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

PRINTED: 06/29/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/15/2010

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
F 000	INITIAL COMMENTS A Recertification Survey was conducted on 06/13-15/10, a Life Safety Code Survey was conducted on 06/14/10. Deficiencies were cited with the highest scope/severity being a "F".	F 000	483.10(b)-(10), 483.10(b)(1) Notice of Rights, rights, services, charges. The Facility contacted and ordered the Title 18 and Title 19 posters from the Cabinet for Health and Family Services, Office of the Inspector General, Division of Long Term Care. The posters are now prominently displayed as of 7/8/10.	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,	F 156	Residents were informed of the posters during the resident council meeting on 7/8/10 by the Activities Coordinator to assure that they are aware of the information and where to locate it. New admissions will be informed during the admission process by the admission coordinator. Other residents will not be affected because the posters are now prominently displayed (as of 7/8/10). The Quality Assurance nurse will complete a bi-annual audit to assure that the posters remain in good condition and are prominently displayed. The posters will be replaced if needed. Monitoring will be completed by the Quality Assurance Nurse bi-annually and reported during the quality assurance meeting on a bi-annual basis.	Completion Date 7/9/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Roy Baker — TITLE: Administrator — (X6) DATE: 7/13/10

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/15/2010

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
F 156	Continued From page 1 including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/15/2010

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
F 156	Continued From page 2 provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to prominently display written information as to how to apply for and use Medicare and Medicaid benefits, the name, addresses and telephone numbers for all state client advocacy groups, the Protection and Advocacy Network and the Medicaid Fraud Control Unit. The findings include: A tour of the facility on 06/14/10 at 10:25 AM revealed there was no posting of how to apply for and use Medicare and Medicaid benefits. Also, the names, addresses, and telephone numbers of all pertinent State client advocacy groups such as	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/15/2010

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
F 156	Continued From page 3 the State survey and certification agency, State ombudsman program, protection and advocacy network, and the Medicaid fraud control unit were observed not to be posted, as required. Interview on 06/14/10 at 10:25 AM with the Administrator revealed the information was provided in the resident's packet and was displayed on the bulletin board; however, he was unaware that the displayed information did not meet regulatory requirements. Interview on 06/14/10 at 10:30 AM with the Assistant Director of Nursing revealed the admission packet was the only information they have posted in the 16 years she has worked there.	F 156	483.20(d), 483.20(k)(1) Develop Comprehensive Care Plans. Resident #4's care plan was updated for vision and dental needs and Resident #5's care plan was updated for cognitive and communication needs on 6/14/10. An in-service was conducted with both care plan nurses on 6/15/10 by the Director of Nurses regarding care plan completion in the areas of vision, dental, cognitive, and communication and including addressing all triggered areas that require care planning. An audit was completed to assure all residents care plans were complete for all triggered areas on 7/8/10 by the Quality Assurance Nurse. The Quality Assurance Nurse will audit care plans on a monthly basis to assure that all triggered areas are properly care planned as indicated. The Quality Assurance nurse will report the audit results to the Quality Assurance team on a monthly basis to assure that all triggered areas are appropriately Care Planned.	Completion Date 7/9/10
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND HAVEN NURSING HOME	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
F 279	Continued From page 4 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to develop a Comprehensive Plan of Care for (2) two of (14) fourteen sampled Residents (Residents # 4 and # 5). The facility assessed and identified the need for a Comprehensive Plan of Care for Resident #4 related to vision and dental needs, however; a Plan of Care was not developed. The facility assessed and identified the need for a Comprehensive Plan of Care for Resident #5 related to Cognitive Loss and Communication needs, however; a Plan of Care was not developed. The findings include: 1. Resident #4 was admitted on 11/20/09 with diagnoses which included Seizure Disorder, Chronic Obstructive Pulmonary Disease, Arthritis, Mini Strokes, Aortic Stenosis, History of Left Wrist Fracture, and Cataract of Right Eye. Review of RAPS (Resident Assessment Protocol Summary) related to Visual Function dated 02/23/10 revealed the facility identified the resident as having a Cataract and wore glasses for reading. Further review of the RAPS related to Dental Care revealed the facility noted the resident had upper dentures, one (1) tooth on the bottom, and did not wear a partial plate. The RAPS documentation indicated the facility would develop a care plan related to these needs. However, review of Resident #4's Comprehensive Plan of Care revealed no documented evidence of interventions related to the resident's vision	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/15/2010

