

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

PRINTED: 04/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ APR 2015 OFFICE OF INSPECTOR GENERAL B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2015
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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
<p>F 000</p> <p>F 323 SS=E</p>	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was conducted on 03/31/15 through 04/02/15 with deficiencies cited at the highest Scope and Severity of an "E".</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review it was determined the facility failed to ensure the resident environment remains free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents. Three resident bathrooms and a hall bathroom either had a call light cord that was too short or no cord at all. In addition, the hazardous waste container located outside the building by the staff parking lot and near the designated resident smoking area was observed unsecured with boxes of full sharps containers in it.</p> <p>The findings include:</p> <p>1. Interview with the Plant Operations Director, on 04/02/15 at 10:53 AM, revealed there was no written policy related to call light cords he was aware of.</p>	<p>F 000</p> <p>F 323</p>	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare Requirements.</p>	<p>5/8/15 Ⓢ</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Gracie Shephey* TITLE: *Administrator* (X6) DATE: *4/30/15*

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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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG F 323	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 323	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Continued From page 1</p> <p>On 03/31/15 a tour of the facility was conducted starting at 10:00 AM and revealed the following:</p> <p>A. Observation of Resident room #16 revealed there was no pull cord on the call light box of the resident bathroom.</p> <p>B. Observations of the bathrooms in Resident Rooms #27 and #30 revealed the call light boxes had cords but they were too short and not of adequate length.</p> <p>C. Observation of the A Hall bathroom which was available for resident use was observed without a cord on the call light box.</p> <p>Interview with the Plant Operations Director, on 04/02/15 at 10:53 AM, revealed he was not aware of the missing call light cords or cords that were too short. He stated the staff were supposed to put in a work order when those types of issues were identified and he had not received any work orders related to the bathroom call lights.</p> <p>Interview with the Director of Nursing (DON), on 04/02/15 at 2:45 PM, revealed the Plant Operations Director was responsible for keeping the call light cords in working order and at appropriate lengths. The DON stated someone should have identified the missing cords and cords that were too short but did not.</p> <p>2. Review of a facility policy titled, "Regulated Medical Waste", dated 2007, revealed the facility designates a locked locked regulated waste storage area.</p> <p>Observation on 04/01/15 starting at 10:00 AM</p>		<p>F223</p> <p><u>Residents affected</u></p> <ol style="list-style-type: none"> Resident Room #16 bathroom had call cord replaced on 4/2/15 by Maintenance Director. Resident room # 27 and 30 had new call cord replaced on 4/2/15 by Maintenance Director. A Hall bathroom was locked with automatic lock and made a public restroom by Maintenance Director on 4/2/15. 100% audit completed on bathroom call cords to check length and Placed new lock on Biohazard container located outside of the facility on 4/2/15 by Maintenance Director. <p><u>Residents Potentially Affected</u></p> <ol style="list-style-type: none"> A 100% audit completed on all resident bathroom call cords to check length and placement 4/21/15 by Maintenance Director. No further concerns were identified. All public bathrooms were audited by the maintenance director on 4/22/15 to determine if any other public bathrooms were unsecured without a call light. None were noted. 	5/8/15 a	

