

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

PRINTED: 07/01/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185177	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/08/2014
NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 505 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED A Recertification Survey was conducted on 05/06/14 through 05/08/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest Scope and Severity cited at an "F".	F 000	PLAN OF CORRECTION GRAYSON MANOR NURSING HOME SURVEY COMPLETION DATE OF May 08, 2014	
F 360 SS=E	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide the daily nutritional and special dietary needs for one (1) of fifteen (15) sampled residents (Resident #4) and three (3) unsampled residents (Resident E, F, G). The findings include: 1. Record review revealed the facility admitted Resident #4 on 04/22/12 with diagnoses which included Atrial Fibrillation, Hypertension, Non-Alzheimer's Dementia, Seizure Disorder, Anxiety and Depression. Observation, on 05/07/14 at 12:54 PM during the lunch meal, revealed Resident #4's diet card	F 360	F360 Dietary Cards for resident # 4, E, F & G were reviewed on 5/9/14 for accuracy. Dietary and Nurse Aides were educated to the content of resident # 4, E, F & G dietary needs. Dietary Manager reviewed all SNF/NF residents' tray cards for accuracy according to orders. Social Services audited on 05/09/2014 all SNF/NF residents' meal trays with the dietary cards to ensure accuracy. Dietary Supervisor educated all dietary staff on the daily nutritional	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *James B. Vance* TITLE Administrator (X6) DATE July 1, 2014

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 GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 605 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754		
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F 360	<p>Continued From page 1</p> <p>revealed he/she should receive a Magic Cup. Further observation revealed there was no Magic Cup on the resident's meal tray.</p> <p>2. Record review revealed the facility admitted Resident F on 11/06/13 with diagnoses which included Alzheimer's, Acute Kidney Failure, Psychosis, Depressive Disorder, Hyperlipidemia, Anxiety and Muscle Wasting.</p> <p>Observation, on 05/07/14 at 1:04 PM, during the lunch meal, revealed Resident F's diet card revealed he/she was allergic to tomatoes. Further observation revealed the resident was served Lasagna with diced tomatoes cooked into the entree'.</p> <p>3. Record review revealed the facility admitted Resident G on 06/30/12 with diagnoses which included Alzheimer's Disease, Mood Disorder, Hypertension, Cerebrovascular Disease, Blindness of both eyes, Hypothyroidism, Convulsions and Gastroesophageal Reflux.</p> <p>Observation, on 05/07/14 at 1:07 PM during the lunch meal, revealed Resident G's diet card revealed he/she should not be served dry bread. Further observation revealed the resident was served dry bread.</p> <p>Interview with the Restorative Aide, on 05/07/14 at 1:11 PM, revealed staff serving trays should monitor the diet cards to ensure the food on the tray matches what was on the diet card. The Aide stated if a food allergy was identified on the diet card and that food was placed on the tray, the resident should not be served that tray. The Restorative Aide stated Resident F should have never been served tomatoes due to his/her</p>	F 360	<p>and special dietary needs for the residents on 5/9/14. The In-service Coordinator educated all staff including dietary staff on 5/13/14 on providing each resident with a nourishing, palatable, well-balanced diet that will meet the daily nutritional and special dietary needs of each resident to include proper supplements, correctness of dietary tray cards, adhering to dietary restrictions and allergies.</p> <p>The Quality Assurance Coordinator implemented an audit on proper dietary compliance and the importance of insuring the resident receives dietary supplements they need as well as adhering to dietary restrictions and allergies. The Restorative Nurse will do this audit. It will be conducted weekly times four weeks then monthly times 3 months then quarterly maintaining 100 % compliance. This audit will be conducted as part of the Facility's Quality Assurance Program.</p>	5/14/2014	

