resident #9 was required by the facility to go out on the porch to smoke even though the resident thought it was too cold to go outside and desired to smoke in the dining room. The findings include: A review of the facility's smoking policy, undated,	F 242	F242 Resident #9 is now given his choice on which designated smoking area he wishes to smoke at. All residents will be notified by facility's Social Service Director regarding their right to choose and how this right applies to the smoking policy. The facility's Social Service Director will provide an inservice to all staff regarding the resident's right to choose. The Social Service Director or designee will monitor the resident's choice and staff intervention on a daily basis. The facility's Social Service Director or designee will perform an audit addressing resident choice on a monthly basis X 3, then quarterly thereafter. The results of the audit will be submitted to the facility's Quality Assessment and Assurance Team for further consideration of any corrective action.	06/05/11



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

[Handwritten Signature]

TITLE

ADMINISTRATOR

(X6) DATE

05/10/11

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 242	<p>Continued From page 1</p> <p>revealed smoking was prohibited in all areas of the facility except the front patio and, during inclement weather, the designated area of the dining room.</p> <p>A review of the medical record for resident #9 revealed the resident was admitted to the facility on March 15, 2009. According to the resident's most recent Quarterly Assessment dated March 7, 2011, the resident was assessed to be cognitively intact. In addition, a review of the assessment and care plan revealed the resident required monitoring and supervision when smoking.</p> <p>Observations conducted on April 21, 2011, at 1:45 p.m., revealed six residents on the front patio smoking tobacco products. One resident was observed to be dressed in shorts and a shirt and one resident was observed to be wearing a T-shirt and pants. The remaining four residents, including resident #9, were observed wearing coats over their clothing. Additional observations conducted on April 21, 2011, at 2:20 p.m., revealed the patio area was shaded and the air temperature was 60 degrees Fahrenheit with moderate wind.</p> <p>An interview conducted with resident #9 on April 21, 2011, at 2:40 p.m., revealed the resident was required to go out in the cold to smoke and was not offered a choice to stay inside to smoke in the dining room. Further interview revealed that a meeting had been held the previous summer to discuss ways to reduce the smoke odor in the facility and, at that time, residents had agreed to go outside and smoke when the weather was "nice." Additional interview conducted with</p>	F 242			

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F 242	Continued From page 2 resident #9 revealed residents were often required to go outside and smoke on the porch when the weather was cold and residents were not offered a choice to smoke in the dining room. An interview conducted with the Activities Director on April 21, 2011, at 2:15 p.m., revealed the Activities Director had been instructed by the Administrator and the Director of Nursing (DON) to have residents smoke on the patio because the weather was "nice" outside. According to the Activities Director, residents who were dressed in shorts and T-shirts were encouraged to wear a coat outside but had refused. Further interview with the Activities Director revealed that residents were not asked if they thought the weather was too cold to go outside and smoke and had not been offered the opportunity to smoke in the dining room. An interview conducted with the Administrator and the Director of Nursing (DON) on April 21, 2011, at 2:30 p.m., revealed residents had been allowed to smoke in the dining room on the morning of April 21, 2011, because the weather was cool outside. However, the Administrator and the DON stated that when the weather became warm outside the Activities Director had been instructed to take the residents outside to smoke on the front porch. According to the Administrator and the Director of Nursing, the facility had not established guidelines to give residents the right to make choices about all aspects of the resident's life, including the resident's preference to smoke in the designated area located inside the facility or to go outside to smoke.	F 242		
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		

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F 253 SS=C	<p>Continued From page 3</p> <p>MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide housekeeping services necessary to maintain a sanitary interior. Wax and dirt buildup was observed on baseboard and tile edges near the walls in resident rooms, the 100 and 200 Halls, the dining room, and the main hallway/foyer near the nurses' station.</p> <p>The findings include:</p> <p>A review of the facility housekeeping policy and procedures regarding the cleaning of resident rooms and common areas revealed all floors were to be swept and mopped daily. The policy did not address stripping of the floors.</p> <p>Observations were conducted on April 20, 2011, at 4:25 p.m., and during an environmental tour of the facility with the Housekeeping Supervisor on April 21, 2011, at 3:50 p.m. A buildup of wax and dirt was observed on baseboards and tile edges in resident rooms 106, 108, and 112, the dining room, the main foyer by the nurses' station, and the 100 and 200 Hallways.</p> <p>An interview conducted with a facility</p>	F 253	<p>F253</p> <p>The baseboards will be cleaned and floor edges stripped in resident rooms #106, #108 and #112 by the Housekeeping Department.</p> <p>All baseboards will be cleaned and floor edges stripped in all resident rooms, the dining room, the main foyer and the 100 and 200 Hallways by the Housekeeping Department.</p> <p>The Housekeeping Supervisor will provide an inservice to the Housekeeping staff regarding floor maintenance. The Housekeeping Supervisor or designee will conduct daily environmental rounds to ensure a sanitary, orderly and comfortable interior is maintained.</p> <p>The Housekeeping Supervisor will provide the results of the daily environmental rounds to the Quality Assessment and Assurance Team on a monthly basis X3, and quarterly ;thereafter, to ensure compliance and determine what further corrective action is needed.</p>	06/05/11	

