

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

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185378	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2014
NAME OF PROVIDER OR SUPPLIER MASONIC HOME OF SHELBYVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 711 FRANKFORT ROAD SHELBYVILLE, KY 40066	
(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	F 000	The preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law. 1. No resident was identified as being affected by the issue identified. However, the facility has implemented corrective actions to address the identified issue in items 3, 4, and 5 below. 2. No other residents were determined to be affected by the identified issue. However, the facility has implemented corrective actions to address the issue identified in items 3, 4, and 5 below. 3. The facility has initiated the following corrective measures to assure the identified deficient practice does not reoccur as follows: a. Results of the most recent survey of the facility, any subsequent extended surveys, and any deficiencies resulting from any subsequent complaint investigations were placed in accessible area in Rehabilitation Entrance to ensure availability for examination.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A Recertification Survey was initiated on 07/15/2014 and concluded on 07/17/2014 with deficiencies cited at the highest scope and severity of an "E". A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's admission packet containing Residents' Rights For Residents in Kentucky Long-Term Care Facilities, it was determined the facility failed to ensure the survey results were readily available to residents for three (3) of three (3) nursing units. The findings include: Review of the Residents' Rights for Residents in Kentucky Long-Term Care Facilities in the facility's admission packet revealed each resident and the responsible party and/or guardian had the right to have access to all inspection reports on the facility.	F 167		

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

TITLE

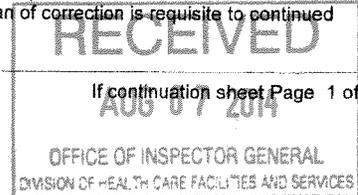
(X6) DATE

Robert N. Cooper

Administrator

8-4-2014

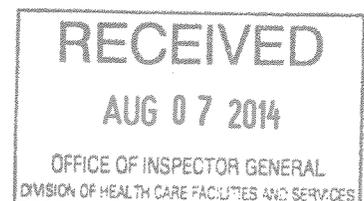
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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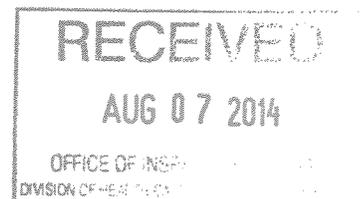
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F 167	Continued From page 1 Observation, on 07/15/14 at 9:18 AM, of the Rehabilitation Unit entrance located on the same level as resident rooms, revealed there was no survey book in the waiting area for review. Observation of the Main entrance area on the upper level at 9:35 AM, revealed the survey book was located on a table by the business office. Staff had to propel and transport residents up and down an inclind ramp to the Main entrance, that separated the resident's from access to the survey book. Interview with the Maintenance Director, on 07/17/14 at 6:09 PM, revealed he had measured a distance of two hundred eighty-eight (288) feet from the main entrance by the survey book to the central nursing station located at the bottom of the ramp. Interview with Certified Nursing Assistant (CNA) #2, on 07/17/14 at 1:50 PM, revealed she was not aware of any residents who could self-propel themselves up the ramp because it was too steep. The CNA revealed staff have always had to help them up the ramp. The CNA revealed she had not seen a survey book accessible on the lower level. Interview with the Unit Secretary, on 07/17/14 at 1:55 PM, revealed she could not recall a survey binder located on the lower level for residents' to view. Interview with the Central Unit Coordinator, on 07/17/14 at 2:00 PM, revealed she was told there was a survey binder at the Rehabilitation entrance. While the Unit Coordinator was looking around the waiting area at the Rehabilitation	F 167	4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows: a. Survey Results Audit (A-21) was implemented on 7/28/2014 by QA Committee to ensure availability and access to survey results b. Re-education was provided to all employees on 7/25/2014 by Education Director to ensure availability and access of survey results to residents 5. The Quality Assurance Committee will review required audits and supportive documentation to ensure effectiveness of the compliance plan and make revisions as necessary on an ongoing basis completed by	8/4/2014	