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
F 279	Continued From page 5 and/or dental issues. An interview was conducted on 06/14/10 at 1:30 PM with LPN #2/MDS Coordinator related to Resident #4's visual and dental issues not being addressed on the Comprehensive Plan of Care. She stated "we just missed adding it to the (ADL) Activity of Daily Living care plan". 2. Based on clinical record review, Resident #5 was admitted to the facility on 10/14/09 with diagnoses which included Femur Fracture, Osteoporosis, Debility, Anxiety, Parkinson's Disease, and Chronic Gastritis. Review of the resident's RAPS, dated 10/28/09, revealed the facility noted the resident as having Cognitive Loss and Communication issues, related to hearing loss and difficulty understanding others. The facility indicated they would proceed to the care plan. However, review of Resident #5's Comprehensive Plan of Care revealed no documented evidence that interventions related to the resident's Cognitive Loss and Communication had been incorporated into the care plan. During an interview on 6/14/10 at 4:50 PM, LPN #2/MDS Coordinator revealed she had failed to create a care plan for Resident #5's Cognitive Loss and Communication, and was unsure how that happened. LPN #2 indicated she should have included these issues the Activities of Daily Living Care Plan.	F 279		
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.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/15/2010

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
F 323	Continued From page 6	F 323	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	
	This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as possible. Water temperatures in residents' rooms were as high as 116 degrees Farenheit, a wooden chair in room 113 had a nail head protruding out of the arm, the presence of chemicals in the unlocked Beauty Shop, and the presence of an unlocked cleaning cart which was accessible to residents. The findings include: Observation during the Environmental tour with the Administrator and Housekeeping Supervisor on 06/14/10 at 10:03 AM revealed the following: The water temperatures ranged from 112 to 116 degrees Farenheit in Resident Rooms #100, #107, #113, #203 and #210. The Administrator decreased the temperature on the water heaters, and the temperatures were checked again at 2:20 PM, revealing that temperatures continued to range from 110 to 114 degrees Farenheit in Resident Rooms #104, #113, #202, #207, #213 as well as the 100 hall Shower Room. The Administrator decreased the temperature on the water heaters again, and at 4:15 PM, the thermometers were re-calibrated and the water temperature in Room #106 was 114 degrees Farenheit and 116 degrees Farenheit in 100 hall Shower Room. The Administrator decreased the water heater temperatures again and, at 5:35 PM,		As of the date of the survey, water temperatures in all rooms identified were maintained at the required temperature range. The chair found to have a protruding nail in room #113 was corrected on 6/14/10. All chemicals located in the beauty shop in unlocked cabinets were removed and cabinet doors were locked on the day of survey. All chemicals found in the unlocked housekeeping utility cart were removed on the day of survey. A self-locking door knob and poster were applied to the beauty shop alerting staff that the door is to remain closed and locked at all times (unless beautician or staff member is present) on 6/13/10. All residents living in the facility had the potential to be affected by this practice. The housekeeping supervisor made environmental rounds to assess for environmental hazards on 6/15/10 to assure no other environmental hazards were present. New housekeeping carts with working locks were ordered and put into use on 6/16/10, the Housekeeping Supervisor conducted an in-service	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/15/2010