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F 360	<p>Continued From page 2</p> <p>allergy to them and Resident G should have never been served bread.</p> <p>Interview with Registered Nurse (RN) #2, on 05/07/14 at 1:20 PM, revealed staff in the dining room should monitor the residents' diet cards to ensure the proper diet was served. The RN stated staff should monitor for mechanical altered diets, allergies and nutritional supplements. Further interview revealed the kitchen staff should monitor first when preparing the tray and staff serving trays should check before serving the tray to the resident.</p> <p>Interview with Dietary Aide, on 05/07/14 at 2:00 PM, revealed she was not aware a resident had been served a food on their allergy list but they should have never been served it. She stated the meal tray was checked by four (4) staff members before it gets to the resident. She revealed staff in the dining area should provide nutritional supplements such as a Magic Cup and health shakes when checking the diet cards in the dining area.</p> <p>Interview with Dietary Supervisor, on 05/07/14 at 1:45 PM, revealed she had been the supervisor for about a month. She stated she was made aware of Resident F being served food identified as an allergy and the resident should have never been served this food. The Dietary Supervisor revealed the trays were checked by four (4) staff to include the preparation person in the kitchen, the cook, the person at the end of the serving line, and the staff serving the meal in the dining room. She stated staff should provide nutritional supplements such as a Magic Cup and health shakes when they check the diet card in the dining room. She revealed Resident G should not</p>	F 360			

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F 360	Continued From page 3 been served dry bread.	F 360			
F 371 SS=F	<p>Interview with Director of Nursing (DON), on 05/08/14 at 9:27 AM, revealed she expected the staff in the kitchen to monitor and verify that the proper food was served on each resident's meal tray. She stated if there was an allergy, mechanically altered diet or nutritional supplement listed on the diet card, this should be observed at all times. She revealed if a resident received a food listed as an allergy, the resident could have an allergic reaction.</p> <p>483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to serve food under sanitary conditions as staff failed to clean the food thermometer probe appropriately while obtaining food temperatures.</p> <p>Review of the Census and Condition, dated 05/06/14, revealed there were sixty-eight (68) residents in the building and one (1) resident who</p>	F 371	<p>F371</p> <p>On 5/9/14 the Dietary Thermometer Probe was immediately cleaned between each test and all Dietary staff was educated on proper protocol for cleaning of thermometer probe.</p> <p>Dietary supervisor audited all temperature control procedures on 5/9/14 that included all steam tables and cooking stoves for cross contamination between foods.</p> <p>The Dietary Supervisor educated all dietary staff in the proper</p>		

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F 371	Continued From page 4 received tube feedings, on the day of the survey. The findings include: Review of the "Guidelines for Keeping Hot Food Hot" policy/procedures, undated, revealed to clean and sanitize the food thermometer before and after each use. Observation, on 05/06/14 at 11:15 AM, revealed Cook #1 obtained a temperature of the au gratin potatoes, green beans and gravy. Then the cook checked the corn without cleaning the food thermometer between items. She cleaned the thermometer with an alcohol wipe after the corn; however, she obtained a temperature of the pureed chicken, pureed hominy, and ground chicken without cleaning the probe between items. Interview with the Dietary Supervisor, on 05/07/14 at 2:30 PM, revealed the food thermometer probe should be cleaned with an alcohol wipe between each food item. Interview with the Administrator, on 05/08/14 at 11:40 AM, revealed staff should sanitize the food thermometer probe after each use.	F 371	protocol for cleaning the thermometer probe. The Quality Assurance Coordinator educated all staff including dietary staff on 5/13/14 on the protocol for cleaning the thermometer probe. The Quality Assurance Coordinator implemented an audit on temperature control procedures and cleaning of the thermometer probe. The Quality Assurance Coordinator will conduct this audit. It will be conducted weekly times four weeks then monthly times 3 months then quarterly maintaining 100 % compliance. This audit will be conducted as part of the Facility's Quality Assurance Program.	5/14/2014	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	F425 Resident #A's physician clarified order on 5/9/14 and new physician's orders were reconciled by pharmacy and reprinted for chart.		