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F 323	<p>Continued From page 2</p> <p>revealed the hazardous waste storage container located outside the building by the employee parking lot had a broken lock leaving the container unsecured. Further observation revealed there were two (2) cardboard boxes containing numerous full sharps containers located in the unsecured hazardous waste storage container.</p> <p>Interview with Environmental Services Staff #1, on 04/01/15 at 10:00 AM, revealed nursing staff were responsible to place full sharp containers into the hazardous waste storage container and secure the container by locking the lock.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 04/01/15 at 10:35 AM, revealed the sharps containers were located in the resident rooms and on the medication carts. The LPN stated the sharps included used medication syringes with needles and used razors. The LPN further revealed if a narcotic medication was dropped during a medication pass, two (2) licensed nurses would sign the narcotic as wasted and it would be placed into a sharps container.</p> <p>Interview with Registered Nurse (RN) #2, on 04/01/15 at 10:25 AM, revealed when the sharps containers located throughout the facility became full, nurses would change them out and place the full ones in the hazardous storage container located outside the back of the building. She stated she did not know if nursing had a key to access the storage box and was not sure who did.</p> <p>Interview with RN #1, on 04/02/15 at 10:40 AM, revealed nurses place full sharps containers from the resident rooms and medication carts into the</p>	F 323	<p>3. On 4/2/15 the Maintenance Director conducted an audit of all bio-hazard storage areas and determined all had an automatic lock and were secured.</p> <p><u>Measures/Systematic Changes</u></p> <ol style="list-style-type: none"> All staff have been reeducated on importance of reporting any bathroom call cords that are too short or missing to Maintenance Director or Administrator by Administrator or unable to work until completing the education on 4/22/15. Maintenance Director was educated on checking the call cords monthly during scheduled bathroom audits in TELS. All licensed nurses and maintenance to be reeducated on the biohazard policy on 4/22/15 by Administrator or unable to work until completing the education. <p><u>Monitoring Changes</u></p> <ol style="list-style-type: none"> Maintenance Director was educated on checking the call cords monthly during scheduled bathroom audits in TELS 	5/8/15 OR

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F 323	Continued From page 3 big storage chest outside at the back of the building. RN #1 stated the nurses had a key to the hazardous waste storage box and were to ensure the box was locked. Interview with the DON, on 04/02/15 at 2:45 PM, revealed she expected the hazardous waste storage box located outside the facility to be locked at all times and nursing had a key at the nursing station. Interview with the Plant Operations Manager, on 04/02/15 at 10:53 AM, revealed nursing put the full sharps containers into the hazardous waste container at the back of the building and the container was to be secured by locking. He gave no explanation as to why the hazardous waste storage container was observed unlocked. He revealed the storage container should always be secured by locking.	F 323	2. Biohazard container will be audited by Maintenance Director, ADON or Housekeeping Supervisor monthly x4 months to ascertain container is locked. 3. The Maintenance Director will conduct monthly audits for three months of all bio-hazard storage areas to ensure that all are secured with working lock, resident bathroom call lights to ensure that that call light cord is in place and the appropriate length and public bathrooms to ensure that there is an automatic lock or call light system in place. The results of the audits will be reviewed at the Quality Assurance Committee (Director of Nursing, Administrator, Assistant Director of Nursing, MDS, Nursing Supervisors, , Social Services, Administrator and , Dining Services) meeting monthly for three (3) months with the Medical Director attending at least quarterly. . Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed.	5/8/15 CD
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy review and	F 371	<u>F371</u> <u>Residents affected</u>	

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F 371	<p>Continued From page 4</p> <p>interviews it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions. Observations of the walk in freezer on 03/31/15 and on 04/01/15 revealed water that was leaking from a water line had frozen into three (3) waterfall formations and had extended down into boxes of food items. An opened box of frozen spinach had a large mound of the frozen water that had dripped into it. A box of pizza crusts and a box of cranberries also had ice from the frozen water that had dripped onto them.</p> <p>Review of the Census and Condition, dated 03/31/15, revealed the facility census was fifty-eight and there were four (4) residents who received tube feedings.</p> <p>The findings include:</p> <p>Interview on 04/01/15 at 8:30 AM with the Dietary Manager revealed she was not aware of a facility policy related to maintenance of the walk in freezer</p> <p>Interview with the Administrator, on 04/01/15 at 3:00 PM revealed there was not a facility policy related to maintenance of the walk in freezer</p> <p>Review of Dietician Weekly reporting document, dated 03/25/15, revealed there was a leak in the walk in freezer and the leak was now a "frozen waterfall. "Please have this repaired".</p> <p>Observation of the facility kitchen, on 03/31/15 at 10:30 AM, to include the walk in freezer revealed the water line that extended across the top of the freezer to the exterior wall of the freezer was observed to have three (3) separate frozen</p>	F 371	<p>Frozen water removed from freezer and container placed under leaking condensation on pipe. All food affected was thrown away and all food removed from water leak area 4/2/15 by Dietary manager. Insulation placed on pipe on 4/20/15 to prevent condensation by Maintenance Director.</p> <p><u>Residents Potentially Affected</u></p> <p>Observation by the Dietary Services Manager on 2/23/15 noted that there were no further water leaks in the refrigerator.</p> <p><u>Measures/Systematic Changes</u></p> <p>Dietary staff have been re-educated importance of checking freezer daily, keeping doors closed to freezer and removing any frozen water(condensation) from pipes by Administrator on 4/22/15. Dietary reeducation on not storing any food products under affected area by Dietary Manager and Administrator or unable to work until completing the education on 4/22/15.</p> <p><u>Monitoring Changes</u></p> <p>Dietary Manager will audit freezer weekly to ensure staff are completing the freezer checks daily looking for any frozen condensation.</p>	5/8/15 JD