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
F 323	Continued From page 7 the temperatures ranged from 102 to 110 degrees Farenheit in Rooms #106, #207, 100 hall and 200 hall Shower Rooms. A wooden chair located next to an unsampled resident's bed in Room #113 had a nailhead protruding on the top surface of the left arm. At 2:20 PM the nailhead was still protruding. By 5:35 PM, the nailhead could no longer be felt. Observation of the Beauty Shop on 06/14/10 at 8:57 AM revealed the door to be unlocked, and the following chemicals were observed to be stored in an unlocked cabinet: Barbicide Hospital Germicide Pseudomonacide Fungicide Virucide (MSDS Health Hazards - Direct eye contact may cause irreversible damage, Repeated contact may cause skin irritation or burns, Probable mucosal damage or serious injury/death if ingested, Call a physician, May irritate or damage mucus membrane if inhaled.), and 10 Hair and personal care products. The following chemicals were found in an unlocked cabinet drawer: Silvadene Cream (prescription label revealed it belonged to Resident #3), Double Antibiotic Ointment and Aloevesta Skin Protectant. During the Environmental tour at 10:35 AM, the above chemicals were still present. At 10:15 AM, an unlocked cleaning cart was observed in the 100 hall with the following chemicals: Puritan T and T Porcelain and Tile Cleaner (MSDS Health Hazards- Causes eye irritation- avoid contact with eyes, Wash thoroughly after handling, Slightly irritating to skin and respiratory system), Endust Furniture Polish (MSDS Health Hazards- WARNING! Flammable Aerosols, May be harmful if swallowed, May cause eye irritation, Can cause central nervous system (CNS) depression, Intentional misuse by deliberate inhalation may be	F 323	with housekeeping staff on 6/15/10 educating them on environmental hazards (including areas of deficiency and other environmental hazards). The Housekeeping supervisor or her designee will monitor locks on a monthly basis to assure proper function. The Housekeeping supervisor or designee will assure that housekeeping carts and the beauty shop cabinets are locked daily. All chairs with nails have been examined and no other chairs with nail protrusions were identified, the Housekeeping Supervisor or designee will complete environmental rounds on a monthly basis. Water temperatures were being monitored once daily prior to this survey and are now being monitored twice daily by the Housekeeping supervisor or designee to assure compliance to temperature regulations. The housekeeping staff will monitor cart locks on a daily basis and the Housekeeping supervisor or designee will monitor the housekeeping locks at least monthly to assure proper function and immediately notify the Administrator if locks do not function properly. The housekeeping supervisor or designee will conduct monthly environmental rounds to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185332		06/15/2010

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
F 323	Continued From page 8 harmful or fatal, Do not ingest, Avoid contact with eyes, High vapor concentrations can cause headaches, dizziness, drowsiness and nausea and may lead to unconsciousness), Nilium Deodorizer (MSDS Health Hazards- Direct exposure may irritate eyes, Prolonged or repeated exposure may irritate skin). Housekeeping Supervisor revealed lock is broken. Interview with Administrator on 06/14/10 at 10:15 AM revealed he was unaware the cleaning cart lock was broken, and explained he would order a replacement lock. Interview with Administrator on 06/14/10 at 10:35 AM revealed the chemicals should not be stored in Beauty Shop. He explained and door was usually locked because medication carts were stored in the room. He was unsure why the door to the room was unlocked at 8:57 AM.	F 323	ensure compliance to a safe environment. Water temperature monitoring was increased to twice daily as of the day of survey; any temperature noted to be outside of the regulatory range will be immediately notified to the Administrator. Results of the environmental rounds will be reviewed at the Quality Assurance meetings which are conducted weekly.	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a safe, functional, sanitary and comfortable environment for the residents. The findings include:	F 465		Completion Date 7/30/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/15/2010