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F 425	<p>Continued From page 5</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the policy/procedure, it was determined the facility failed to provide pharmaceutical services to assure the accurate administering of all drugs and biologicals to meet the needs of one resident (A), not in the selected sample.</p> <p>The findings include:</p> <p>Review of the Documentation of Physician Orders policy/procedure, undated, revealed pharmacy would input medication into the electronic Medication Administration Record (eMAR). The nurse was to ensure the order was transcribed correctly to the Physician's Order for medication administration. The Pharmacist would reconcile the printed Physician's Orders with the original source prescriber's order. The orders would not be filled by pharmacy until they had been reconciled.</p>	F 425	<p>Nursing Administration matched all residents physician's orders with EMAR on 5/9/14 and any discrepancies were addressed and corrected.</p> <p>All nurses were educated on 5/13/14 by In-service Coordinator & Director of Nursing regarding proper protocol for new orders and reconciliation with pharmacy.</p> <p>The Quality Assurance Coordinator implemented an audit on the process of reconciling the new physician's orders with the pharmacy and reprinting them for the chart. The Restorative Nurse will conduct this audit. It will be conducted weekly times four weeks then monthly times 3 months then quarterly maintaining 100 % compliance. This audit will be conducted as part of the Facility's Quality Assurance Program.</p>	5/14/2014	

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F 425	Continued From page 6 Observation of a medication pass for Resident A, on 05/07/14 at 8:08 AM, revealed Kentucky Medication Aide (KMA) #1 administered the resident Lisinopril (antihypertensive) 5 milligrams (mg), one tablet by mouth. Review of the Physician's Orders, dated 04/29/14, revealed an order for Lisinopril 10 milligrams (mg) by mouth daily; however, review of the MAR, dated 04/07/14-05/07/14, revealed an order for Lisinopril 5 mg by mouth daily. Interview with the Pharmacist, on 05/08/14 at 10:45 AM, revealed the pharmacy had a link to the software at the facility, enabling them to enter information into the eMAR. He revealed the pharmacy technician usually enters the orders; however, all orders entered into the eMAR were checked by a pharmacist. Interview with Licensed Practical Nurse (LPN) #1, on 05/08/14 at 11:30 AM, revealed she was responsible to check all new orders after the pharmacy had entered them into the eMAR; however, she does not document the reconciliation. Interview with the Director of Nursing (DON), on 05/08/14 at 11:30 AM, revealed the orders should be checked twice; after pharmacy enters the orders into the eMAR and the nurse should check to ensure the right dose of each medication was entered.	F 425			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	F441 RN #1 was counseled on 5/9/14 by Director of Nursing concerning proper infection control while doing peri-care and wound care.		

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F 441	Continued From page 7 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined	F 441	On 5/9/14 Infection Control Nurse observed all Nurses on staff that perform wound care, including Nurse #1, for proper infection control techniques during wound and peri-care. Also Director of Nursing left detailed voice message to ALL nurses concerning the deficient practice and the proper procedures to performing wound care and peri-care. The Quality Assurance Coordinator educated all nursing staff on 5/13/14 of the importance of proper infection control during resident care to include peri care and wound care. The Quality assurance Coordinator implemented an audit on Hand-washing and glove changing during resident care. This audit will be performed by the Infection		

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F 441	<p>Continued From page 8</p> <p>the facility failed to ensure appropriate handwashing/glove changes during a skin assessment for one resident (#2) in the selected sample of fifteen (15) residents.</p> <p>The findings include:</p> <p>Review of the Standard Precautions policy/procedure, undated, revealed to change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. The policy further revealed to wash hands immediately after gloves were removed.</p> <p>Observation of a skin assessment for Resident #2, on 05/07/14 at 9:55 AM, revealed Registered Nurse (RN) #1 removed the old dressing and measured a wound on the resident's right heel and left ankle, while wearing gloves. She then removed the resident's brief, touching the resident's genital area and measuring redness to the resident's coccyx while wearing the same soiled gloves.</p> <p>Interview with RN #1, on 05/07/14 at 4:15 PM, revealed she should have removed her gloves and washed her hands after measuring the resident's wound on the right heel and left ankle.</p> <p>Interview with the Director of Nursing (DON), on 05/08/14 at 11:30 AM, revealed she expected staff to change their gloves between touching each wound while performing skin assessments. She revealed taking off an old dressing would contaminate their gloves.</p>	F 441	<p>Control Nurse and will be conducted weekly times four weeks then monthly times three months then quarterly maintaining 100 % compliance. This audit will be conducted as part of the Facility's Quality Assurance Program.</p> <p>The Quality Assurance Coordinator also implemented an audit of the charge nurses on dressing changes and the use of proper Hand-washing and glove changing. This audit will be performed by the Infection Control Nurse and will be conducted weekly times four weeks then monthly times three months then quarterly maintaining 100 % compliance. This audit will be conducted as part of the Facility's Quality Assurance Program.</p>	5/14/2014	

