

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

PRINTED: 01/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2014
NAME OF PROVIDER OR SUPPLIER GLASGOW HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141		
(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 and Abbreviated Survey investigating KY00022587 was initiated on 12/16/14 and concluded on 12/19/14. KY00022587 was unsubstantiated with no related deficiencies cited. Deficiencies were cited on the Recertification Survey with the highest Scope and Severity of a "D".	F 000	The Preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in this Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law.		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the Resident Assessment Instrument (RAI) User Manual 3.0, it was determined the facility failed to complete a comprehensive assessment after a resident experienced a significant change in his/her status for one (1) of fifteen (15) sampled residents (Resident #4).	F 274			

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JAN 16 2015

[Handwritten Signature]

ADMINISTRATOR

1/16/15

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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Resident #4 was noted to have sustained: a significant weight loss; developed a Pressure Sore; declined in bowel continence; and had a change in his/her communication status in October 2014. A Quarterly Minimum Data Set (MDS) Assessment was completed for Resident #4; however, there was no documented evidence the facility completed a Significant Change MDS Assessment as required for the resident.

The findings include:

Interview on 12/18/14 at 2:55 PM with the Administrator revealed the facility did not have a policy specific to Significant Change MDS Assessments. The Administrator stated the facility utilized the RAI User Manual 3.0 guidelines.

Review of the RAI User Manual 3.0 revealed a Significant Change MDS Assessment should be completed when a resident experienced a decline in two (2) or more areas which included: a change in a resident's decision-making; change in mood and/or behaviors; any decline in an Activities of Daily Living (ADLs) physical functioning area where a resident is newly coded as extensive assistance, total dependence or activity did not occur; the resident's incontinence pattern changed; emergence of unplanned weight loss; emergence of a new Pressure Ulcer at Stage II or higher; and overall deterioration of the resident's condition.

Record review revealed the facility admitted Resident #4 on 10/27/09 with diagnoses which included Hypertension, Seizure Disorder, Anxiety, and Diabetes. Review of the Annual MDS Assessment dated 07/14/14, revealed the facility

F 274 F274

1. A comprehensive assessment was completed by the MDS Coordinator on Resident #4 on 01/14/2015.
2. The MDS Coordinator and Interdisciplinary Team reviewed the most current MDS compared to the previous MDS for each resident to determine if there had been any Significant Change Assessments missed. This was completed on 01/15/2015.
3. Corporate Consultant reviewed the Significant Change criteria with the MDS Coordinator on 01/02/2015. MDS Coordinator will attend the facility morning meeting, the facility Medicare Review meeting, review 24 hour reports, and receive copies of all MD orders for review to assist in identifying changes in resident condition that may indicate a need for a Significant Change Assessment.
4. Director of Nursing will review 25% of all MDS's completed monthly for 6 months then quarterly for two quarters and compare them to the previous MDS to ensure no Significant Change Assessment was needed and not completed. Any missed Significant Change Assessment will be completed, if needed. Results of these audits will be presented to the facility QA Committee no less than quarterly for review.
5. Completion Date: January 17, 2015

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had assessed Resident #4 as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was cognitively intact. Continued review of the Annual MDS Assessment revealed the facility assessed Resident #4: to have no pressure areas; be occasionally incontinent of bowel; to require limited assistance of one (1) with eating; and to have a weight of two hundred and two (202) pounds.

Review of the Quarterly MDS Assessment dated 10/07/14 revealed the facility assessed Resident #4: to have three (3) Stage II Pressure Ulcers; as always being incontinent of bowel; to require extensive assistance with eating; and to have a weight of one hundred and eighty-seven (187) pounds. Further review of the Quarterly MDS Assessment revealed the facility assessed Resident #4 to have sustained a significant weight loss, and to have a decline in his/her communication status.

Observation on 12/16/14 at 12:45 PM, 2:53 PM and 3:55 PM revealed Resident #4 to be lying on the bed. Interview at the times of observation revealed Resident #4's speech could not be understood.

Interview on 12/16/14 at 12:55 PM, with Resident #4's daughter revealed the resident had experienced an overall decline recently due to having been diagnosed with a brain tumor which was affecting his/her speech.

