

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

PRINTED: 03/07/2014  
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 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/20/2014
NAME OF PROVIDER OR SUPPLIER  BOWLING GREEN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1581 NEWTON AVE. BOWLING GREEN, KY 42104	
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K 025	Continued From page 7 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.	K 025		
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 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  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to maintain	K 029	K. 029 1. On 2/19/14 the Administrator noted the hazardous door next to the conference room was not propped open. 2. On 2/19/14 the Administrator observed that there were no doors propped open to hazardous areas. 3. All staff will be educated by Administrator, DON, ADON or Maintenance Director on not to prop doors open with any materials and keep egress doors clear by 3/28/14. 4. Audit will be conducted by Maintenance Director or Administrator to ensure egress doors and self closings are not blocked with any materials once a week for three months The results of these audits will be reviewed with the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality	3/21/14

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K 029	<p>Continued From page 8</p> <p>self-closing doors protecting hazardous areas.</p> <p>The findings include:</p> <p>Observation, on 02/18/14 at 11:13 AM, with the Maintenance Director from a sister facility revealed the door to a hazardous room located next to the Conference Room had a self-closing device installed to keep the door closed; however, the door was held open with a book-end and a paint can leaving the room open to the egress corridor.</p> <p>Interview, on 02/18/14 at 11:13 AM, with the Maintenance Director revealed contractors working on the building had held the door open and they were not aware of the requirements for protection from hazards.</p> <p>Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed he was not aware the door had been held open. Further interview revealed he was not aware of a policy for self-closing doors on hazardous rooms.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated</p>	K 029	<p>Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.</p>		

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K 029	Continued From page 9 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 <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), 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 field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	K 038 1. New locks that allow proper delayed egress and released when fire alarm is activated will be complete by 3/28/14. On 3/17/14 the three identified exit doors had signage placed that was at least one inch tall. 2. The Maintenance Director was educated by the administrator on or by 3/14/14 regarding ensuring delayed egress doors and exits were	3/31/14

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K 038	<p>Continued From page 10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, sixty-six (66) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure doors with delayed egress locks were operational and had proper signage.</p> <p>The findings include:</p> <p>Observation, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed the exit door located in the B-Hall was equipped with a delayed egress lock that failed to release when tested. The door would release with the fire alarm and with the keypad. Random staff members were asked to open the door with a 100% success rate; however, the code was not posted.</p> <p>Interview, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed he was not aware the delayed egress door was not functioning properly.</p> <p>Observation, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed the delayed egress signage on three (3) of three (3) exit doors did not have letters that were one (1) inch tall.</p> <p>Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy for delayed egress doors. Further interview</p>	K 038	<p>maintained in accordance with NFPA standards.</p> <p>3. Starting the week of 3/17/14, the Maintenance Director or Administrator will complete audits weekly for 8 weeks and then monthly for two months to ensure proper release of doors in the facility. The Maintenance Director will be educated by the Administrator by 3/28/14 regarding ensuring delayed egress doors and exits were maintained in accordance with NFPA standards.</p> <p>4. The Maintenance Director or Administrator will complete audits weekly for 8 weeks and then monthly for two months to ensure proper release of doors in the facility. The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly</p>		

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K 038	<p>Continued From page 11</p> <p>revealed the delayed egress doors were checked weekly; however, he was not aware the delayed egress door was not functioning properly.</p> <p>Reference:</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met:</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6:</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock</p>	K 038		

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K 038	Continued From page 12 within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.  (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS  7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.	K 038		

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K 038	Continued From page 13  7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.  Reference: NFPA 101 (2000 edition)  7.1.10.1* Means of egress shall be continuously maintained, free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.	K 038		

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K 038	Continued From page 14 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.  Reference: CMS S&C letter 5-38 7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 3 1/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below.	K 038		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Emergency lighting of at least 1 1/2 hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on interview and battery light testing record review, it was determined the facility failed to provide emergency lighting in accordance with	K 046	K-046 1. The facility will install new up to date emergency lighting throughout by 3/28/14. 2. An audit on 3/14/14 of all emergency lighting was conducted to ensure compliance with NFPA standards. No concerns were identified. 3. The Maintenance Director or Administrator will test the emergency lighting for a minimum duration of (30) thirty seconds monthly and 11/2 hour annually. This will be in accordance with the facility TELS program with battery back-up located at the transfer switch and the generator. Education of the Maintenance Director by the Administrator to audit proper emergency lighting by 3/28/14. 4. The Maintenance Director or Administrator will audit to ensure compliance of emergency lighting on a monthly basis for three months. The Maintenance Director or Administrator will monitor for deficiency findings and report findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of Nursing, Administrator, ADON, DON, Dietary Director, Maintenance Director, Social Services Director, and Activities Director with the Medical Director at least Quarterly.	3/31/14