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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: 1964, 1976, & 2010.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1964 with 12 smoke detectors and 16 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1964 and upgraded in 2012.</p> <p>GENERATOR: Type II generator installed in 2010. Fuel source is Diesel.</p> <p>A standard Life Safety Code Survey was conducted on 05/06/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Seventy-Two (72) beds with a census of Sixty-Eight (68) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>PLAN OF CORRECTION GRAYSON MANOR NURSING HOME SURVEY COMPLETION DATE OF May 06, 2014</p> 	

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

Joseph B. Vance

TITLE

Administrator

(X6) DATE

May 26, 2014

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 011 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire wall was in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for seventy-two (72) beds and at the time of the survey, the census was sixty-eight (68). The findings include: Observation, on 05/06/14 at 1:35 PM with the Maintenance Supervisor, revealed the two (2) hour wall separating the skilled nursing facility from the personal care home had doors and frame installed that did not have fire rating tags	K 011	K011 Maintenance Supervisor placed order with Schiller Architectural Hardware out of Louisville KY on May 27, 2014 to replace frames and doors between Personal Care wing and SNF/NF wing. Maintenance Supervisor audited on May 9, 2014 all doors throughout the facility for proper fire rating and fire rating tags on all doors and all door frames. Maintenance Supervisor educated all Maintenance staff on the NFPA standard regarding fire rating and fire rating tags of doors and door frames on May 7, 2013. In-Service Coordinator and Maintenance Director educated all staff	

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 505 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	
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K 011	<p>Continued From page 2 applied in the two (2) hour fire wall.</p> <p>Interview, on 05/06/14 at 1:35 PM with the Maintenance Supervisor, revealed he knows the doors have a fire rating but could not find any documentation for the rating of the doors.</p> <p>The census of sixty-eight (68) was verified by the Administrator on 05/06/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/06/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 19.1.1.4 Additions, Conversions, Modernization, Renovation, and Construction Operations. 19.1.1.4.1 Additions. Additions shall be separated from any existing structure not conforming to the provisions within Chapter 19 by a fire barrier having not less than a 2-hour fire resistance rating and constructed of materials as required for the addition. (See 4.6.11 and 4.6.6.) 19.1.1.4.2 Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire doors. (See also Section 8.2.) 19.1.1.4.3 Doors in barriers required by 19.1.1.4.1 shall normally be kept closed. Exception: Doors shall be permitted to be held open if they meet the requirements of 19.2.2.2.6.</p> <p>8.2.3.2 Fire Protection-Rated Opening Protectives.</p>	K 011	<p>including Maintenance Department on NFPA standards regarding fire rating and fire rating tags of doors and door frames on May 14, 2014.</p> <p>Quality Assurance Coordinator placed all doors on Maintenance Quarterly Check-Off List. The Maintenance Quarterly Check-Off List will be presented at least annually at the Quarterly QA Meeting. The Maintenance Check-Off List will assure that all fire rated doors are properly rated and tags are in place and not painted over.</p>	6/5/2014

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K 011	Continued From page 3 8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1.	K 011		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke	K 025	K025 On May 9, 2014 Maintenance Supervisor and Administrator contracted with Jason Brooks Dry Walling Company Leitchfield KY to construct smoke barrier walls in the attic by Rooms #40, #49 and #43. Licensed Electrician with Ready Electric Company repaired sleeve in fire wall by kitchen on May 9, 2014.	

