

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

PRINTED: 10/08/2013
FORM APPROVED
OMB NO. 0938-0391

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|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 09/26/2013 |
| NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENTS A standard health survey was conducted from 09/24/13 through 09/26/13 and a Life Safety Code survey was conducted on 09/26/13. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition | F 000 | | |
| F 156 SS=B | 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged; and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. | F 156 | 1. Administrator immediately located the poster containing District and State Ombudsman contact information and re-placed it in the front foyer. 2. Administrator checked all three District and State Ombudsman postings to ensure proper placement. 3. Administrator re-educated all staff on 9/27/13 regarding the importance of ensuring that staff, residents, family, and visitors have access to Ombudsman contact information. 4. Administrator will check Ombudsman postings for proper placement weekly for three months, and then reassess the frequency of audits. Administrator will report results of audits at QA on 11/7/13 and no less than quarterly thereafter. | 11-07-13 11-8-13 PH A Note by PB 11-22-13 |

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

[Signature]

TITLE

Administrator

(X6) DATE

10/17/13

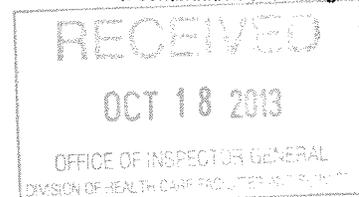
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

OCT 19 2013
OFFICE OF INSPECTION AND COMPLIANCE
DIVISION OF HEALTH CARE SERVICES

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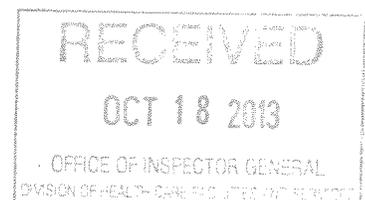
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| F 156 | <p>Continued From page 1</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the</p> | F 156 | | | |



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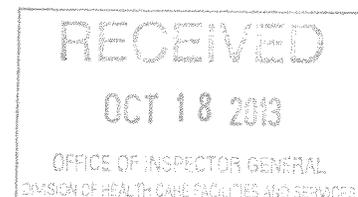
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| F 156 | <p>Continued From page 2</p> <p>name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to post signage in a public area where all residents and visitors could access contact information for the District and State Long Term Care (LTC) Ombudsman.</p> <p>The findings include:</p> <p>Review of the facility's admission packet revealed contact information for the State and District Ombudsman printed on the back of a document titled Residents' Rights: For Residents in Kentucky Long-Term Care Facilities (undated).</p> <p>The facility did not provide a policy for posting contact information for state client advocacy agencies such as the State and District Ombudsman.</p> <p>Observation, on 09/24/13 at 9:00 AM, during the initial tour of the facility revealed contact information for the District and State Ombudsman was not posted in public areas (hallways, foyers,</p> | F 156 | | | |



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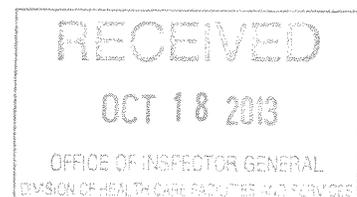
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| F 156 | <p>Continued From page 3</p> <p>sitting rooms, etc.) so that residents and visitors could access this information without first contacting the facility's staff.</p> <p>Observation, on 09/26/13 at 1:00 PM, revealed signs with contact information for the District and State Ombudsman were not posted in public areas (hallways, foyers, sitting rooms, etc.) of the facility.</p> <p>Observation, on 09/26/13 at 1:05 PM, during a tour of the building with the Administrator, revealed the poster that listed contact information for the District Ombudsman was posted on a bulletin board in the employee break room.</p> <p>Observation, on 09/26/13 at 1:15 PM, revealed an additional poster with Ombudsman contact information posted on a bulletin board inside the admissions office.</p> <p>Interview, on 09/26/13 at 1:15 PM, with the Admissions and Marketing Director revealed she made residents and family members aware of the Ombudsman's contact information during the admission process.</p> <p>Interview, on 09/26/13 at 1:35 PM, with the Administrator, revealed the poster found in the employee break room was previously posted in facility's front foyer. He stated it should be there now, and he was not sure why it had been moved. The Administrator stated it was important for residents, any visitors to the facility, and staff members to have ready access to the District and State Ombudsman's contact information if they needed this agency's assistance regarding quality of resident care concerns.</p> | F 156 | | | |