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K 046	<p>Continued From page 15</p> <p>NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, sixty-six (66) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure they conducted monthly and annual emergency battery light testing for the minimum duration requirement of Emergency lighting for at least thirty (30) seconds monthly and 1-1/2 hour annually.</p> <p>The findings include:</p> <p>Emergency battery light testing record review, on 02/20/14 at 9:00 AM with the Administrator revealed the facility failed to test the emergency lights, with battery backup, located at the transfer switch and the generator for thirty (30) seconds monthly or 1-1/2 hours annually.</p> <p>Interview, on 02/20/14 at 9:00 AM, with the Administrator revealed he was not aware the lighting had to be tested for thirty (30) seconds monthly or 1-1/2 hours annually. Further interview revealed the facility did not have a policy for the testing of battery lights; however it was listed in the TELS program for monthly checks.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at</p>	K 046		

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K 046	Continued From page 16 floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.  7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  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	K 047	K 047 1. Exit signs and directional signs were installed in the kitchen on 2/24/14 Non -Exit signs will be installed at the front door to be completed on 03/28/2014. 2. The Maintenance Director or Administrator will inspect all exits in the building for proper signage by	3/31/14

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K 047	<p>Continued From page 17</p> <p>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 NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, and Kitchen Staff. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/18/13 at 1:40 PM, with the Maintenance Director from a sister facility, revealed the front door did not have signage to indicate if it was an Exit or No Exit. Review of the Plan of Correction from the previous survey revealed the front door had been removed from the egress path in the event of an emergency.</p> <p>Interview, on 02/18/13 at 1:40 PM, with the Maintenance Director revealed he was not aware the front door did not have the proper signage.</p> <p>Observation, on 02/19/13 at 10:20 AM, with the Maintenance Director revealed the kitchen did not have proper exit signage to make the path of egress clearly recognizable.</p> <p>Interview, on 02/19/13 at 10:20 AM, with the Maintenance Director revealed he was not aware the kitchen did not have proper exit signage.</p> <p>Interview, on 02/20/13 at 1:30 PM, with the Administrator revealed the facility did not have a policy for exit signage. Further interview revealed he was not aware the kitchen or the front door did not have proper exit signage.</p>	K 047	<p>3/28/14 any identified concerns will be corrected by 03/28/14.</p> <p>3. Education of the Maintenance Director by the Administrator to audit proper Exit and Non-exit signs by 3/28/14.</p> <p>4. The Maintenance Director or Administrator will inspect monthly for three months all exit doors for proper signs and ensure signs are maintained. The Maintenance Director or Administrator will present audit findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly</p>	

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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 047	<p>Continued From page 18</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>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.</p> <p>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,</p>	K 047			

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K 047	Continued From page 19 readily visible signs in all cases where the exit or 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.	K 047		

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K 047	Continued From page 20 Every sign required in Section 7.10 shall be 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.	K 047			

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K 047	<p>Continued From page 21</p> <p>7.10.5.2* Continuous Illumination. 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.</p> <p>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.</p> <p>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</p>	K 047		

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K 047	<p>Continued From page 22</p> <p>stroke. The directional indicator shall be located 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.</p> <p>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.</p> <p>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.</p> <p>7.10.7.2* Photoluminescent Signs. The face of a photoluminescent sign shall be continually illuminated while the building is occupied. The illumination levels on the face of the photoluminescent sign shall be in accordance with its listing. The charging illumination shall be a reliable light source as determined by the authority having jurisdiction. The charging light source shall be of a type specified in the product markings.</p> <p>7.10.8 Special Signs. 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows:</p>	K 047		