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F 371	<p>Continued From page 5</p> <p>formations from dripping water that looked like frozen waterfalls. Further observation revealed the dripping water that had frozen into waterfall formations extended down from the pipe of the ceiling of the freezer into an opened box case of frozen spinach on the freezer shelf. The frozen waterfalls also were covering a box of cranberries and a box of pizza crusts. Additional observation on 04/01/15 revealed the water was continuing to drip in the in the freezer and on those food items.</p> <p>Interview with the Dietary Manager, on 03/31/15 at 10:30 AM, revealed she was not sure how long the dripping water had been dripping and freezing in the waterfall formations. Further interview on 4/01/15 at 8:30 AM, with the Dietary Manager revealed she thought the dripping water from the leaks had been going on for about a month and she had told the maintenance man but she did not recall on what date. She stated she had spoke with him about it but no work order was filled out.</p> <p>Interview with the Administrator, on 04/01/15 at 3:00 PM, revealed she was aware of the leaking pipe in the walk-in freezer and the maintenance man had said there was not a lot they could do other than put a wrap of some sort on the pipe. The Administrator stated the milk company had informed the facility they would not replace the pipe and dietary staff had been informed not to place food items under the dripping water. The Administrator revealed the Dietary Manager was responsible and could have put a pan or something under the drip to keep it off food items.</p>	F 371	<p>Audits will be performed weekly for four (4) weeks, monthly for two (2) months and then quarterly for (1) quarter.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (Director of Nursing, Administrator, Assistant Director of Nursing, MDS, Nursing Supervisors, , Social Services, Administrator and , Dining Services) meeting monthly for three (3) months with the Medical Director attending at least quarterly. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further reccomendations as needed.</p>	5/10/15 	

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1982.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1962, with 21 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1962 and upgraded in 2010.</p> <p>GENERATOR: Type II generator installed in 2011. Fuel source is Natural Gas.</p> <p>A Recertification Life Safety Code Survey was conducted on 04/01/15. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility has the capacity for sixty-six (66) beds with a census of fifty-eight (58) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		<p>5/8/15</p> <p><i>[Signature]</i></p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Glenn Sheperd</i>	TITLE <i>Administrator</i> (X6) DATE <i>4/30/15</i>
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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 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 025 SS=F	Deficiencies were cited with the highest deficiency identified at a Scope and Severity of an "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 maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-six (66) beds and at the time of the survey, the census was fifty-eight (58). The findings include: Observation, on 04/01/15 at 2:15 PM, with the	K 025	K 025 – Unsealed penetration located in the smoke barrier extending above the ceiling located at A hall nurses station, unsealed penetration located in the smoke barrier extending above the ceiling located in the A hall by the therapy gym, unsealed penetration located in the smoke barrier extending above the ceiling located in the B hall by the nurses station, sealed / repaired on 4/3/15 with fire rated acrylic sealant by Maintenance Director. Maintenance staff will be re-educated on NFPA 101 by ADMINISTRATOR ON 4/22/15. Maintenance Director or Administrator will audit for unsealed penetrations monthly x 3 months .	5/8/15 