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F 167	<p>Continued From page 2</p> <p>entrance, the Business Office Manager was observed walking through the entrance and handing a survey binder to the Administrative Assistant behind the desk.</p> <p>Interview with the Administrative Assistant, on 07/17/14 at 2:02p PM, revealed she normally kept the binder in the bottom of the cabinet behind the desk. The Administrative Assistant revealed she was not aware the survey binder needed to be accessible to the residents.</p> <p>Interview with the Business Office Manager, on 07/17/14 at 2:03 PM, revealed the resident could still access the binder if they came behind the desk and removed it from the cabinet. Observation of the desk revealed it was enclosed by a wooden swinging door. Continued interview with the Business Office Manager revealed she did not know if wheelchairs could fit through the opening with the swinging door, did not know if the residents were aware of the survey binder location in the cabinet, and did not know if residents and visitors were even allowed behind the desk.</p> <p>Interview with the Central Unit Coordinator, on 07/17/14 at 2:05 PM, revealed the survey book should be readily accessible for residents to review and was a resident's right to have access to the survey book.</p> <p>Interview with Administrator, on 07/17/14 at 3:45 PM, revealed he was aware access to the survey book was a resident right; however, he did not see where the ramp created a problem for the residents because the residents could go outside and wheel themselves to the other entrance to access the survey binder. The Administrator</p>	F 167			



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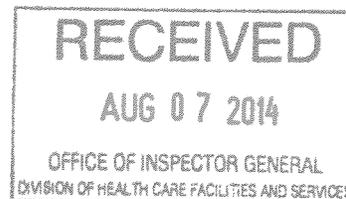
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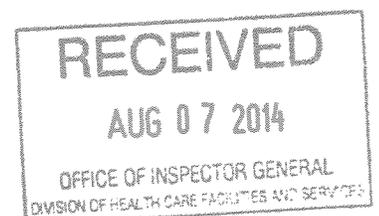
F 167	Continued From page 3 revealed he was not aware of another binder ever being kept at the Rehabilitation entrance. Interview during the Quality of Life Assessment Group Interview, on 07/15/14 at 3:45 PM, revealed Resident #14 was not aware of a survey information binder, nor was the resident knowledgeable of the location of the survey binder to review.	F 167		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure handrails were securely fastened to the wall on three (3) of the seven (7) resident hallways. The findings include: The facility did not provide a policy regarding maintenance of the handrails. Observations during the environment tour, on 07/17/14 at 1:25 PM, revealed the handrail beside room 406, between rooms 408 and 410, and between rooms 302 and 304 were found loose and not firmly secured to the wall. The handrail located by room 308, which extended to the end of the hall was found loose and the back board it was attached to easily pulled out of the wall. Interview with the Maintenance Assistant, on	F 468	1. No resident was identified as being affected by the issue identified. However, the facility has implemented corrective actions to address the identified issue in items 3, 4, and 5 below. 2. No other residents were determined to be affected by the identified issue. However, the facility has implemented corrective actions to address the issue identified in items 3, 4, and 5 below. 3. The facility has initiated the following corrective measures to assure the identified deficient practice does not reoccur as follows: a. Maintenance Inspection Checklist QA Audit (MNT-31) was reviewed on 7/28/2014 by QA to ensure inclusion of Handrail Inspection b. Re-education was provided to all employees on 7/25/2014 by Education Director to assure maintenance of secured handrails	



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F 468	Continued From page 4 07/17/14 at 2:50 PM, revealed handrails were assessed monthly to ensure they were secure and was last completed at the end of June, 2014. The Maintenance Assistant revealed he was not aware of the loose sections of handrails but stated they were an older type of handrail that tends to come loose more easily. The Maintenance Assistant revealed handrails should be secured to the wall for resident safety.	F 468	4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows: a. Maintenance Director will continue to use Maintenance Inspection Checklist QA Audit (MNT-31) to ensure all Handrails are inspected on a monthly basis. b. Maintenance Staff was re-educated on 7/25/2014 by Maintenance Director on secure handrails. 5. The Quality Assurance Committee will review required audits and supportive documentation to ensure effectiveness of the compliance plan and make revisions as necessary on an ongoing basis completed by	8/4/2014	