Interview with the MDS Nurse on 12/18/14 at 2:15 PM, revealed she had started as the MDS nurse for the facility in mid-September, 2014. The MDS Nurse stated Resident #4 had experienced some

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F 274 : Continued From page 3
gradual declines which included his/her communication abilities. She revealed she felt as if a Significant Change MDS Assessment should have been completed for the resident related to the declines. Per interview, she had not completed a Significant Change MDS Assessment however, because she did not know all of the criteria required for completing a Significant Change MDS Assessment at the time of Resident #4's Quarterly MDS Assessment.

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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)
BUILDING: 01.
PLAN APPROVAL: 1985.
SURVEY UNDER: 2000 Existing.
FACILITY TYPE: SNF/NF.
TYPE OF STRUCTURE: One (1) story, Type III (211).
SMOKE COMPARTMENTS: Seven (7) smoke compartments.
FIRE ALARM: Complete fire alarm system installed in 1985 and upgraded in 2008, with eighty-six (86) smoke detectors and three (3) heat detectors.
SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1985 and upgraded in 2009.
GENERATOR: Type II generator installed in 1987. Fuel source is natural gas.
A Standard Life Safety Code Survey utilizing the CMS-2786S Short Form was conducted on 12/16/14. The facility was found to be in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty-eight (68) beds with a census of sixty-six (66) on the day of the survey.

The findings that follow demonstrate

K 000

The Preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in this Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law.

K017

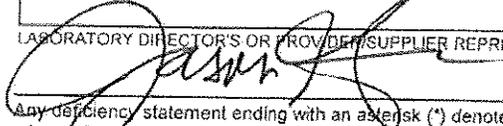
1. On 01/14/2015, the facility installed a connection to the fire alarm to the existing roll down type door which would shut the roll down door in the event of an emergency.
2. The facility checked all the egress paths in the facility to insure that there was not another separation which needed to be protected in the egress path. There were no other separations noted when checked on 01/14/2015 by the Maintenance Director.
3. The facility maintenance director will audit the egress paths within the facility each quarter, to insure that no new penetrations or changes in the paths occur which would result in a recurrence of this deficient practice. Results of the audit will be presented to the facility QA committee.
4. The QA committee will meet no less than quarterly to review the audits presented by the facility maintenance director related to the egress paths.
5. Completion Date: January 17, 2015

1/17/15

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

TITLE

(X6) DATE



Administrator

1/16/15

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K 000 Continued From page 1
noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).

K 000

K 017
SS=D NFPA 101 LIFE SAFETY CODE STANDARD

K 017

Deficiencies were cited with the highest deficiency identified at a "D" level.
Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.)
19.3.6.1, 19.3.6.2.1, 19.3.6.5

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure corridors were separated from use areas in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents in the dining room, staff

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K 017 Continued From page 2
and visitors. The facility has the capacity for sixty-eight (68) beds and the census was sixty-six (66) on the day of the survey.

K 017

The findings include:

Observation, on 12/16/14 at 9:51 AM, with the Director of Maintenance revealed a roll down type service door located in the corridor wall separating the kitchen from the egress path. The roll down type door was not self-closing or connected to the fire alarm to close in the event of an emergency.

Interview, on 12/16/14 at 9:52 AM, with the Director of Maintenance revealed he was not aware of the requirements for corridor walls protecting the egress path.

The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 12/16/14.

Reference: NFPA 101 (2000 edition)

19.3.6.3 Corridor Doors.

19.3.6.3.1*

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.

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K 017	Continued From page 3 Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service. 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. 19.3.6.3.4 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 017		
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K 017 Continued From page 4
Reference: NFPA 80, Standard for Fire Doors and Windows (1999 Edition)

Chapter 10 Fire Shutters
10-1 Shutters.
10-1.1 Construction.
Fire doors without glass lights shall be used as fire shutters.
10-1.2 Types.
Shutters shall be of the following three general types:
(a) Swinging door
(b) Horizontally or vertically sliding door
(c) Rolling steel door
10-2 Installation.
The installation of shutters shall be in accordance with the requirements for installation of swinging, sliding, and rolling steel doors.
10-3 Operation.
10-3.1 Automatic Closing.
All shutters shall be equipped to close automatically in the event of fire.
10-3.2* Weather Protection.
Where shutters are installed on the outside of an opening, they shall be protected against the weather to ensure proper operation.
10-3.3 Other Requirements.
The operation of shutters shall be in accordance with the requirements for operation of swinging, sliding, and rolling steel doors.
Chapter 11 Access Doors
11-1 Doors.
11-1.1 General.
This chapter shall cover the installation of both horizontal and vertical access doors in fire-rated walls, floors, and floor-ceiling or roof-ceiling assemblies.
11-1.2 Components.
An access door shall be an integral unit including