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K 047	Continued From page 23 NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approved existing signs. 7.10.8.2 Elevator Signs. Elevators that are a part of a means of egress (see 7.2.13.1) shall have the following signs, with minimum letter height of 5/8 in. (1.6 cm), in every elevator lobby: (1) * Signs that indicate that the elevator can be used for egress, including any restrictions on use (2) * Signs that indicate the operational status of elevators 7.10.9 Testing and Maintenance. 7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days. 7.10.9.2 Testing. Exit signs connected to or provided with a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3.  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.  Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual	K 047		

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K 047	Continued From page 24 activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system.	K 047		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments.	K 050	K 050 1. The Maintenance Director or Administrator will schedule and document fire drills at unexpected random times and 2 hours apart from previous quarter drills this schedule was reviewed by the Administrator on 03/14/14 2. The Maintenance Director or Administrator will schedule and document fire drills at unexpected random times and 2 hours apart from previous quarter drills this schedule was reviewed by the Administrator on 03/14/14 3. The Administrator will educate maintenance director on fire drills to be schedule randomly including weekends by 3/28/14.	3/31/14

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K 050	<p>Continued From page 25</p> <p>sixty-six (66) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure the fire drills were conducted quarterly on each shift at unexpected times.</p> <p>The findings include:</p> <p>Fire Drill record review, on 02/20/14 at 9:00 AM, with the Administrator revealed the facility failed to conduct quarterly fire drills for each shift at random times. The facility has three (3) shifts that work Monday-Friday and weekend staff that work three (3) shifts Saturday and Sunday. The Monday-Friday third shift fire drills were not being conducted at random times. The weekend staff (Saturday and Sunday) did not conduct quarterly fire drills for all three (3) shifts. Only three (3) fire drills were conducted on the weekend between 06/02/13 and 12/07/13 for the three (3) shifts.</p> <p>Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy to detail when to conduct fire drills. Further interview revealed the Maintenance Director was responsible for conducting the fire drills. Further interview revealed he was aware of the requirements for fire drills; however, he was not aware the fire drills were not being conducted in accordance with NFPA standards.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p>	K 050	<p>4. The Maintenance Director or Administrator will conduct fire drills on each shift and reports will be reviewed monthly for three months and then quarterly. The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.</p>	

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K 050	Continued From page 26 Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system required for life safety is	K 052		

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K 052	Continued From page 27 installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4  This STANDARD is not met as evidenced by: Based on observation, interview and fire alarm test it was determined the facility failed to maintain the fire alarm system per NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, sixty-six (66) residents, staff, and visitors. The facility has sixty-six (66) certified beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure manual fire pull stations were not blocked and keys were readily available.  The findings include:  Observation, on 02/18/14 at 11:10 AM, with the Maintenance Director from a sister facility revealed the manual pull station located by the exit door next to the Therapy Room was blocked by the storage of boxes and construction supplies in the corridor.	K 052	K 052 1. All storage of boxes and construction supplies will be removed and pull stations will be free of all obstructions by 3/28/14. New keys to the manual pull stations will be made and placed on the Maintenance Director or designee key ring and in the fire system box by 3/28/14 2. Daily rounds will be conducted to ensure that compliance is ongoing. 3. Education of staff will be conducted by the Administrator and Maintenance Director that all pull stations need to be clear of obstructions by 3/28/14. 4 The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.	3/31/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185224	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/20/2014
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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 052	<p>Continued From page 28</p> <p>Interview, on 02/18/14 between 11:10 AM and 4:30 PM, with the Maintenance Director revealed he was not normally in this building and was not aware they were storing items in the corridor blocking the manual fire pull.</p> <p>Observation of the Fire Alarm Test, on 02/19/14 at 2:00 PM, with the Maintenance Director revealed the facility did not have a key to reset the manual pull stations to discontinue the fire alarm test and reset the fire alarm control panel. The facility had to call a fire alarm contractor to bring out a key. The facility initiated a Fire Watch until the contractor arrived to reset the fire alarm control panel.</p> <p>Interview, on 02/19/14 2:00 PM, with the Maintenance Director revealed he was not aware the Maintenance Director, who was on medical leave, had taken the key home.</p> <p>Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy about blocking the fire pull station but was aware they were not to be blocked. Further interview revealed he was not aware the Maintenance Director who was on medical leave, had the key to reset the fire alarm.</p> <p>Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.</p>	K 052		
K 054	NFPA 101 LIFE SAFETY CODE STANDARD	K 054		