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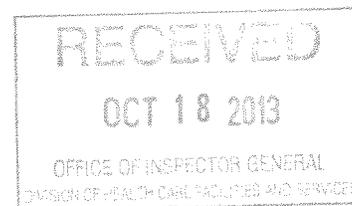
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| F 246 F 246 SS=D | Continued From page 4 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to provide an assistive device to assist a resident to turn in bed for one (1) of two (2) unsampled residents, Unsampled Resident C. The facility failed to provide Unsampled Resident C with a means to turn themself in bed. The findings include: Observations, on 09/24/13 at 11:20 AM, revealed in room 12-A Unsampled Resident C had bolsters on each side of their mattress. Unsampled Resident C was obese, had Dementia, and was unable to be interviewed. On each side of the mattress was a bolster. The resident was unable to turn from side to side. His/ her body was wedged between the two bolsters. The resident stated, "I can't turn". The resident was attempting to get a leg over the bolster that was down the side of the mattress from approximately six (6) inches from the head of the bed to approximately six (6) inches from the foot of the bed. The bolster was thinner in width at the top and it became broader at the foot of the bed. | F 246 F 246 | 1. The Care Team assessed Resident C for the appropriate device to accommodate her needs. The bolsters were removed and replaced with a raised perimeter mattress to allow for increased bed mobility. 1. The Care Team assessed all residents with bolsters. Any bolsters that limited bed mobility, except those that would endanger the health or safety of the resident, were removed and replaced with a more appropriate device. 2. Director of Nursing will re-educate all nursing staff and the Care Team regarding the appropriate use of bolsters and their impact on bed mobility on 11/8/13. 3. The QA Nurse will audit 100% of bolsters weekly for four weeks, then monthly to ensure appropriate use. The QA Nurse will present results of audits at QA on 11/7/13 and not less than Quarterly thereafter. | 11/7/13 11-9-13 <i>Rn A. White</i> <i>by RB/D-22-13</i> | |



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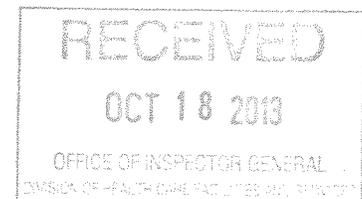
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| F 246 | Continued From page 5 Observations during the initial tour of resident rooms 1-A through 16-B, on 09/24/13 at 9:07 AM, revealed residents had scoop mattresses or bolsters on their beds. Observations with the Director of Nursing (DON) and Administrator, on 09/25/13 at 2:30 PM, revealed with the bolsters on both sides of Resident C's bed there was not enough space for Resident C to turn due to his/her obesity. Interview, on 09/25/13 at 2:45 PM, with the DON revealed the facility used a scoop mattress and bolsters to prevent falls. The facility did not use upper side rails. The DON stated the bolsters restricted the movement of Resident C. Interview with the Administrator and DON, on 09/25/13 at 3:10 PM, revealed they both felt the scoop mattresses and bolster's would assist with decreasing resident falls. However, they determined upper side rails would be of benefit for Resident C due to his/her ability to turn in bed but was limited with the use of bolsters due to obesity. | F 246 | | |
| 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 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 - | F 441 | | |



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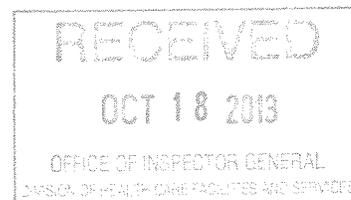
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| F 441 | Continued From page 6 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective 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 facility policy reveiw, it was determined the facility failed to maintain an Infection and Prevention Control Program by not ensuring the appropriate storage of respiratory equipment for three (3) of fifteen (15) sampled and two (2) unsampled residents. Residents A and B had their nebulizer face mask stored uncovered in their room. Resident #1 had a nasal cannula stored uncovered on top of an | F 441 | 1. Director of Nursing and Unit Coordinator immediately cleaned and properly stored nasal cannulae and nebulizer masks of all residents cited. 2. Director of Nursing audited all facility respiratory equipment on 9/25/13 to ensure all nasal cannulae and nebulizer masks were properly cleaned and stored. 3. Director of Nursing will re-educate all nursing staff on 11/8/13 on proper procedures for cleaning and storing all respiratory equipment. 4. Quality Assurance Nurse will audit 100% of all respiratory equipment weekly for three months, and then re-assess the frequency of the audits. Quality Assurance Nurse will report results of audits to QA on 11/7/13 and not less than quarterly thereafter. | 11/7/13 11-9-13 per A. Wade Dy/B 12-22-13 |