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F 253	Continued From page 4 housekeeper on April 21, 2011, at 10:45 a.m., revealed resident rooms were cleaned and mopped daily and two rooms were selected and "deep" cleaned daily in accordance with the facility's schedule. However, according to the housekeeper, deep cleaning did not involve the removal of wax or stripping the floors. An interview conducted with the Housekeeping Supervisor on April 21, 2011, at 3:50 p.m., revealed the floors had been previously stripped. However, the wax and dirt were not removed because the floor stripper did not reach the edge of the floor near the baseboards. Further interview with the Housekeeping Supervisor revealed the facility did not have a policy or schedule regarding stripping wax from the floors of the facility.	F 253			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of water temperature logs and facility policies, it was determined the facility failed to ensure the resident environment remained as free of accident hazard as possible. The hot water temperatures in central bathtubs in the 100 and	F 323			

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F 323	<p>Continued From page 5</p> <p>200 Hall baths was observed to be 120 degrees Fahrenheit. In addition, a therapy room on the 200 Hall was left unattended and unsecured on April 19 and 20, 2011, and allowed resident access to a Hydrocollator (a liquid heating device used to store "hot packs" for therapeutic use, with a recommended operating temperature of 160 degrees Fahrenheit to 166 degrees Fahrenheit), which created a burn hazard for residents.</p> <p>The findings include:</p> <p>A review of the facility policy titled Temperatures of Domestic Hot Water, undated, revealed the facility's hot water supply should be maintained within 100 to 110 degrees Fahrenheit. Further review of the policy revealed the water temperatures were to be monitored daily by the Housekeeping Department and work orders were to be completed promptly. There was no documented evidence provided that the facility had developed a policy regarding securing the therapy room to prevent resident access to hazardous equipment, i.e., the Hydrocollator.</p> <p>1. Observations conducted during the initial tour of the facility on April 19, 2011, at 3:00 p.m., revealed hot water temperatures in resident bathtubs on the 100 and 200 Halls were noted to be 120 degrees Fahrenheit.</p> <p>An interview conducted with the Assistant Director of Nursing (ADON) on April 20, 2011, at 3:00 p.m., revealed the facility had recently experienced problems with water temperatures in resident rooms and that maintenance personnel had adjusted water temperatures. The ADON also stated housekeeping staff was required to</p>	F 323	<p>F323</p> <p>The water temperature of the Hall 100 tub is being monitored daily. This tub is also equipped with an Anti- Scald device to maintain the water temperature of 100- 110 degrees Fahrenheit. The tub in the Hall 200 Bath has been disabled to prevent any accidents. The facility has applied for a variance to have the Hall 200 tub removed. A self- locking mechanism will be place on the Therapy door to prevent any unsupervised visits from residents.</p> <p>All staff will be inserviced regarding safety precautions for all aspects of the facility by facility's ADON in order to ensure safety awareness. The facility's Interdisciplinary Team will review each resident for safety concerns and update the care plan as needed.</p> <p>Water temperatures throughout facility will continue to be monitored on a daily basis and adjusted if need be by the Housekeeping and/or Maintenance Departments. The facility's Rehab Director or designee will ensure the Therapy door remains locked.</p>	