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K 054 SS=E	<p>Continued From page 29</p> <p>All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure battery smoke detectors were inspected and tested in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, sixty-six (66) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure that the battery powered smoke detectors located in resident rooms were being properly tested and cleaned.</p> <p>The findings include:</p> <p>Record review, on 02/18/14 at 3:00 PM, with the Administrator revealed the facility failed to provide documentation when the battery smoke detectors were installed. Further review revealed no documented evidence the weekly/monthly testing or cleaning of the battery powered smoke detectors located in the facility.</p> <p>Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy for testing battery smoke detectors and he was not aware of the testing requirements.</p> <p>Reference: NFPA 72 (1999 ed.)</p>	K 054	<p>K 054</p> <ol style="list-style-type: none"> <li>1. All battery operated smoke detectors in the facility have been removed by 3/28/14.</li> <li>2. The Maintenance Director or Administrator will audit facility to make sure all battery operated smoke detectors have been removed by 3/28/14.</li> <li>3. Education of staff will be conducted by the Administrator and Maintenance Director or designee on smoke detectors and other fire prevention devices related to NFPA standards by 3/28/14.</li> <li>4. The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.</li> </ol>	3/31/14

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K 054	Continued From page 30 7-4.1 Fire alarm system equipment shall be maintained in accordance with the manufacturer ' s instructions. The frequency of maintenance shall depend on the type of equipment and the local ambient conditions. Reference; NFPA 101 (2000 ed.) 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 4.6.12.2* Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. 4.6.12.3 Equipment requiring periodic testing or operation to ensure its maintenance shall be tested or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. 4.6.12.4 Maintenance and testing shall be under the supervision of a responsible person who shall ensure that testing and maintenance are made at specified intervals in accordance with applicable NFPA standards or as directed by the authority having jurisdiction.	K 054			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are	K 062			

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(X4) ID PREFIX TAG K 062	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG K 052	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
	<p>Continued From page 31</p> <p>continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, sixty-six residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure sprinkler heads located in the attic were free from foreign material, and storage was maintained eighteen (18) inches from a sprinkler head.</p> <p>The findings include:</p> <p>Observations, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed random sprinkler heads located in the attic throughout the facility to be covered in newly installed blow in fiberglass insulation. Further observation revealed there was storage within eighteen (18) inches of a sprinkler head located in the closet of room #15.</p> <p>Interview, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director, revealed he was not aware of the insulation covering the sprinkler heads in the attic or the storage within eighteen (18) inches of the sprinkler head.</p> <p>Interview, on 02/20/14 at 1:30 PM, with the</p>		<p>1. In Room #15, the item in the closet was removed away from the sprinkler head to maintain eighteen inches from a sprinkler head 2/19/14. The Maintenance Director has air blown the sprinkler heads to clean off fiberglass insulation in the attic by 3/28/14.</p> <p>2. The Maintenance Director will audit facility to make sure sprinkler heads are clear from any material by 3/28/14. <span style="float: right;">3/31/14</span></p> <p>3. Education by the Administrator and Maintenance Director that sprinkler heads are clear of obstructions by 3/28/14.</p> <p>4. The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.</p>

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K 062	Continued From page 32 Administrator revealed the facility did not have a policy for cleaning sprinkler heads. Further interview revealed he was aware of the requirements for sprinkler heads; however he was not aware of the insulation covering the sprinkler heads in the attic or the storage within eighteen (18) inches of the sprinkler head.  Reference: NFPA 13 (1999 Edition)  5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2.  2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall	K 062		

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K 062	Continued From page 33 never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062		
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the installation of portable fire extinguishers in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, thirty-three (33) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey.  The findings include:	K 064	K 064 1. All storage of boxes and construction supplies will be removed and fire extinguishers will not be obstructed 2/20/14. 2. Fire Extinguisher will be mounted in the back parking lot at our designate smoke area. The fire blanket will be mounted by 3/28/14. New urns and self closing ashtrays have been ordered for the smoking area by 3/28/14. The portable fire extinguisher will mounted by 3/28/14 in the kitchen. 3. Weekly audits will be conducted to ensure that compliance is met by the Maintenance Director or Administrator. Education of the staff will be conducted by the	3/31/14