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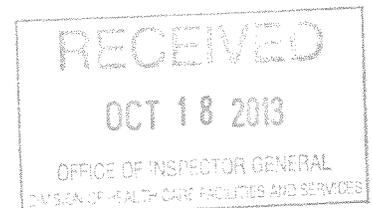
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| F 441 | Continued From page 7 oxygen concentrator. The findings include: Review of the facility's policy regarding Infection Control, undated, revealed there was no policy on the storage of oxygen equipment, including nasal cannulas and face masks. Observation, on 09/25/13 during the tour of the facility which began at 9:00 AM, revealed in Room 25-2 a face mask/nebulizer uncovered sitting on the bedside table. In Room 30-1 was another face mask/nebulizer sitting out uncovered by the sink. In Room 29-2 was a nasal cannula and tubing sitting on top of an oxygen concentrator uncovered. Interview, on 09/26/13 at 1:12 PM, with the Director of Nursing (DON) revealed oxygen equipment such as nebulizer face masks and nasal cannulas were to be stored in a bag in the resident's room. She revealed it was the responsibility of the nurses to ensure proper storage and it was part of the nurses routine to monitor for the proper storage of oxygen equipment. The DON stated the nurses had been educated during a medical supply in-service about the storage of the equipment and the risk to the resident of infection if the equipment was not properly stored. Interview, on 09/26/13 at 1:22 PM, with Licensed Practical Nurse (LPN) #1 revealed oxygen equipment was to be stored in a bag after use once the equipment was rinsed out with warm or hot water and air dried. She revealed the nurses and unit managers were responsible to monitor the oxygen equipment. She revealed bacteria | F 441 | | |



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| F 441 | Continued From page 8 could set up in the equipment without proper storage which may cause an infection to the resident. LPN #1 stated she had attended an in-service on the storage of oxygen equipment. Interview, on 09/26/13 at 1:30 PM, with Registered Nurse (RN) #1 revealed oxygen equipment was to be stored in little bags in the resident's room. She stated this was the responsibility of the desk or med cart nurse. LPN #1 revealed proper storage of the oxygen equipment would keep bacteria from getting in the nose or airway of the resident causing a risk for infection to the resident. | F 441 | | | |



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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: 1977, 1989, 2007</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V Unprotected.</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator installed in 2005. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 09/26/13. Green Valley Health and Rehabilitation Center was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has seventy-eight (78) certified beds and the census was seventy-four (74) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p> | K 000 | | |

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

[Signature]

TITLE

Administrator

(X6) DATE

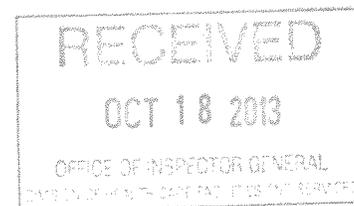
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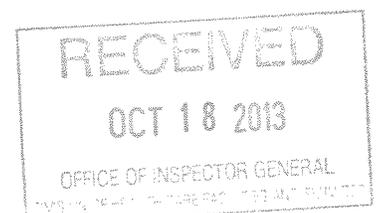
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 09/26/2013 |
|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045 | |
| (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 000 | Continued From page 1 Fire). | K 000 | | |
| 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 barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, seventy four (74) residents, staff and visitors. The facility is certified for seventy eight (78) beds, with a census of seventy four (74) on the day of the survey. The facility failed to ensure smoke partitions were sealed to resist the passage of smoke. The findings include: Observation, on 09/26/13 at 10:30 AM, with the | K 025 | <ol style="list-style-type: none"> Maintenance Director sealed all penetrations cited on the Skilled and West Hall smoke barriers on 9/27/13. All smoke barriers inspected by Maintenance Director on 9/27/13. No additional penetrations exist. Maintenance staff re-educated by Administrator on 9/27/13 regarding regulation of smoke compartments. TELS preventative maintenance includes monthly checks of smoke barriers Maintenance Director will report results of monthly inspections at QA on 11/7/13 and not less than quarterly thereafter. | 11/07/13 11-8-13 for A. Wade by PB, p 22-13 |