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F 323	<p>Continued From page 6</p> <p>monitor the water temperatures on a daily basis.</p> <p>An interview conducted with the Maintenance Director on April 21, 2011, at 3:35 p.m., revealed the facility's hot water temperatures had become out of range since mixing valves had been placed on resident sinks and showers. However, the Maintenance Director had not placed mixing valves on the resident bathtubs.</p> <p>An interview conducted with the Housekeeping Supervisor on April 21, 2011, at 3:50 p.m., revealed the Housekeeping Supervisor monitored water temperatures in the resident bath areas on a daily basis but had failed to monitor the water temperature of the bathtubs.</p> <p>A review of the Facility Water Temperature Logs dated January 2011 to April 2011 confirmed the bathtub water temperatures had not been monitored.</p> <p>2. Environment observations conducted on April 19, 2011, at 5:50 p.m., and on April 20, 2011, at 4:25 p.m., revealed an unlocked door to the Therapy room on the 200 Hall. The Therapy room was observed to be unattended and a Hydrocollator (a liquid heating device used to store "hot packs" for therapeutic use, with a recommended operating temperature of 160 degrees Fahrenheit to 166 degrees Fahrenheit) was observed in the Therapy room. A review of the temperature log revealed the water temperature of the Hydrocollator was 150 degrees Fahrenheit.</p> <p>An interview conducted with a Restorative Nurse Aide on February 21, 2011, at 1:40 p.m., revealed</p>	F 323	<p>The results of the recorded water temperatures will be provided to the Quality Assessment and Assurance Team on a monthly basis X 3, and quarterly; thereafter, to ensure compliance and determine what further corrective action might be needed.</p>	06/05/11	

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F 323	Continued From page 7 the Therapy Room door was to be kept locked when not in use or unattended. However, the therapy aide had reportedly failed to lock the door to the Therapy room when the aide left the facility on April 19 and 20, 2011. An interview conducted on April 21, 2011, at 9:25 a.m., with the Therapy Supervisor revealed the facility did not have an established policy related to security of the Therapy room, to ensure resident safety. An interview conducted with the facility Administrator on February 20, 2011, at 4:25 p.m., revealed the Administrator was not aware the door to the Therapy room had been left unlocked. The Administrator immediately locked the door to the Therapy room. Further interview revealed the Administrator was not aware of any resident trying to enter the room nor had any resident been burned by the equipment.	F 323	F363 All resident council concerns with meal service and menus will be answered by facility's Dietary Manager and Dietician. Their answers to these concerns will be approved by the facility's Nursing Home Administrator prior to the following resident council. All staff will be inserviced regarding Meal Service and Menus by the facility's Dietary Manager to raise their awareness of these issues. Any resident concerns regarding meals will be forwarded by the staff member to the Dietary Manager and Nursing Home Administrator.		
F 363 SS=B	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a preview of menus and resident council meetings, the facility failed to prepare, cook, and serve the foods listed on the pre-planned menu.	F 363	The Dietary Manager or designee, and Dietician will conduct audits on a daily basis to ensure Meal Satisfaction. The facility will not make any menu changes unless it is authorized by the Nursing Home Administrator or designee. The results of these audits will be provided to the facility's Quality Assessment and Assurance Team on a monthly basis X 3, then quarterly; thereafter, in order to ensure		

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F 363	<p>Continued From page 8</p> <p>Observation of the evening meal on April 20, 2011, at 5:30 p.m., revealed the residents were served canned fruit cocktail. A review of the pre-planned menu prepared by the facility dietitian revealed the facility dietitian had planned fresh fruit as a dessert.</p> <p>The findings include:</p> <p>Observation of the evening meal on April 20, 2011, at 5:30 p.m., revealed the residents received meatloaf, mashed potatoes, buttered corn, sliced white bread, and canned fruit cocktail. A review of the facility's pre-planned menu for April 20, 2011, revealed the facility dietitian had planned for the residents to receive fresh fruit instead of canned fruit.</p> <p>During the group meeting conducted on April 21, 2011, at 3:30 p.m., with 12 alert and oriented residents, the residents stated they were not always served the foods listed on the menu board at meals.</p> <p>A review of the Resident Council Minutes recorded by the facility Activities Director on March 14, 2011, revealed residents had complained that foods listed on the menu board were not always served. The residents also complained that they were receiving too much canned fruit and preferred other fresh food items.</p> <p>An interview was conducted with the facility Dietary Manager on April 20, 2011, at 6:00 p.m. The Dietary Manager stated she did not have any fresh fruit to serve the residents for the evening meal on April 20, 2011.</p>	F 363	compliance and determine if further corrective action is needed.	06/05/11