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K 064	<p>Continued From page 34</p> <p>Observation, on 02/18/14 at 11:10 AM, with the Maintenance Director from a sister facility revealed the wall mounted, portable fire extinguisher located by the exit door next to the Therapy Room was blocked by the storage of construction tools and supplies being stored in the corridor.</p> <p>Observation, on 02/18/14 between 11:10 AM and 4:00 PM, with the Maintenance Director revealed a smoking area on the Front Porch and another smoking area in the back parking lot. Neither smoking area had a fire extinguisher installed.</p> <p>Observation, on 02/18/14 between 11:10 AM and 4:00 PM, with the Maintenance Director revealed a fire extinguisher sitting on the floor of a hazardous storage room located next to the conference room. Further observation revealed a fire extinguisher sitting on the floor of the Dining Room.</p> <p>Observation, on 02/19/14 at 10:20 AM, with the Maintenance Director revealed the wall mounted, K-class portable fire extinguisher located in the kitchen was blocked by carts. Further observation revealed there was no placard stating that the hood suppression system must be used before the class K fire extinguisher located in the kitchen. This type of extinguisher is used as a secondary measure to the range hood extinguishing system.</p> <p>Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed he was not aware the fire extinguishers were sitting on the floor or were blocked. He further stated that was no policy for fire extinguishers but it was part of the monthly rounds to check the fire extinguishers. Further</p>	K 064	<p>Administrator and Maintenance Director that all fire extinguishers are to remain off the floor and mounted correctly by 3/28/14.</p> <p>4. The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.</p>	

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K 064	<p>Continued From page 35</p> <p>interview revealed there was a smoking policy that stated all smoking areas would have a fire extinguisher. The Administrator stated he was not aware the smoking areas did not have a fire extinguisher.</p> <p>Reference: NFPA 10 1998 edition</p> <p>3-7 Fire Extinguisher Size and Placement for Class K Fires.</p> <p>3-7.1 Fire extinguishers shall be provided for hazards where there is a potential for fires involving combustible cooking media (vegetable or animal oils and fats).</p> <p>3-7.2 Maximum travel distance shall not exceed 30 ft (9.15 m) from the hazard to the extinguishers.</p> <p>Reference: NFPA 10 1999</p> <p>4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items:</p> <ul style="list-style-type: none"> <li>(a) Location in designated place</li> <li>(b) No obstruction to access or visibility</li> <li>(c) Operating instructions on nameplate legible and facing outward</li> <li>(d)* Safety seals and tamper indicators not broken or missing</li> <li>(e) Fullness determined by weighing or "hefting"</li> <li>(f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle</li> <li>(g) Pressure gauge reading or indicator in the operable range or position</li> <li>(h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units)</li> <li>(i) HMIS label in place</li> </ul>	K 064			

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K 064	Continued From page 36 4-3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 4-3.2 (a), (b), (h), and (i), immediate corrective action shall be taken.  Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.  Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	K-066 1. New urns and self closed ashtrays have been ordered for the smoking area 3/13/14. A new metal container with a self-closing cover device into which ashtrays can be emptied will be readily available to the smoking area by 3/28/14. A fire extinguisher will be mounted in the back parking lot at our designated smoking area. The fire blanket will be mounted by 3/28/14. 2. Weekly audits will be conducted to ensure that compliance is met by the Maintenance Director or Administrator. 3. Education of staff will be conducted by the Administrator or Maintenance Director to follow NFPA standards by 3/2/8/14. 4. The Maintenance Director of Administrator will monitor for deficiency findings and report any findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance committee will consist of at a minimum the DON, Administrator, ADON, Dietary Director, Maintenance Director, Social Services Director, and Activities Director with the Medical Director at least Quarterly.	3/31/14
K 066 SS=F	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.	K 066		

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K 066	Continued From page 37  (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, interview and policy review, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure the smoking areas had a metal container with a self-closing lid to dump ashtrays, a fire extinguisher, and a fire blanket.  The findings include:  Observation, on 02/18/14 at 1:45 PM, with the Maintenance Director from a sister facility revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, fire extinguisher, or a fire blanket located in the designated smoking areas, which	K 066		