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K 017	<p>Continued From page 5</p> <p>the door, frame, hinges, latch, and closing device (where required) bearing a label that reads "Frame and Fire Door Assembly. "</p> <p>Exception: A vertical access door shall be permitted to have hinges that are not part of the labeled assembly, provided the hinges conform to Table 2-4.3.1.</p> <p>11-1.2.1 Access doors shall be self-closing.</p> <p>11-1.2.2 Access doors shall be self-latching. Exception: A horizontal access door that does not open downward and that remains in place when an upward force of 1 psf (48 N/m²) is applied over the entire exposed surface of the door shall not be required to be self-latching.</p> <p>11-1.2.3 Self-closing access doors that are intended to be used to allow a person to enter the concealed space behind the door completely shall be operable from the inside without the use of a key or tool.</p> <p>11-1.2.4 Access doors shall be installed in accordance with their listing.</p> <p>11-2 Types of Doors. 11-2.1 Horizontal Access Doors. 11-2.1.1 Door assemblies used in fire-rated floors or floor-ceiling or roof-ceiling assemblies shall be tested in the horizontal position in accordance with the procedures described in NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials, and shall be labeled as horizontal access doors. 11-2.1.2 A horizontal access door shall bear a label that includes the additional wording " For Horizontal Installation. "</p>	K 017		
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K 017	Continued From page 6 11-2.1.3 A horizontal access door shall be used in a fire-rated floor or floor-ceiling or roof-ceiling assembly only where it has been tested and listed for use as a component of the assembly. 11-2.1.4 Horizontal access doors shall not be required to be subject to the hose stream test. 11-2.2 Vertical Access Doors. 11-2.2.1 Vertical access doors shall have a fire protection rating of 3/4 hour, 1 hour, or 1 1/2 hours. (See Appendix F.) 11-2.2.2 Vertical access doors shall be used only in walls. 11-2.2.3 Where the authority having jurisdiction determines that a vertical access door is located in proximity to combustibles so that, in a fire condition, the door is likely to transmit sufficient heat to ignite the combustibles, the temperature rise on the unexposed face of the door shall not exceed 250°F (139°C) at the end of a 30-minute exposure to the standard fire test as described in NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Such an access door shall bear a label indicating a maximum temperature rise of 250°F (139°C). 11-2.2.4 Closing by means of gravity using top-hinging vertical access doors shall be permitted to meet the requirements for self-closing doors. 11-2.2.5 A vertical access door shall bear a label that includes the additional wording " For Vertical Installation. "	K 017		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 047		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185340	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2014
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NAME OF PROVIDER OR SUPPLIER GLASGOW HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141
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Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, twelve (12) residents, staff and visitors. The facility has the capacity for sixty-eight (68) beds and at the time of the survey, the census was sixty-six (66).

The findings include:

Observation, on 12/16/14 at 9:54 PM with the Director of Maintenance, revealed the Grace Dining Room did not have complete exit signage to make the path of egress clearly recognizable.

Interview, on 12/16/14 at 9:54 PM with the Director of Maintenance, revealed he was unaware the Dining Room did not have proper exit signage.

The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 12/16/14.

Actual NFPA Standard:

Reference: NFPA 101 (2000 edition)

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1. On 01/09/2015, the maintenance director installed the exit sign in the dining room.
2. On 01/09/2015, the facility maintenance director checked the facility to insure that no other exit signs were needed. There was no additional exit signs needed at this particular time.
3. The maintenance director will audit for fire exit signs each quarter for the next year, and report the results of these audits to the quality assurance committee.
4. The QA committee will meet no less than quarterly to review the audits presented by the maintenance director related to exit signs.
5. Completion Date: January 17, 2015

1/17/15

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19.2.10 Marking of Means of Egress.
19.2.10.1
Means of egress shall have signs in accordance with Section 7.10.
Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons.