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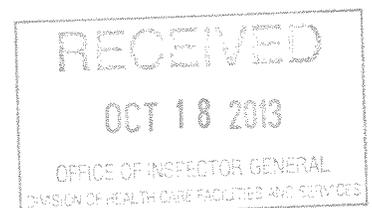
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| K 025 | <p>Continued From page 2</p> <p>Director of Maintenance revealed the smoke partitions extending above the ceiling located in the Skilled Hall, and in the West Hall had penetrations that were not sealed to resist the passage of smoke. The smoke partition located in the Skilled Hall had unsealed penetrations around wood framing protruding through the wall. The smoke partition located in the West Hall had a two (2) foot by two (2) foot hole cut in the drywall next to a HVAC duct work.</p> <p>Interview, on-09/26/13 at 10:30 AM, with the Director of Maintenance revealed he was not aware the smoke partitions were not sealed properly.</p> <p>Reference: NFPA 101 (2000 edition) 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. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through</p> | K 025 | | |



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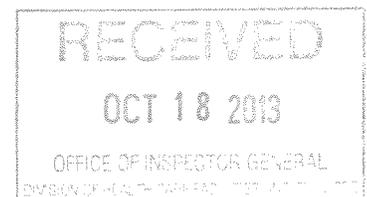
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| K 025 | Continued From page 3 floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (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. 19.3.7.4 Not less than 30 net ft ² (2.8 net m ²) per patient in a hospital or nursing home, or not less than 15 net ft ² (1.4 net m ²) per resident in a limited care facility, shall be provided within the aggregate area of corridors, patient rooms, treatment rooms, lounge or dining areas, and other low hazard areas on each side of the smoke barrier. On stories not housing bed or litterborne patients, not less than 6 net ft ² (0.56 net m ²) per occupant shall be provided on each side of the smoke barrier for the total number of occupants in adjoining compartments. 19.3.7.5 Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors; or | K 025 | | |



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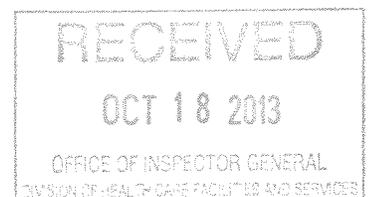
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| K 025 | Continued From page 4 by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2. | K 025 | | 11/7/13 | |
| K 029 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy eight (78) beds with a census of seventy four (74) on the day of the survey. The facility failed to maintain self-closing doors protecting hazardous areas. | K 029 | <ol style="list-style-type: none"> Automatic closers installed by Maintenance Director on Server Room and Social Services office doors on 9/30/13. All doors in facility leading to potentially hazardous areas checked to ensure automatic door closers in place and functioning properly by Maintenance Director on 9/30/13. Maintenance Director re-educated on regulation by Regional Maintenance Director on 10/15/13 and will add inspection of automatic door closers to his monthly preventative maintenance checklist. Administrator will audit inspections monthly beginning November 2013 and will report results at QA on 11/07/13 and not less than quarterly thereafter. | 11-8-13 per A. note by PB 10-22-13 | |



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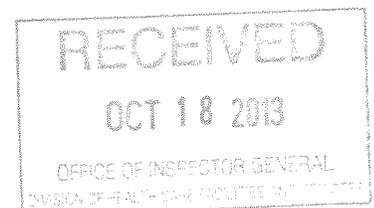
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| K 029 | <p>Continued From page 5</p> <p>The findings include:</p> <p>Observation, on 09/26/13 at 12:46 PM, with the Director of Maintenance revealed four boxes of combustible paper stored on the floor outside of the Server Room next to the Front Desk located in the Lobby. The combustible paper was observed being in storage on the floor for more than thirty (30) minutes. Further observation revealed the Server Room next to the Front Desk located in the Lobby to have large amounts of combustible paper stored in the room and the door did not have a self-closing device installed to keep the door closed. The door was found to be routinely left open.</p> <p>Interview, on 09/26/13 at 12:46 PM, with the Director of Maintenance revealed the paper on the floor was just delivered the day of the survey, but he was not aware of why it was left outside of a protected room. Further interview revealed he was not aware the door to the Server Room was required to be self-closing.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions</p> | K 029 | | |