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K 066	Continued From page 38 were located at the front entrance, and the rear exit.  Interview, on 02/18/14 at 1:44 PM, with the Maintenance Director revealed he was not aware the smoking area did not have the required metal container with a self-closing lid for dumping ashtrays, the fire extinguisher, or the fire blanket.  Policy review, on 02/19/14 at 2:38 PM, with the Administrator revealed the smoking policy stated that the facility would provide a metal container with a self-closing lid, a fire extinguisher, and a fire blanket in all designated smoking areas.  Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed he was not familiar with the smoking policy before 02/19/14. He stated he was not aware the smoking areas did not have the required metal container with a self-closing lid for dumping ashtrays, the fire extinguisher, or the fire blanket.  Reference: NFPA Standard 101 (2000 Edition),  19.7.4 Smoking (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		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96  This STANDARD is not met as evidenced by:	K 069	1. The hood will be cleaned and inspected by outside contractor by 3/28/14  Pull stations have been relocated and will remain free of obstructions. The tables in the kitchen will be	

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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
K 069	<p>Continued From page 39</p> <p>Based on interviews, record review and review of the kitchen hood inspection records, it was determined the facility failed to ensure the kitchen hood system was in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure the kitchen hood was cleaned and the hood suppression system was inspected semi-annually.</p> <p>The findings include:</p> <p>Kitchen hood inspection record review, on 02/20/14 at 9:00 AM with the Administrator, revealed the hood inspection had been done; however, the report showed no details of the condition or what was inspected. The report also failed to show when the last hydrostatic test was performed. Further record review revealed the facility failed to produce documentation that the hood had been cleaned within the last year.</p> <p>Interview, on 02/20/14 at 1:30 AM with the Administrator, revealed the facility did not have a policy for Kitchen Hood inspections. Further interview revealed the Administrator was aware of the testing requirements; however, he was not aware the Kitchen Hood was not being inspected as required.</p> <p>Reference: NFPA 10 (1998 Edition).</p> <p>2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using</p>	K 069	<p>removed been removed by 3/28/14.</p> <p>2. Weekly audits will be conducted to ensure that compliance is met the Maintenance Director or Administrator.</p> <p>3. Education of the kitchen staff will be conducted by the Administrator and Maintenance Director that the electrical panel should not be blocked by 3/28/14.</p> <p>4. The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.</p>	3/31/14

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K 069	<p>Continued From page 40 the fire extinguisher.</p> <p>Reference: NFPA 96 (1998 ed.)</p> <p>8-3 Cleaning. 8-3.1* Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a Extinguishers, properly trained, qualified, and certified company or person acceptable to the authority having jurisdiction in accordance with Table 8-3.1.</p> <p>Table 8-3.1 Exhaust System Inspection Schedule</p> <p>Type or Volume of Cooking Frequency Systems serving solid fuel cooking operations Monthly</p> <p>Systems serving high-volume cooking operations Quarterly such as 24-hour cooking, charbroiling or wok cooking</p> <p>Systems serving moderate-volume cooking Semiannually operations</p>	K 069		
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K 069	Continued From page 41 Systems serving low-volume cooking operations, such as churches, day camps, seasonal businesses, or senior centers	K 069		
K 070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview it was determined the facility failed to ensure portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, sixty-six (66) residents, staff, and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed portable space heaters located in the Therapy Office, Minimum Data Set (MDS) Office, Human Resources Office, and room #11. The facility failed to provide documentation that the heating element in the portable heaters did not exceed 212 degrees Fahrenheit.</p>	K 070	<p>K. 070</p> <ol style="list-style-type: none"> <li>1. All portable space heaters will be removed from Room #11, HR, Therapy office, and MDS office by 3/28/14</li> <li>2. Daily room rounds will be conducted by Administrator, Director of Nursing, Dietary Manager, Assistant Director of Nursing, Activity Director, Social Services, Housekeeping Director, MDS Manager, Medical Records, Business office Manager, and Maintenance Director.</li> <li>3. The Administrator will educate Director of Nursing, Dietary Manager, Assistant Director of Nursing, Activity Director, Social Services, Housekeeping Director, MDS Manager, Medical Records, Business office Manager, and Maintenance Director on space heater</li> </ol>	3/31/14