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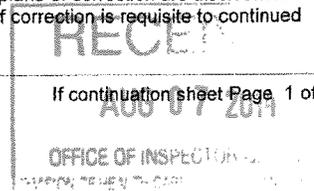
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1902, 1930, 1951</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) stories, Type II (222)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was initiated on 07/16/14 and concluded on 07/17/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has the capacity for one hundred seventeen (117) beds and at the time of the survey, the census was ninety one (91).</p>	K 000	<p>The preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Kolton N. Cooper* TITLE: *Administrator* (X8) DATE: *8-4-2014*

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.

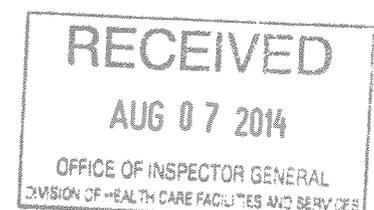
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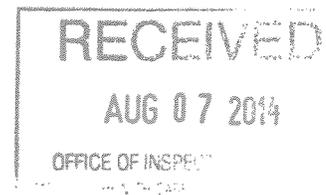
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K 000	Continued From page 1	K 000			
K 056 SS=D	<p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p> <p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with National Fire Protection Agency (NFPA) Standards. The deficient practice has the potential to affect two (2) of eight (8) smoke compartments, thirty (30) residents, staff and visitors. The facility has the capacity for one-hundred-seventeen (117) beds and at the time of the survey, the census was ninety-one</p>	K 056	<ol style="list-style-type: none"> 1. No resident was identified as being affected by the issue identified. However, the facility has implemented corrective actions to address the identified issue in items 3, 4, and 5 below. 2. No other residents were determined to be affected by the identified issue. However, the facility has implemented corrective actions to address the issue identified in items 3, 4, and 5 below. 3. The facility has initiated the following corrective measures to assure the identified deficient practice does not reoccur as follows: <ol style="list-style-type: none"> a. Porch roof (awning type) located at employee ramp was removed on 7/25/2014 b. Combustible material on Porch roof (awning type) location located outside the door of the South Courtyard was removed on 7/28/2014 c. Porch rood (awning type) location on back of building was detached from the building on 7/25/2014 		



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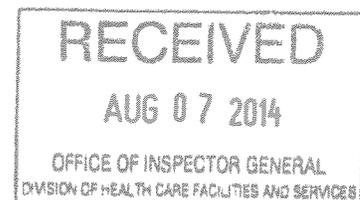
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K 056	<p>Continued From page 2 (91). According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with major problems.</p> <p>The findings include:</p> <p>1. Observation, on 07/17/14 at 9:53 AM, with the Director of Maintenance revealed an exterior porch roof (awning type) extending out greater than four (4) feet that was constructed of combustible canvas material and did not have sprinkler protection installed. The porch roof was located outside the exit door at the employee ramp.</p> <p>Interview, on 07/17/14 at 9:54 AM, with the Director of Maintenance revealed he was not aware the exterior roofs were to be sprinkler protected due to being constructed of combustible canvas materials.</p> <p>2. Observation, on 07/17/14 at 10:45 AM, with the Director of Maintenance revealed an exterior porch roof (awning type) extending out greater than four (4) feet that was constructed of combustible canvas material and did not have sprinkler protection installed. The porch roof was located outside the door to the South Courtyard.</p> <p>Interview, on 07/17/14 at 10:46 AM, with the Director of Maintenance revealed he was not aware the exterior roofs were to be sprinkler protected due to being constructed of combustible canvas materials.</p> <p>3. Observation, on 07/17/14 at 12:50 PM, with the Director of Maintenance revealed an exterior porch roof (awning type) extending out greater than four (4) feet that was constructed of</p>	K 056	<p>d. Maintenance director performed Audit of all exterior roofs on 7/18/2014 to ensure required sprinklers were installed.</p> <p>4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:</p> <p>a. Maintenance Inspection Checklist QA Audit (MNT-31) was revised by QA on 7/28/2014 to ensure all sprinklers under exterior roofs are in compliance.</p> <p>b. Re-education was provided to all employees on 7/25/2014 by Education Director to assure proper use of sprinklers on exterior roofs</p> <p>c. Maintenance Staff was re-educated on 7/25/2014 by Maintenance Director on sprinkler requirements under exterior roofs.</p> <p>5. The Quality Assurance Committee will review required audits and supportive documentation to ensure effectiveness of the compliance plan and make revisions as necessary on an ongoing basis completed by</p>	8/4/2014	