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
F 465	Continued From page 9 Observation during the Environmental tour on 06/14/10 at 10:03 AM revealed the 200 hall Shower Room had four (4) missing tiles on the wall divider, the 100 hall Shower Room had a loose hand rail in the shower, the sink faucet in Room #207 did not function properly, and the bathrooms in Room #112 and Room #212 had a strong urine odor and black substance on the wall. Interview on 06/14/10 at 10:22 AM with the Housekeeping Supervisor revealed the bathroom in Room #112 needed to be cleaned, and that he would make sure it was done. Interview on 06/14/10 at 10:50 AM with the Administrator revealed the bathroom in Room #212 needed to be cleaned. He explained the facility had been unsuccessful in previous attempts in removing black substance.	F 465	483.70(h) SAFE/FUNCTIONAL/SANITARY/ COMFORTABLE ENVIRONMENT The missing tile in 200 Hall Shower room was replaced on 7/12/10, the loose hand rail in 100 Hall Shower room was repaired on 6/15/10. The sink faucet in room 207 was replaced on 6/15/10. The bathrooms in rooms 112 and 212 were thoroughly cleaned and the grout on the wall (referred to as a black substance) was thoroughly cleansed and partially removed on 6/15/10. All residents of the facility have the potential to have been affected by the practice. Environmental rounds were completed by the Housekeeping Supervisor on 6/15/10 to assure no other residents were affected by the same or similar practices. The Housekeeping Supervisor or designee will monitor monthly by environmental rounds to assure that there are no areas that are unsafe, nonfunctional, unsanitary, or uncomfortable. The Housekeeping Supervisor conducted an in-service with housekeeping staff on 6/15/10 regarding safe, functional, sanitary,	

			and comfortable environmental conditions. The Housekeeping Supervisor or designee will conduct weekly environmental rounds to assure safe, functional, sanitary, and comfortable conditions and report any deficient areas immediately to the Administrator and review weekly at the Quality Assurance Meeting.	Completion Date 7/30/10

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

PRINTED: 06/29/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185332	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/14/2010

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 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 06/14/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a " F".	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure a combustible canopy located at the front of the facility was sprinkler-protected, as required. The findings include: Observation on 06/10/10 at 10:30 AM, with the Administrator, revealed a canopy of combustible construction (wood) which was approximately 48 feet by 12 feet in size, located at the front of the facility was noted not to be sprinkler-protected. Interview on 06/10/10 at 10:30 AM, with the Administrator, revealed he was unaware the canopy was not sprinklered. Reference: NFPA 13 (1999 Edition). 5-13.8.1 Sprinklers shall be installed under exterior roofs	K 012	NFPA 101 LIFE SAFETY CODE STANDARD. Three dry pendent sprinklers will be installed in the affected area to meet industry standards and requirements. All residents with the potential to be affected are identified as all residents living in the facility. All areas which require sprinklers have sprinklers. No additions will be made to the facility without assuring needed sprinklers are installed. Bids to add sprinklers have been obtained and agreed upon based on a 6/23/10 proposal. Installation is to begin during the week of 7/12/10. No additional sprinklers are required according to the life safety inspection, thus no other areas exist requiring sprinkler system installation. Any future areas identified as needing sprinkler systems will be reviewed by the Quality Assurance Committee at the time of that any future areas are installed (ie: construction of new awnings).	Completion Date 7/30/10

RECEIVED
JUL 26 2010
BY:

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185332	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/14/2010

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 012	Continued From page 1 or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 012		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide a smoke barrier according to NFPA standards. Penetrations in the smoke barriers were located in the 100 and 200 hall corridors The findings include: Observations on 06/14/10 at 9:54 AM, revealed a total of five (5) penetrations in the 100 hall corridor smoke barrier above the drop in ceiling tiles. The penetrations were around conduit running through the smoke barrier. Further observations revealed two (2) penetrations in the 200 hall corridor smoke barrier above the drop in ceiling tiles. The penetration were around conduit running through the smoke barrier. The	K 025	NFPA 101 Life Safety Code Standard. All penetrations identified on the day of survey were corrected on that date. All residents have the potential to be affected by the cited deficiency, but are no longer at risk due to the penetrations being corrected on the day identified. The Administrator or his designee will conduct a follow-up visual observation to determine if any air penetrations exist at least bi-annually. A Quality Assurance monitoring system has been put into place which requires the Administrator or his designee to perform a follow-up visual exam of any areas of the building where penetrations of a fire wall may have concern. The penetrations were corrected on 6/16/10. The Quality Assurance monitoring was presented to the Quality Assurance committee on 7/13/10 and will be conducted at least bi-annually and presented to the Quality Assurance committee at least bi-annually.	Completion Date 7/13/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185332	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/14/2010