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K 000	INITIAL COMMENTS	K 000			
K 062 SS=F	<p>TYPE OF STRUCTURE: 1980 One-story unprotected frame Type V(000) with a complete automatic sprinkler system throughout.</p> <p>A life safety code survey was initiated and concluded on April 21, 2011. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). Grand Haven Nursing Home was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain their sprinkler system by NFPA standards. This deficient practice affected three of three smoke compartments, staff, and all of the residents. The facility has the capacity for 54 beds with a census of 51 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on April 21,</p>	K 062			

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MAY 13 2011
Division of Health Care
Southern Enforcement Branch

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

[Signature] Administrator 05/10/11

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 062	<p>Continued From page 1</p> <p>2011, at 12:30 p.m., with the Director of Maintenance (DOM), a record review revealed no documentation for an interior pipe inspection of the facility's sprinkler system. This inspection is due every five years. An interview with the DOM on April 21, 2011, at 12:30 p.m., revealed the DOM was unaware of this type of testing. The DOM was also not familiar with the task of draining excess moisture from the sprinkler system.</p> <p>An inspection report dated May 29, 2009, revealed the sprinkler contractor reported there was a concern with the water supply to the facility's sprinkler system. An interview with the DOM on April 21, 2011, at 12:30 p.m., revealed the DOM was not aware if this concern had been corrected.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a</p>	K 062	<p>K062</p> <p>The company that provides our sprinkler testing has been contacted by the facility to provide the latest interior pipe inspection of the facility's sprinkler system. The company has been notified that facility's Maintenance Director needs to be trained on how to drain excess moisture from the sprinkler system.</p> <p>The company that provides our sprinkler testing has been contacted to examine our system internally for obstructions.</p> <p>The facility has designated the Assistant Director of Nursing as the person to maintain all required inspection reports for each facility department. This person will audit and keep a checklist of what reports are current and due dates of future reports.</p> <p>The results of the audits will be provided to the Quality Assessment and Assurance Team on a monthly basis X3, and quarterly; thereafter, to ensure compliance and determine if further corrective action is needed.</p>	06/05/11
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185332	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/21/2011
NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031	
(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 062	Continued From page 2	K 062		
K 144 SS=F	complete flushing program shall be conducted. The work shall be done by qualified personnel. NFWA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFWA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the emergency generator set by NFWA standards. This deficient practice affected three of three smoke compartments, staff, and 51 residents. The facility has the capacity for 54 beds with a census of 51 on the day of the survey. The findings include: During the life safety code tour on April 21, 2011, at 12:05 p.m., an interview with the Director of Maintenance (DOM) revealed the DOM was maintaining fluid levels (water and oil) by checking the gauges on the generator while the generator was in operation instead of checking the actual fluid levels before the operation of the generator. The DOM was also not aware the generator transfer switch was required to be tested on a monthly basis. Observation revealed the DOM was unfamiliar with the generator by not	K 144	K144 The Director of Maintenance will be inserviced on how to properly inspect and maintain the facility generator. Bushes around the generator will be removed. The Director of Maintenance will conduct routine maintenance and operational testing according to the generator's manufacturing guidelines. The DOM will establish a written schedule for routine maintenance and operational testing, including a weekly test and monthly load test. The Director of Maintenance will provide the facility's Assistant Director of Nursing with the weekly inspection schedule and results of the weekly and monthly testing. The ADON will audit the reports for compliance. The results of the generator inspection audits will be provided to the facility's Quality Assessment and Assurance Team on a monthly basis X3 and quarterly; thereafter, in order to ensure compliance and determine if further corrective action is needed.	

06/05/11

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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 106 RODGERS PARK CYNTHIANA, KY 41031		
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K 144	<p>Continued From page 3</p> <p>being able to locate the battery or the oil dipstick. Observation revealed there were bushes around the generator that hampered the DOM from removing access panels to the generator. The DOM stated that the DOM had been at the facility since December 2010. The DOM stated that the DOM did not have access to or was not aware of Life Safety Code requirements in the performance of his duties at the facility.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established</p> <p>6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.</p>	K 144			

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NAME OF PROVIDER OR SUPPLIER GRAND HAVEN NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 105 RODGERS PARK CYNTHIANA, KY 41031
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K 144	Continued From page 4 6-4.7 The routine maintenance and operational testing program shall be overseen by a properly instructed individual.	K 144		
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