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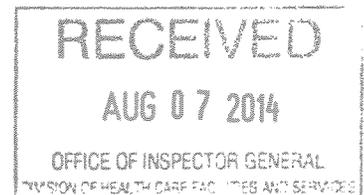
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K 056	Continued From page 3 combustible canvas material and did not have sprinkler protection installed. The porch roof was attached on the back of the building to provide shelter for the staff smoking area. Interview, on 07/17/14 at 12:51 PM, with the Director of Maintenance revealed he was not aware the exterior roofs were to be sprinkler protected due to being constructed of combustible canvas materials. The census of ninety one (91) was verified by the Administrator on 07/17/14. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 07/17/14. Actual NFPA Standard: Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	1. No resident was identified as being affected by the issue identified. However, the facility has implemented corrective actions to address the identified issue in items 3, 4, and 5 below. 2. No other residents were determined to be affected by the identified issue. However, the facility has implemented corrective actions to address the issue identified in items 3, 4, and 5 below.	



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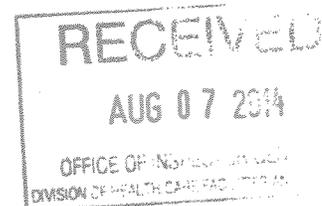
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 076	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage was in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, twelve (12) residents, staff and visitors. The facility has the capacity for one-hundred-seventeen (117) beds and at the time of the survey, the census was ninety-one (91). The findings include: Observation, on 07/17/14 at 10:21 AM, with the Director of Maintenance revealed a light switch (ignition source) installed in the Oxygen Storage Room. The light switch was installed forty-eight (48) inches above the finished floor. The oxygen storage room was storing oxygen in quantities of less than 3000 cubic feet. Interview, on 07/17/14 at 10:22 AM, with the Director of Maintenance revealed he was unaware the light switch would be considered an ignition source. The census of ninety-one (91) was verified by the Administrator, on 07/17/14. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 07/17/14.	K 076	3. The facility has initiated the following corrective measures to assure the identified deficient practice does not reoccur as follows: a. Light Switch (ignition source) was installed sixty (60) inches (5 ft) above the finished floor 4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows: a. Maintenance Inspection Checklist QA Audit (MNT-31) was reviewed by QA on 7/28/2014 to ensure inclusion of the inspection of light switches. b. Re-education was provided to all employees on 7/25/2014 by Education Director to assure proper separation of oxidizing gases and ignition sources c. Maintenance Staff was re-educated ignition sources in oxygen storage rooms on 7/25/2014 by Maintenance Director. 5. The Quality Assurance Committee will review required audits and supportive documentation to ensure effectiveness of the compliance plan and make revisions as necessary on an ongoing basis completed by	8/4/2014



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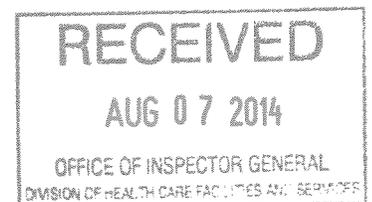
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K 076	Continued From page 5 Actual NFPA Standard: Reference: NFPA 99 (1999 Edition). 8-3.1.11.2 8-3.1.11.2 Storage for nonflammable gases less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet	K 076		