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K 025	<p>Continued From page 2</p> <p>Maintenance Director revealed an unsealed penetration located in the smoke barrier extending above the ceiling located in the A Hall by the Nurses' Station.</p> <p>Interview, on 04/01/15 at 2:16 PM, with the Maintenance Director revealed he was not aware of the penetration.</p> <p>Observation, on 04/01/15 at 2:20 PM, with the Maintenance Director revealed an unsealed penetration located in the smoke barrier extending above the ceiling located in the A Hall by the Therapy Gym.</p> <p>Interview, on 04/01/15 at 2:21 PM, with the Maintenance Director revealed he was not aware of the penetration.</p> <p>Observation, on 04/01/15 at 2:25 PM, with the Maintenance Director revealed an unsealed penetration located in the smoke barrier extending above the ceiling located in the B Hall by the Nurses' Station.</p> <p>Interview, on 04/01/15 at 2:26 PM, with the Maintenance Director revealed he was not aware of the penetration.</p> <p>The census of fifty-eight (58) was verified by the Administrator on 04/01/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/01/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition).19.3.7.3</p>	K 025	<p>The results of the audits will be reviewed at the Quality Assurance Committee (Director of Nursing, Administrator, Assistant Director of Nursing, MDS, Nursing Supervisors, , Social Services, Administrator and , Dining Services) meeting monthly for three (3) months with the Medical Director attending at least quarterly. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed.</p>	5/6/15 <i>[Signature]</i>

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K 025	<p>Continued From page 3</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.7.5</p> <p>Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted.</p> <p>Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2.</p> <p>Reference: NFPA 101 (2000 Edition) 8.3.6.1</p> <p>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:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <p>1. Be filled with a material capable of maintaining</p>	K 025		5/8/15 2
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NAME OF PROVIDER OR SUPPLIER BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1561 NEWTON AVE. BOWLING GREEN, KY 42104	
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K 025	Continued From page 4 the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) 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 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device 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 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		5/8/15 
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029	K029 – Converted back to an office with all hazardous combustibile storage removed on 4/20/15 by Maintenance Director.	

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K 029	<p>Continued From page 5</p> <p>option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-six (66) beds and the census was fifty-eight (58) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/14/15 at 8:30 AM, with the Maintenance Supervisor revealed the self-closing device had been removed from the door to the Human Resources Director Office. The office contained hazardous amounts of combustible storage.</p> <p>Interview, on 01/14/15 at 8:31 AM, with the Maintenance Director revealed he was not aware the self-closing device had been removed.</p> <p>The census of fifty-eight (58) was verified by the Administrator on 04/01/15. The findings were acknowledged by the Administrator and verified</p>	K 029	<p>Re educate Maintenance Director and safety committee on NFPA 101 on 4/22/15 by Administrator.</p> <p>Maintenance Director or Administrator will audit office areas for hazardous combustible storage monthly x 3 months .</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (Director of Nursing, Administrator, Assistant Director of Nursing, MDS, Nursing Supervisors, , Social Services, Administrator and , Dining Services) meeting monthly for three (3) months with the Medical Director attending at least quarterly. . Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed.</p>	5/8/15 

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K 029	Continued From page 6 by the Maintenance Director at the exit interview on 04/01/15. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards. Reference: NFPA 101 (2000 Edition) 9.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or	K 029		5/8/15 2

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K 029	Continued From page 7 field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices. Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2. Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of	K 029		5/8/15 	

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K 029	Continued From page 8 one door in a stair enclosure results in closing all doors serving that stair.	K 029		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.8, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain electronic supervision (tamper switches) for a water supply control valve installed on the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-six (66) beds and at the time of the survey, the census was fifty-eight (58). The findings include: Observation, on 04/01/15 at 1:36 PM, with the Maintenance Director revealed the sprinkler system main valve tamper switch failed to sound an alarm to indicate the valve was closed. Interview on 04/01/15 at 1:37 PM, with the Maintenance Director revealed he depended on the sprinkler contractor to keep the tamper switch working as required.	K 062	K 062 - Safe care came in and installed new tamper switch and documented on 4/10/15. Safe care will be the new company to check tamper switch Quarterly. Maintenance will be re-educated on NFPA 101 Life safety code standard by Administrator on 4/22/15. Maintenance director will audit monthly tamper switch. The results of the audits will be reviewed at the Quality Assurance Committee (Director of Nursing, Administrator, Assistant Director of Nursing, MDS, Nursing Supervisors, , Social Services, Administrator and , Dining Services) meeting monthly for three (3) months with the Medical Director attending at least quarterly. . Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed.	5/8/15 