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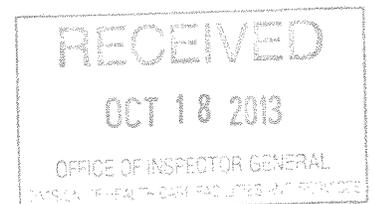
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| K 029 | Continued From page 6 and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. 8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8. | K 029 | | |
| K 038 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 | K 038 | | |



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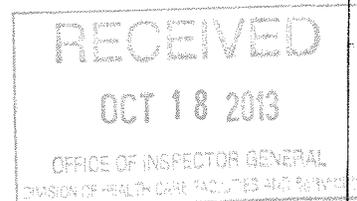
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| K 038 | Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the egress was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is certified for seventy eight (78) beds with a census of seventy four (74) on the day of the survey. The facility failed to ensure the means of egress were free of obstructions and impediments. The findings include: Observation, on 09/26/13 at 2:05 PM, with the Director of Maintenance revealed an unattended chair was left outside the West Hall Exit Door. When the exit door was opened the door hit the chair, pushing the chair into the outside wall stopping the door at a forty five (45) degree angle from the closed position, instead of a ninty (90) degree angle. Interview, on 09/26/13 at 2:05 PM, with the Director of Maintenance revealed he was not aware the chair had been placed outside of the exit door. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in | K 038 | <ol style="list-style-type: none"> The chair was removed from outside the West Hall exit door by Maintenance Director on 9/26/13. All exits inspected by Maintenance Director to ensure unobstructed egress from the building on 9/26/13. Administrator re-educated all staff regarding exit door obstructions on 9/26/13. Maintenance Director or Assistant will inspect exit doors daily to ensure none are obstructed. Results of inspections will be presented at QA 11/7/13 and not less than quarterly thereafter. | 11/7/13 11-8-13 <i>per A. Wode</i> <i>by PB, 10-22-13</i> |



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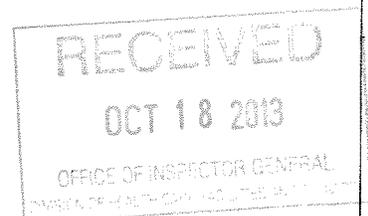
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| K 038 | Continued From page 8 the case of fire or other emergency. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. | K 038 | | |
| K 045 SS=E | 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: Based on observation and interview, it was determined the facility did not meet the requirements for illumination of means of egress in accordance with NFPA standards. The | K 045 | | |



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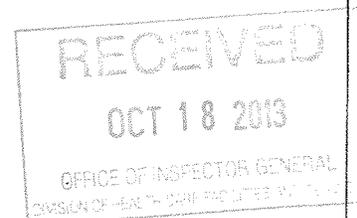
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| K 045 | Continued From page 9 deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy eight (78) beds with a census of seventy four (74) on the day of the survey. The facility failed to provide required illumination outside an exit for discharge. The findings include: Observation, on 09/26/13 between 10:30 AM and 2:30 PM, with the Director of Maintenance revealed the exit located in the Therapy Hall, Kitchen, and the Skilled Hall did not have a light fixture installed outside to provide the required illumination for exit discharge. Interview, on 09/26/13 between 10:30 AM and 2:30 PM, with the Director of Maintenance revealed he was not aware the exit did not have the required illumination for egress lighting. Reference NFPA 101 (2000 edition) 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in 7.7 DISCHARGE FROM EXITS 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply | K 045 | 1. Maintenance Director replaced single light fixtures with dual light fixtures outside of Therapy Hall, Kitchen, and Skilled Hall on 10/16/13 and ensured proper operation. 2. Maintenance Director checked all lighted external areas to ensure proper redundancy of light sources on 9/27/13. 3. Administrator re-educated Maintenance Director regarding external lighting regulations on 9/27/13. 4. Maintenance Director will inspect all external lighting for proper functioning monthly, and report results of inspections at QA on 11/7/13 and not less than quarterly thereafter. | 11/7/13 11-8-13 per A Wade by RB 10-22-13 |