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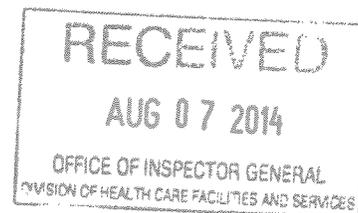
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K 076	Continued From page 6 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, thirty-six (36) residents, staff and visitors. The facility has the capacity for one-hundred-seventeen (117) beds and at the time of the survey, the census was ninety-one (91).	K 147	1. No resident was identified as being affected by the issue identified. However, the facility has implemented corrective actions to address the identified issue in items 3, 4, and 5 below. 2. No other residents were determined to be affected by the identified issue. However, the facility has implemented corrective actions to address the issue identified in items 3, 4, and 5 below. 3. The facility has initiated the following corrective measures to assure the identified deficient practice does not reoccur as follows: a. Medicine cart was immediately placed greater than three (3) feet from electric Panels	



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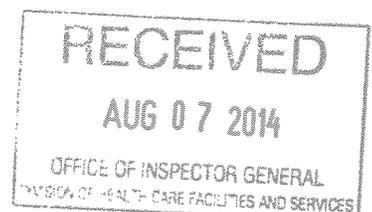
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K 147	<p>Continued From page 7 The findings include:</p> <p>Observations, on 07/17/14 at 10:26 AM, with the Director of Maintenance revealed the electrical panel located in the Central Nurses' Station Medicine Room had storage within three (3) feet of the electrical panels. The panel was blocked by the Medicine Cart.</p> <p>Interview, on 07/17/14 at 10:27 AM, with the Director of Maintenance revealed he was not aware the staff with access to the Medicine Room had been storing the Medicine Cart in front of the electrical panels.</p> <p>The census of ninety-one (91) was verified by the Administrator on 07/17/14. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 07/17/14.</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 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</p>	K 147	<p>b. Red marking tape was placed three (3) feet in front of electric panels to ensure items are kept at required distance from electric panels</p> <p>4. The facility has implemented the following interventions to monitor the corrective action to ensure that performance is sustained as follows:</p> <p>a. QA committee reviewed Electrical Panel Box Audit (MNT-14) on 7/28/2014 to ensure inclusions of all facility electric panels.</p> <p>b. QA committee revised Maintenance CQI calendar on 7/28/2014 to ensure monthly monitoring of Electrical Panel Box Audit (MNT-14)</p> <p>c. Re-education was provided to all employees on 7/25/2014 by Education director regarding required three (3) foot clearance in front of electric panels.</p> <p>d. Re-education was provided to Maintenance Staff on 7/25/2014 by Maintenance Director on three (3) foot clearance in front of electric panels.</p> <p>5. The Quality Assurance Committee will review required audits and supportive documentation to ensure effectiveness of the compliance plan and make revisions as necessary on an ongoing basis completed by</p>	8/4/2014



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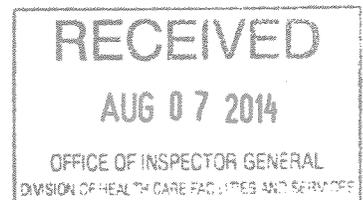
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K 147	<p>Continued From page 8 permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A) (1) unless the requirements of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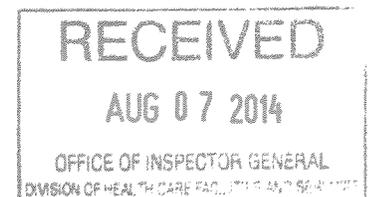
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K 147	Continued From page 9 required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided. (b) Low Voltage. By special permission, smaller working spaces shall be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



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K 147	Continued From page 10 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 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	K 147		



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K 147	Continued From page 11 rooms, the illumination shall not be controlled by automatic means only.	K 147			