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K 025	<p>Continued From page 4</p> <p>barriers in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for seventy-two (72) beds and at the time of the survey, the census was sixty-eight (68).</p> <p>The findings include:</p> <p>Observation, on 05/06/14 at 10:05 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located next to room #49 was not properly sealed. The barrier was constructed with drywall on one side of the barrier and the framing studs exposed on the interior side of the barrier.</p> <p>Interview, on 05/06/14 at 10:06 AM with the Maintenance Supervisor, revealed he was not aware the barrier was not properly constructed to meet the ½ hour rating for a smoke barrier.</p> <p>Observation, on 05/06/14 at 10:08 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located next to room #43 was not properly sealed. The barrier was constructed with drywall on one side of the barrier and the framing studs exposed on the interior side of the barrier.</p> <p>Interview, on 05/06/14 at 10:09 AM with the Maintenance Supervisor, revealed he was not aware the barrier was not properly constructed to meet the ½ hour rating for a smoke barrier.</p> <p>Observation, on 05/06/14 at 10:12 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located next</p>	K 025	<p>On May 9, 2014 Maintenance Supervisor audited entire facility for smoke barrier walls requirements by NFPA and contracted with Jason Brooks Dry Walling Company Leitchfield KY to construct smoke barrier walls in the attic to meet the NFPA requirements. Maintenance Supervisor on May 9, 2014 audited entire attic smoke barriers for penetrations.</p> <p>Maintenance Supervisor educated all Maintenance staff on the NFPA standard regarding fire rating of Smoke Partitions and penetrations on May 7, 2013. In-Service Coordinator and Maintenance Supervisor educated all staff including Maintenance Department on NFPA standards regarding fire ratings of Smoke Partitions and penetrations on May 14, 2014.</p>	

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K 025	<p>Continued From page 5</p> <p>to room# 40 was not properly sealed. The barrier was constructed with drywall on one side of the barrier and the framing studs exposed on the interior side of the barrier.</p> <p>Interview, on 05/06/14 at 10:13 AM with the Maintenance Supervisor, revealed he was not aware the barrier was not properly constructed to meet the ½ hour rating for a smoke barrier.</p> <p>Observation, on 05/06/14 at 10:14 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located next to the kitchen was not properly sealed. The barrier had a plastic tube that was not properly sealed around the wires.</p> <p>Interview, on 05/06/14 at 10:15 AM with the Maintenance Supervisor, revealed he was not aware the barrier had a wire chase that was not properly sealed around the wires.</p> <p>The census of sixty-eight (68) was verified by the Administrator on 05/06/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/06/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</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	<p>Quality Assurance Coordinator placed all Smoke Partitions on the Maintenance Quarterly Check-Off list. The Maintenance Quarterly Check-Off List will be presented at least annually at the Quarterly QA Meeting. The Maintenance Quarterly Check-Off List will assure that all Smoke Partitions are constructed by NFPA standards and if penetrated are repaired with proper fire caulk.</p>	6/5/2014

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K 025	Continued From page 6 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. 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.	K 025		
K 038 SS=E	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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress was maintained at all exit doors in accordance	K 038	K038 Maintenance Supervisor on May 9, 2014 ordered door closures for Mechanical Room #6, Attic Stair Well, and RAI Office. Maintenance Personnel audited all doors for NFPA standards	

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K 038	<p>Continued From page 7</p> <p>with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, thirty (30) residents, staff and visitors. The facility has the capacity for seventy-two (72) beds and at the time of the survey, the census was sixty-eight (68).</p> <p>The findings include:</p> <p>Observation, on 05/06/14 at 11:07 AM with the Maintenance Supervisor, revealed the door for mechanical room #6 opened into the corridor and would not swing back to within 3-1/2 inches of the wall.</p> <p>Interview, on 05/06/14 at 11:08 AM with the Maintenance Supervisor, revealed he was unaware the doors required a closing device if the door did not swing all the way back to within 3-1/2 inches of the wall.</p> <p>Observation, on 05/06/14 at 11:53 AM with the Maintenance Supervisor, revealed the door for the attic stairway room opened into the corridor and would not swing back to within 3-1/2 inches of the wall.</p> <p>Interview, on 05/06/14 at 11:54 AM with the Maintenance Supervisor, revealed he was unaware the doors required a closing device if the door did not swing all the way back to within 3-1/2 inches of the wall.</p> <p>Observation, on 05/06/14 at 12:18 PM with the Maintenance Supervisor, revealed the door for the RAI office opened into the corridor and would not swing back to within 3-1/2 inches of the wall.</p>	K 038	<p>regarding proper door closures and placed orders on May 9, 2014.</p> <p>Maintenance Supervisor educated all Maintenance staff on the NFPA standard regarding door closures on May 7, 2013. In-Service Coordinator and Maintenance Supervisor educated all staff including Maintenance Department on NFPA standards regarding door closures on May 14, 2014.</p> <p>Quality Assurance Coordinator placed all hallway doors on the Maintenance Quarterly Check-Off list. The Maintenance Quarterly Check-Off List will be presented at least annually at the Quarterly QA Meeting. The Maintenance Quarterly Check-Off List will assure that all hallway doors have proper closures to meet NFPA standards and if so are working properly.</p>	6/5/2014	