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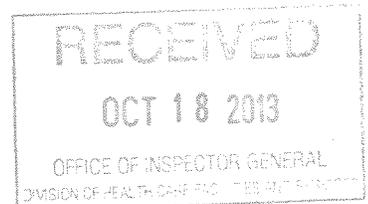
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| K 045 | Continued From page 10 to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. 7.7.2 Not more than 50 percent of the required number of exits, and not more than 50 percent of the required egress capacity, shall be permitted to discharge through areas on the level of exit discharge, provided that the criteria of 7.7.2(1) through (3) are met: (1) Such discharge shall lead to a free and unobstructed way to the exterior of the building, and such way is readily visible and identifiable from the point of discharge from the exit. (2) The level of discharge shall be protected throughout by an approved, automatic sprinkler system in accordance with Section 9.7, or the portion of the level of discharge used for this purpose shall be protected by an approved, automatic sprinkler system in accordance with Section 9.7 and shall be separated from the nonsprinklered portion of the floor by a fire resistance rating meeting the requirements for the enclosure of exits (see 7.1.3.2.1). Exception: The requirement of 7.7.2(2) shall not apply where the discharge area is a vestibule or foyer meeting all of the following: (a) The depth from the exterior of the building shall not be more than 10 ft (3 m) and the length shall not be more than 30 ft (9.1 m). (b) The foyer shall be separated from the remainder of the level of discharge by construction providing protection not less than the equivalent of wired glass in steel frames. | K 045 | | | |



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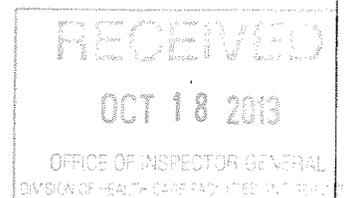
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 09/26/2013 |
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| NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045 | |
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| K 045 | Continued From page 11 (c) The foyer shall serve only as means of egress and shall include an exit directly to the outside. (3) The entire area on the level of discharge shall be separated from areas below by construction having a fire resistance rating not less than that required for the exit enclosure. Exception No. 1: Levels below the level of discharge shall be permitted to be open to the level of discharge in an atrium in accordance with 8.2.5.6. Exception No. 2: One hundred percent of the exits shall be permitted to discharge through areas on the level of exit discharge as provided in Chapters 22 and 23. Exception No. 3: In existing buildings, the 50 percent limit on egress capacity shall not apply if the 50 percent limit on the required number of exits is met. 7.7.3 The exit discharge shall be arranged and marked to make clear the direction of egress to a public way. Stairs shall be arranged so as to make clear the direction of egress to a public way. Stairs that continue more than one-half story beyond the level of exit discharge shall be interrupted at the level of exit discharge by partitions, doors, or other effective means. 7.7.4 Doors, stairs, ramps, corridors, exit passageways, bridges, balconies, escalators, moving walks, and other components of an exit discharge shall comply with the detailed requirements of this chapter for such components. 7.7.5 Signs. (See 7.2.2.5.4 and 7.2.2.5.5.) 7.7.6 Where approved by the authority having | K 045 | | |



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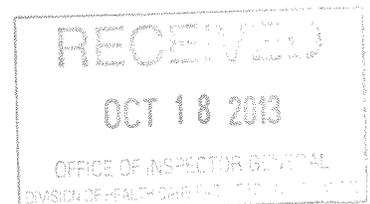
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| K 045 | Continued From page 12 jurisdiction, exits shall be permitted to discharge to roofs or other sections of the building or an adjoining building where the following criteria are met: (1) The roof construction has a fire resistance rating not less than that required for the exit enclosure. (2) There is a continuous and safe means of egress from the roof. 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area | K 045 | | |



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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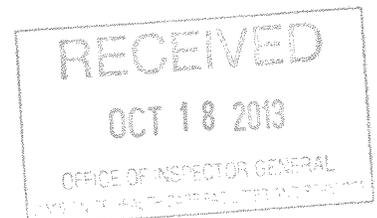
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| K 045 | Continued From page 13 served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 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. Reference: NFPA 101 (2000 Edition) 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. | K 045 | | |
| K 046 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on battery light testing record review, and interview, it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, | K 046 | | |