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K 070	Continued From page 42  Interviews, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director revealed he was not aware of the portable heaters in the building.  Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy for the use of portable heaters. Further interview revealed he was aware of the portable heater in room #11 due to the recent cold weather, but he was not aware of the portable heaters located in the offices.  Reference: NFPA 101 (2000 edition)  19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070	K-072 1. Obstructions will be removed to have clear egress throughout the building by 3/28/14. Ice carts, medicine carts, trash carts, and rolling carts have assigned locations to have a clear and free egress for residents by 3/28/14. Ice carts are located in the front closet areas. Medicine carts are stored in the A&B Nursing Station areas, trash carts are stored in the shower rooms. 2. Daily room rounds will be conducted by Administrator, DON, ADON, Dietary Director, Activities Director, Social Services Director, Housekeeping Director, MDS Director, Medical Records, Business Office Manager and Maintenance Director. 3. The Administrator will educate Department managers on keeping egress areas clear and free by 3/28/14. 4. The Maintenance Director or Administrator will monitor for deficient findings and report deficient findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the DON, Administrator, ADON, Dietary Director, Maintenance Director, Social Services Director, and Activities Director with the Medical Director at least Quarterly.	3/31/14	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072			

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K 072	<p>Continued From page 43</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, sixty-six (66) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure the means of egress was free of all obstructions or impediments.</p> <p>The findings include:</p> <p>Observations, on 02/18/14 between 11:10 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed the exit by the Therapy Room to have storage of construction tools and supplies consisting of twenty-five (25) cardboard boxes, seven (7) 5-gallon buckets of drywall joint compound, one (1) open 5-gallon bucket of water, drywall tools, and a worker's coat. Further observation revealed a cardboard box, trash carts, a lift, and a medicine cart stored in the A-Hall. Further observation revealed a copy machine, a rolling cart, two (2) ice carts, and a medicine cart stored in the Front Hall; and, an ice cart, medicine cart, chair, and two (2) trash carts stored in the B-Hall.</p> <p>Interview, on 02/18/14 between 11:10 AM and 4:00 PM, with the Maintenance Director revealed he was not aware the items were being stored in the corridors.</p> <p>Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed there was no policy for the storage in the corridors, and he was aware the items were being stored in the corridors.</p>	K 072		

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K 072	Continued From page 44	K 072		
K 073 SS=F	<p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and policy review it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, sixty-six (66) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure decorations brought into the facility were being properly fire treated.</p> <p>The findings include:</p> <p>Observation, on 02/20/14 at 9:00 AM, with the Administrator revealed the facility failed to document the treatment of non-flame retardant decorations.</p> <p>Policy review, on 02/20/14 at 9:00 AM, with the Administrator revealed the facility had a policy that stated all newly introduced decorations would be treated with a flame retardant and</p>	K 073	<p>K 073</p> <ol style="list-style-type: none"> <li>1. Fire retardant was ordered on 3/12/14.</li> <li>2. Weekly audits will be conducted to ensure that compliance of NFPA standards of application of fire retardant is being met.</li> <li>3. The Maintenance Director or Administrator will conduct room rounds to treat any decorations and documentation will be reviewed monthly for three months and then quarterly. Any new admissions will have all identified articles treated with fire retardant within 72 hrs of admission by 3/28/14.</li> <li>4 The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary</li> </ol> <p style="text-align: right;"><i>3/31/14</i></p>	

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K 073	Continued From page 45 documentation would be kept.  Interview, on 02/20/14 at 9:00 AM, with the Administrator revealed he was not aware the documentallon had not been kept for treating decorations with a flame retardant.  Reference: NFPA 101 (2000 Edition)  19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.	
K 130 SS=E	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the hazardous areas in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, thirty-three (33) residents, staff and visitors. The facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey.  The findings include:  Observation, on 02/18/14 at 11:12 AM, with the Maintenance Director from a sister facility revealed a door wedge holding the Therapy Room door open to the corridor. Further	K 130	K 130 1. The dryer will be cleaned and clear of all lint by Maintenance Director by 3/28/14 The Therapy door wedge was removed 3/10/14. A magnet release lock for the therapy door will be installed by 3/28/14 The slide lock will be removed by 3/28/14. 2. Weekly audits will be conducted on dryers for lint removal and no slide locks are on any door by the Maintenance Director. 3. The Maintenance Director will document any deficiencies. This will be reviewed monthly for three months and then quarterly. 4. The Maintenance Director or Administrator will monitor for all deficiency findings to the Quality	3/31/14