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K 038	Continued From page 8 Interview, on 05/06/14 at 12:19 PM with the Maintenance Supervisor, revealed he was unaware the doors required a closing device if the door did not swing all the way back to within 3-1/2 inches of the wall. The census of sixty-eight (68) was verified by the Administrator on 05/06/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/06/14. Actual NFPA Standard: NFPA 101 (2000 Edition) 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. Reference: S&C letter 5-38 S&C-12-21-LSC	K 038		
K 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by:	K 045	K045 A Licensed Electrician for Ready Electric Company replaced old exit lights with new exit lights that meets the NFPA standards at the exterior exit at the Belmont Dining Room, exterior exit for the Kitchen,	

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K 045	<p>Continued From page 9</p> <p>Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for seventy-two (72) beds and at the time of the survey, the census was sixty-eight (68).</p> <p>The findings include:</p> <p>Observation, on 05/06/14 at 11:04 AM with the Maintenance Supervisor, revealed the exterior exit at the Belmont dining room had a single light for illumination of the outside of the exit.</p> <p>Observation, on 05/06/14 at 11:15 AM with the Maintenance Supervisor, revealed the exterior exit for the kitchen had a single light for illumination of the outside of the exit.</p> <p>Observation, on 05/06/14 at 11:20 AM with the Maintenance Supervisor, revealed the exterior exit at the back of the dining hall had a single light for illumination of the outside of the exit.</p> <p>Observation, on 05/06/14 at 11:40 AM with the Maintenance Supervisor, revealed the exterior exit at the short hall exit had a single light for illumination of the outside of the exit.</p> <p>Observation, on 05/06/14 at 12:10 PM with the Maintenance Supervisor, revealed the exterior exit facing Churchill had a single light for illumination of the outside of the exit.</p> <p>Interview, on 05/06/14 at 12:11 PM with the Maintenance Supervisor, revealed he was</p>	K 045	<p>exterior exit at the back of Dining Hall, exterior exit at the Short Hall Way, exterior exit facing Churchill Dining, exterior exit at room #29 and exterior exit at the Churchill Dining on May 14, 2014.</p> <p>A Licensed Electrician for Ready Electric Company audited entire facility for proper exit lights that meets the NFPA standards and placed order with Brite Electric Co. on May 09, 2014.</p> <p>Maintenance Supervisor educated all Maintenance staff on the NFPA standard regarding lighting of exterior exits on May 7, 2013. In-Service Coordinator and Maintenance Supervisor educated all staff including Maintenance Department on NFPA standards regarding lighting of exterior exits on May 14, 2014.</p>		

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K 045	Continued From page 10 unaware exits required more than a single bulb for exterior illumination. Observation, on 05/06/14 at 11:30 AM with the Maintenance Supervisor, revealed the exterior exit at room #29 had no lights for illumination of the outside of the exit. Observation, on 05/06/14 at 12:20 PM with the Maintenance Supervisor, revealed the exterior exit at the Churchill dining had two (2) light fixtures but neither light was operational. Interview, on 05/06/14 at 12:21 PM with the Maintenance Supervisor, revealed he was unaware the exterior lights were not functioning at the Churchill dining room. The census of sixty-eight (68) was verified by the Administrator on 05/06/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/06/14. Actual NFPA Standard: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	Quality Assurance Coordinator placed all exterior exit lights on the Maintenance Quarterly Check-Off list. The Maintenance Quarterly Check-Off List will be presented at least annually at the Quarterly QA Meeting. The Maintenance Quarterly Check-Off List will assure that all exterior exit lights meet NFPA standards and if so are working properly.	6/5/2014
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with	K 064	Maintenance personnel started lowering fire extinguisher cabinets	