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K 062	<p>Continued From page 9</p> <p>The census of fifty-eight (58) was verified by the Administrator on 04/01/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/01/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. 19.3.5.2* Where this Code permits exceptions for fully sprinklered buildings or smoke compartments, the sprinkler system shall meet the following criteria: (1) It shall be in accordance with Section 9.7. (2) It shall be electrically connected to the fire alarm system. (3) It shall be fully supervised. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as</p>	K 062		5/8/15 

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K 062	Continued From page 10 nonsprinklered. Reference: NFPA 101 (2000 Edition) 9.7.2.1*. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.	K 062		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation, and interview, the facility failed to maintain the generator set by National	K 144	K 144 -Generator repaired and enunciator operational for 24 hour monitoring on 4/21/15. Rented generator was removed. Safecare to be new generator vendor. Maintenance staff will be re-educated on Life Safety Code Standard - NFPA 99, 3.4.4.1. on 4/22/15 by Administrator. Maintenance Director or Administrator will audit and ascertain compliance with generator weekly x4 and monthly x3.	5/8/15 AD

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K 144	<p>Continued From page 11</p> <p>Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-six (66) beds with a census of fifty-eight (58) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 04/01/15 at 11:30 AM, with the Maintenance Director revealed the annunciator for the generator was not located in an area that it was likely to be heard. The facility was utilizing a rented generator while the facility generator was out of service. The rented generator was not connected to the annunciator panel inside the facility so staff could monitor the generator as required.</p> <p>Interview, on 04/01/15 at 11:31 AM, with the Maintenance Director revealed he was not aware the rented generator would have to meet the same requirements.</p> <p>Observation, on 04/01/15 at 1:30 AM, with the Maintenance Director revealed the battery charger located inside the generator enclosure to keep the battery charged for the emergency generator was connected directly to the battery terminals.</p> <p>Interview, on 04/01/15 at 1:31 AM, with the Maintenance Director revealed he was not aware the battery charger could not be connected directly to the battery terminals.</p> <p>The census of fifty-eight (58) was verified by the Administrator on 04/01/15. The findings were</p>	K 144	<p>Maintenance Director or Administrator will audit and ascertain compliance with generator weekly x4 and monthly x3.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (Director of Nursing, Administrator, Assistant Director of Nursing, MDS, Nursing Supervisors, Social Services, Administrator and Dining Services) meeting monthly for three (3) months with the Medical Director attending at least quarterly. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further recommendations as needed.</p>	5/8/15 	

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K 144	<p>Continued From page 12 acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/01/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 99 (1999 Edition) 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>a. Individual visual signals shall indicate the following:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning <p>b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually.</p>	K 144		5/8/15 	

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K 144	<p>Continued From page 13 [110: 3-5.5.2]</p> <p>Reference: NFPA 110 (1999 Edition) 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p> <p>Reference: NFPA 99 (1999 Edition) 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1. (b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b). Actual Standard: NFPA 110, 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. Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p>	K 144		5/8/15 

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K 144	<p>Continued From page 14</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing.</p> <p>1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p> <p>Reference: NFPA 99 (1999 Edition) 6-1.1* The</p>	K 144		5/8/15 

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K 144	<p>Continued From page 15</p> <p>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>Reference: NFPA 99 (1999 Edition) 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established</p> <p>Reference: NFPA 99 (1999 Edition) 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>Reference: NFPA 99 (1999 Edition) 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> <p>Reference: NFPA 101 (2000 edition) 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted.</p> <p>Reference: NFPA 110 (1999 ed.) 5-7 Heating, Cooling, and Ventilating. 5-7.1* Consideration shall be given to properly sizing the ventilation or air-conditioning systems to remove all the heat rejected to the EPS equipment room by the energy converter, uninsulated or insulated exhaust pipes, and other heat-producing equipment.</p>	K 144		7/8/15 2