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K 130	<p>Continued From page 46</p> <p>observation revealed a book-end and paint can holding a door to a hazardous room located in the A-Hall next to the Conference Room.</p> <p>Interview, on 02/18/14 at 11:12 AM, with the Maintenance Director revealed he was not aware they were holding doors open with wedges and paint cans.</p> <p>Observation, on 02/19/14 at 9:38 AM, with the Maintenance Director revealed an unapproved lock [slide-bolt type] was installed on the egress side of the door to the Business Office.</p> <p>Interview, on 02/19/14 at 9:38 AM, with the Maintenance Director revealed he was aware slide bolt locks were not approved; however, he was not aware the slide bolt lock was installed on the egress side of the Business Office door.</p> <p>Observation, on 02/19/14 at 11:57 AM, with the Maintenance Director revealed a heavy buildup of lint in the top of the dryers located in the Laundry Room.</p> <p>Interview, on 02/19/14 at 11:57 AM, with the Maintenance Director revealed it was the Maintenance Director's job to ensure the lint was cleaned from the top of the dryers; however, the Maintenance Director for this facility had been on Medical Leave.</p> <p>Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy for door wedges, slide-bolt locks, or lint removal from the dryers. He stated he was aware door wedges and slide-bolt locks were not permitted; however, he was not aware they were in use. Further interview revealed he was not</p>	K 130	<p>Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly.</p>	

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K 130	Continued From page 47 aware of the lint build-up in the top of the dryers.  Reference: NFPA 101 (2000 Edition)  19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.  NFPA 101 (2000 Edition) 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.	K 130		
K 147 SS=E	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 NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, sixty-six (66) residents, staff, and visitors. The	K 147	1. All extension cords will be removed from room # 3 by 3/28/14. The power strip in room #17 will be taken off the wall by 2/20/14. The attic extension cord will be removed by 2/20/14. The tables in the kitchen will be removed from near the electrical panel by 3/28/14. The electrical panel on B-Hall will be locked by 2/19/14. 2. Weekly audits will be conducted on all electrical panels to ensure they are locked and there are no power cords on wall, by the Maintenance	3/31/14

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K 147	<p>Continued From page 48</p> <p>facility is certified for sixty-six (66) beds with a census of fifty-seven (57) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director from a sister facility revealed:</p> <ol style="list-style-type: none"> <li>1) An oxygen concentrator was plugged into a power strip located in room #13.</li> <li>2) A power strip was mounted to the wall located in room #17.</li> <li>3) An extension cord to a television located in room #3.</li> <li>4) An extension cord running up the wall through the attic access plugged into attic lights located in room #2.</li> <li>5) An electrical panel was blocked by a table with a microwave located in the Kitchen.</li> <li>6) An electrical panel located in the B-Hall was not locked.</li> </ol> <p>Interview, on 02/19/14 between 8:30 AM and 4:00 PM, with the Maintenance Director revealed he was not aware the power strips and extension cords were being misused. Further interview revealed he was not aware the electrical panel in the Kitchen was blocked or the electrical panel in the B-Hall had been left unlocked.</p> <p>Interview, on 02/20/14 at 1:30 PM, with the Administrator revealed the facility did not have a policy for the proper use of power strips and extension cords and for locking or blocking electrical panels. Further interview revealed the Administrator was aware of the proper uses for power strips, extension cords, and requirements</p>	K 147	<p>Director or Administrator.</p> <p>3. The Maintenance Director or Administrator will be educated to make rounds on new residents to have no extension cords and will document any deficiencies. This will be reviewed monthly for three months and then quarterly.</p> <p>4. The Maintenance Director or Administrator will monitor egress for all deficiency findings to the Quality Assurance Committee monthly for three months for follow-up and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Assistant Director of Nursing, Dietary Manager, Maintenance Director, Social Services Director, and Activity Director with the Medical Director at least quarterly</p>	

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

PRINTED: 03/07/2014  
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 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  02/20/2014
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 147	<p>Continued From page 49 for electrical panels.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 400-8</p> <p>( Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces. Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 70 (1999 edition)</p>	K 147			

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K 147	Continued From page 50  370.28(c) Covers.  All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.  110-26. Spaces  About Electrical Equipment. Sufficient access and working space shall be provided and maintained around 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.  Reference: NFPA 70 (1999 edition)  Reference: NFPA 101 (2000 Edition)  9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.	K 147		