7.10 MARKING OF MEANS OF EGRESS
7.10.1 General.
7.10.1.1 Where Required.
Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42.
7.10.1.2* Exits.
Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.
7.10.1.3 Exit Stair Door Tactile Signage.
Tactile signage shall be located at each door into an exit stair enclosure, and such signage shall read as follows:
EXIT
Signage shall comply with CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, and shall be installed adjacent to the latch side of the door 60 in. (152 cm) above the finished floor to the centerline of the sign.
Exception: This requirement shall not apply to existing buildings, provided that the occupancy classification does not change.
7.10.1.4* Exit Access.
Access to exits shall be marked by approved, readily visible signs in all cases where the exit or

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K 047	Continued From page 9 way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements. 7.10.1.5* Floor Proximity Exit Signs. Where floor proximity exit signs are required in Chapters 11 through 42, signs shall be placed near the floor level in addition to those signs required for doors or corridors. These signs shall be illuminated in accordance with 7.10.5. Externally illuminated signs shall be sized in accordance with 7.10.6.1. The bottom of the sign shall be not less than 6 in. (15.2 cm) but not more than 8 in. (20.3 cm) above the floor. For exit doors, the sign shall be mounted on the door or adjacent to the door with the nearest edge of the sign within 4 in. (10.2 cm) of the door frame. 7.10.1.6* Floor Proximity Egress Path Marking. Where floor proximity egress path marking is required in Chapters 11 through 42, a listed and approved floor proximity egress path marking system that is internally illuminated shall be installed within 8 in. (20.3 cm) of the floor. The system shall provide a visible delineation of the path of travel along the designated exit access and shall be essentially continuous, except as interrupted by doorways, hallways, corridors, or other such architectural features. The system shall operate continuously or at any time the building fire alarm system is activated. The activation, duration, and continuity of operation of the system shall be in accordance with 7.9.2. 7.10.1.7* Visibility. Every sign required in Section 7.10 shall be	K 047		

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located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted.
7.10.2* Directional Signs.
A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent.
7.10.3* Sign Legend.
Signs required by 7.10.1 and 7.10.2 shall have the word EXIT or other appropriate wording in plainly legible letters.
7.10.4* Power Source.
Where emergency lighting facilities are required by the applicable provisions of Chapters 11 through 42 for individual occupancies, the signs, other than approved self-luminous signs, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration.
7.10.5 Illumination of Signs.
7.10.5.1* General.
Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode.
7.10.5.2* Continuous Illumination.

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Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8.
Exception*: Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system.
7.10.6 Externally Illuminated Signs.
7.10.6.1* Size of Signs.
Externally illuminated signs required by 7.10.1 and 7.10.2, other than approved existing signs, shall have the word EXIT or other appropriate wording in plainly legible letters not less than 6 in. (15.2 cm) high with the principal strokes of letters not less than 3/4 in. (1.9 cm) wide. The word EXIT shall have letters of a width not less than 2 in. (5 cm), except the letter I, and the minimum spacing between letters shall be not less than 3/8 in. (1 cm). Signs larger than the minimum established in this paragraph shall have letter widths, strokes, and spacing in proportion to their height.
Exception No. 1: This requirement shall not apply to existing signs having the required wording in plainly legible letters not less than 4 in. (10.2 cm) high.
Exception No. 2: This requirement shall not apply to marking required by 7.10.1.3 and 7.10.1.5.
7.10.6.2* Size and Location of Directional Indicator.
The directional indicator shall be located outside of the EXIT legend, not less than 3/8 in. (1 cm) from any letter. The directional indicator shall be of a chevron type, as shown in Figure 7.10.6.2. The directional indicator shall be identifiable as a directional indicator at a distance of 40 ft (12.2 m). A directional indicator larger than the minimum established in this paragraph shall be proportionately increased in height, width and stroke. The directional indicator shall be located

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K 047	Continued From page 12 at the end of the sign for the direction indicated. Exception: This requirement shall not apply to approved existing signs. Figure 7.10.6.2 Chevron-type indicator. 7.10.6.3* Level of Illumination. Externally illuminated signs shall be illuminated by not less than 5 ft-candles (54 lux) at the illuminated surface and shall have a contrast ratio of not less than 0.5. 7.10.7 Internally Illuminated Signs. 7.10.7.1 Listing. Internally illuminated signs, other than approved existing signs, or existing signs having the required wording in legible letters not less than 4 in. (10.2 cm) high, shall be listed in accordance with UL 924, Standard for Safety Emergency Lighting and Power Equipment. Exception: This requirement shall not apply to signs that are in accordance with 7.10.1.3 and 7.10.1.5.	K 047		
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