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 025	Continued From page 2 Administrator was present during the observation. Interview on 06/14/10 at 9:54 AM, with the Administrator, revealed he was unaware of the penetrations. Reference: NFPA 101 2000 Edition 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3 SMOKE BARRIERS 8.3.1* General. Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.	K 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185332	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/14/2010

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 025	Continued From page 3 Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier. 8.3.3 Fire Barrier Used as Smoke Barrier. A fire barrier shall be permitted to be used as a smoke barrier, provided that it meets the requirements of 8.3.4 through 8.3.6. 8.3.4 Doors. 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. 8.3.4.2* Where a fire resistance rating for smoke barriers is specified elsewhere in the Code, openings shall be protected as follows: (1) Door opening protectives shall have a fire protection rating of not less than 20 minutes where tested in accordance with NFPA 252, Standard Methods of Fire Tests of Door Assemblies, without the hose stream test, unless otherwise specified by Chapters 12 through 42. (2) Fire windows shall comply with 8.2.3.2.2. Exception: Latching hardware shall not be required on doors in smoke barriers where so indicated by Chapters 12 through 42. 8.3.4.3* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1. 8.3.5 Smoke Dampers. 8.3.5.1 An approved damper designed to resist the passage of smoke shall be provided for each air	K 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185332	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/14/2010

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 025	Continued From page 4 transfer opening or duct penetration of a required smoke barrier, unless otherwise specifically exempted by Chapters 12 through 42. Exception No. 1: This requirement shall not apply to ducts or air transfer openings that are part of an engineered smoke control system in accordance with Section 9.3. Exception No. 2: This requirement shall not apply to ducts where the air continues to move and the air-handling system installed is arranged to prevent recirculation of exhaust or return air under fire emergency conditions. Exception No. 3: This requirement shall not apply where the air inlet or outlet openings in ducts are limited to a single smoke compartment. Exception No. 4: This requirement shall not apply where ducts penetrate floors that serve as smoke barriers. 8.3.5.2 Required smoke dampers in ducts penetrating smoke barriers shall close upon detection of smoke by approved smoke detectors in accordance with NFPA 72, National Fire Alarm Code. Exception No. 1: Duct detectors shall not be required where ducts penetrate smoke barriers above the smoke barrier doors and the door release detector actuates the damper. Exception No. 2: Approved smoke detector installations located within the ducts in existing installations shall be exempt from the requirements of NFPA 72, National Fire Alarm Code. 8.3.5.3 Required smoke dampers in air transfer openings shall close upon detection of smoke by approved smoke detectors in accordance with NFPA 72, National Fire Alarm Code. Exception: Where a duct is provided on one side	K 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	185332		06/14/2010

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 025	Continued From page 5	K 025		

of the smoke barrier, the smoke detectors on the duct side shall be in accordance with 8.3.5.2.
8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers.
8.3.6.1
Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:
(1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions:
a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.
b. It shall be protected by an approved device that is designed for the specific purpose.
(2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions:
a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.
b. It shall be protected by an approved device that is designed for the specific purpose.
(3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions:
a. It shall be made on either side of the smoke barrier.
b. It shall be made by an approved device that is designed for the specific purpose.
8.3.6.2
Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185332	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/14/2010

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 025	Continued From page 6 meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure noncombustible ashtrays were provided in the	K 066	NFPA 101 LIFE SAFETY CODE STANDARD. All combustible ashtrays identified were discarded on the date identified during survey. All residents have the potential to be affected by the practice, but are no longer affected because the ashtrays were immediately disposed of once they were identified during survey. All ashtrays which might be purchased in the future will be constructed of noncombustible materials. Any future purchases of ashtrays will be reviewed by the Administrator or his designee and such purchases will be reviewed by the Quality Assurance committee at least quarterly.	Completion Date 6/13/10

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

PRINTED: 06/29/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185332	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/14/2010

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 066	Continued From page 7 smoking areas, according to NFPA standards. Observation on 06/14/10 at 10:22 AM revealed an ashtray in the designated smoking area constructed of combustible material (plastic). The Administrator was present during the observation. Interview on 06/14/10 at 10:22 AM, with the Administrator, revealed he was unaware the ashtray did not meet the requirements. 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		