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K 144	<p>Continued From page 16</p> <p>5-7.2 Adequate ventilation shall be provided to prevent temperatures or temperature rises in the EPS and related accessory equipment that exceed the recommendations of the manufacturer.</p> <p>5-7.3 For the EPS equipment room, the ventilation or cooling equipment, or both, shall be sized so that the ambient temperature shall not exceed the EPS equipment manufacturer ' s criteria or allowable maximum temperatures.</p> <p>Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in this room.</p> <p>Reference: NFPA 110 (1999 Edition) 5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize</p>	K 144		5/8/15 D	

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K 144	Continued From page 17 voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers ' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-six (66) beds and at the time of the survey, the census was fifty-eight (58). The findings include: Observations, on 04/01/15 at 10:30 AM, with the Maintenance Director revealed an oxygen concentrator was plugged into a power strip (UL 1449) located in Room #3. Interview, on 04/01/15 at 10:31 AM, with the Maintenance Director revealed he was unaware of the requirements for the use of power strips.	K 147	K 147 – Power strip removed 4/2/15 by Maintenance Director. 100% audit completed on 4/20/15 for power strip usage By maintenance Director. All storage removed from electrical box area on 4/2/15 by Maintenance Director. Maintenance will install 4 plug electrical box in place of power strip 4/21/15. Sign placed not to have storage within 3 feet of the electrical boxes Administrator on 4/22/15. Maintenance staff will be re-educated on Life Safety Code Standard – NFPA 70, National Electrical Code 9.1.2 on 4/22/15 by Administrator. Maintenance Director or Administrator or Housekeeping Supervisor will audit and ascertain compliance power strip usage and storage in electrical box areas weekly x4 then monthly x3.	5/8/15 

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K 147	<p>Continued From page 18</p> <p>Observations, on 04/01/15 at 11:20 AM, with the Maintenance Director revealed the electrical panel located in the Maintenance Room had storage within three (3) feet of the electrical panels.</p> <p>Interview, on 04/01/15 at 11:21 PM, with the Maintenance Director revealed he was not aware of the storage requirements around electrical panels.</p> <p>The census of fifty-eight (58) was verified by the Administrator on 04/01/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/01/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 70 (1999 edition) 110-26. Spaces 10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall</p>	K 147	<p>The results of the audits will be reviewed at the Quality Assurance Committee (Director of Nursing, Administrator, Assistant Director of Nursing, MDS, Nursing Supervisors, , Social Services, Administrator and , Dining Services) meeting monthly for three (3) months with the Medical Director attending at least quarterly. Anytime concerns are identified the Quality Assurance Committee will convene to review and make further reccomendations as needed.</p>	5/8/15 

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K 147	<p>Continued From page 19</p> <p>not be less than that specified in Table 110.26(A) (1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="3">Minimum Clear Distance</th> </tr> <tr> <th>Condition 1</th> <th>Condition 2</th> <th colspan="2">Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td>900 mm (3 ft)</td> <td colspan="2">1 m (3½ ft) 1.2 m (4 ft)</td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p> <p>(a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall</p>	Nominal Voltage to Ground	Minimum Clear Distance			Condition 1	Condition 2	Condition 3		0-150	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600	900 mm (3 ft)	1 m (3½ ft) 1.2 m (4 ft)		K 147		5/9/15 J
Nominal Voltage to Ground	Minimum Clear Distance																			
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K 147	Continued From page 20 be provided. (b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc. (c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. (C) Entrance to Working Space. (1) Minimum Required. At least one entrance of	K 147		5/8/15 <i>[Signature]</i>

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K 147	Continued From page 21 sufficient area shall be provided to give access to working space about electrical equipment. (2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met. (a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted. (b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition. (D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.	K 147		5/8/15 