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K 064	<p>Continued From page 11 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>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 per National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, thirty-two (32) residents, staff and visitors. The facility has the capacity for seventy-two (72) beds and at the time of the survey, the census was sixty-eight (68).</p> <p>The findings include:</p> <p>Observations, on 05/06/14 at 11:15 AM with the Maintenance Supervisor, revealed the wall mounted, portable fire extinguisher located by the RAI office was mounted one (1) foot above the maximum allowable height of five (5) feet above the finish floor.</p> <p>Observations, on 05/06/14 at 11:37 AM with the Maintenance Supervisor, revealed the wall mounted, portable fire extinguisher located by the west nurses station was mounted one (1) foot above the maximum allowable height of five (5) feet above the finish floor.</p> <p>Observations, on 05/06/14 at 12:23 PM with the Maintenance Supervisor, revealed the wall mounted, portable fire extinguisher located by room# 46 was mounted one (1) foot above the maximum allowable height of five (5) feet above</p>	K 064	<p>by the RAI Office, West Nurses Station and by RM #46 on May 9, 2014.</p> <p>Maintenance personnel audited entire facility for the deficient practice of fire extinguisher cabinets being at the appropriate height that meets NFPA standards on May 9, 2014.</p> <p>Maintenance Supervisor educated all Maintenance staff on the NFPA standard regarding fire extinguisher cabinet's proper height on May 7, 2013. In-Service Coordinator and Maintenance educated all staff including Maintenance Department on NFPA standards regarding fire extinguisher cabinet's proper height on May 14, 2014.</p> <p>Quality Assurance Coordinator placed all fire extinguishers on the</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185177	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/06/2014
NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 605 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	
(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 064	Continued From page 12 the finish floor. Interview, on 05/06/14 at 12:24 PM with the Maintenance Supervisor, revealed that he was aware off the height limitations of fire extinguishers and he had been working on moving the extinguishers down. The census of sixty-eight (68) was verified by the Administrator on 05/06/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/06/14. Actual NFPA Standard: 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	Maintenance Quarterly Check-Off list. The Maintenance Quarterly Check-Off List will be presented at least annually at the Quarterly QA Meeting. The Maintenance Quarterly Check-Off List will assure that all fire extinguisher cabinets meet NFPA standards and if so are working properly.	6/5/2014
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	K 147	K147 The Coke representative moved the coke machine on May 23, 2014.	

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 505 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	
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K 147	<p>Continued From page 13</p> <p>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 one (1) of five (5) smoke compartments, six (6) residents, staff and visitors. The facility has the capacity for seventy-two (72) beds and at the time of the survey, the census was sixty-eight (68).</p> <p>The findings include:</p> <p>Observations, on 05/06/14 at 11:10 AM with the Maintenance Supervisor, revealed the electrical panel in the kitchen had storage within three (3) feet of the electrical panels. The panel was blocked by the coke machine supply cases.</p> <p>Interview, on 05/06/14 at 11:11 AM with the Maintenance Supervisor, revealed he was unaware the coke products could not be placed in front of the electrical panel.</p> <p>The census of sixty-eight (68) was verified by the Administrator on 05/06/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 05/06/14.</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</p>	K 147	<p>A licensed Electrician from Ready Electric Company audited the entire facility for the deficient practice of proper clearance around electrical panels on May 11, 2014.</p> <p>Maintenance Supervisor educated all Maintenance staff on the NFPA standard regarding clearance around Electrical Panels on May 7, 2013. In-Service Coordinator and Maintenance Supervisor educated all staff including Maintenance Department on NFPA standards regarding clearance around Electrical Panels on May 14, 2014.</p> <p>Quality Assurance Coordinator placed all electrical panels on the Maintenance Quarterly Check-Off list. The Maintenance Quarterly Check-Off List will be presented at least annually at the Quarterly QA Meeting. The Maintenance</p>	

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 505 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754		
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K 147	Continued From page 14 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 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. Table 110.26(A)(1) Working Spaces 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) 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	K 147	Quarterly Check-Off List will assure that all electrical panels will have sufficient access and working space to permit ready and safe operation and maintenance of such equipment to meet NFPA standards.	6/5/2014	

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 505 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754
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K 147	<p>Continued From page 15 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 be provided.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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,</p>	K 147		
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K 147	Continued From page 16 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 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	K 147		

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K 147	Continued From page 17 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			