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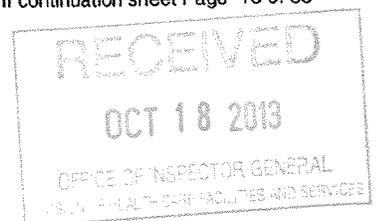
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| K 046 | <p>Continued From page 14</p> <p>seventy four (74) residents, staff and visitors. The facility is certified for seventy eight (78) beds with a census of seventy four (74) on the day of the survey. The facility failed to test emergency battery lighting for thirty (30) seconds monthly and ninety (90) minutes annually.</p> <p>The findings include:</p> <p>Battery light testing record review, on 09/26/13 at 1:27 PM, with the Director of Maintenance revealed the facility did not have documentation for the thirty (30) second monthly test, or the ninety (90) minute annual testing of emergency battery lighting located in the facility.</p> <p>Interview, on 09/26/13 at 1:27 PM, with the Director of Maintenance revealed he was not aware documentation was to be kept for emergency battery light testing.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting</p> | K 046 | <ol style="list-style-type: none"> Maintenance Director performed a 30 second test battery light test on 9/27/13 and will perform a 90 minute battery lighting test on 11/5/13. All emergency lighting working properly. Maintenance Director performed a 30 second test battery light test on 9/27/13 and will perform a 90 minute battery lighting test on 11/5/13. All emergency lighting working properly. Regional Maintenance Director re-educated facility Maintenance Director on 10/15/13 regarding battery light testing and the proper procedures for documenting results. Administrator will audit monthly and annual tests quarterly to ensure proper procedures are followed and report results of audit to QA on 11/7/13 and not less than quarterly thereafter. | <p>11/7/13 11-8-13 an A write 10/12/13</p> |



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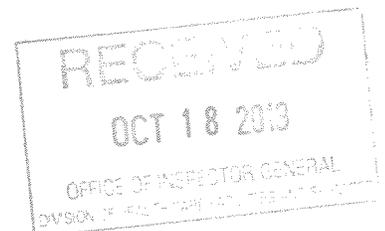
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| K 046 | Continued From page 15 Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. | K 046 | | |
| K 050 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire | K 050 | <ol style="list-style-type: none"> Maintenance Director held a second shift fire drill at 10 PM on 10/16/13. Maintenance Director held a second shift fire drill at 3:00am on 10/16/13. Administrator re-educated Maintenance Director on 9/26/13 regarding appropriately varying fire drill times. Administrator will audit fire drills monthly for appropriately varying times and will report results of audit to QA on 11/7/13 and not less than quarterly thereafter. | 11/7/13 11-8-13 per Arvde KJPB 10-22-13 |



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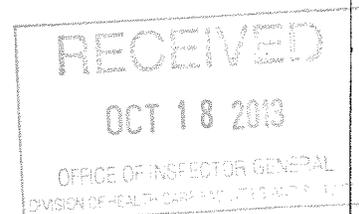
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| K 050 | <p>Continued From page 16</p> <p>drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, seventy four (74) residents, staff and visitors. The facility is certified for seventy eight (78) beds with a census of seventy four (74) on the day of the survey. The facility failed to ensure the fire drills were conducted quarterly at unexpected times.</p> <p>The findings include:</p> <p>Fire Drill record review, on 09/26/13 at 11:12 AM, with Director of Maintenance revealed the facility failed to conduct fire drills at unexpected times under varied conditions on both shifts. The facility has two (2) shifts. First shift is from 7:00 AM -7:00 PM, and second shift is from 7:00 PM - 7:00 AM.</p> <p>First Shift Fire Drills:</p> <ol style="list-style-type: none"> 1) 09-20-13 @ 10:30 AM 2) 06-29-13 @ 2:25 PM 3) 03-29-13 @ 3:30 PM 4) 12-30-13 @ 2:15 PM <p>Second Shift Fire Drills:</p> <ol style="list-style-type: none"> 1) 07-31-13 @ 8:00 PM 2) 04-30-13 @ 7:50 PM 3) 01-31-13 @ 8:50 PM 4) 10-31-13 @ 8:50 PM <p>Extra Fire Drills at shift change:</p> <ol style="list-style-type: none"> 1) 08-23-13 @ 7:00 PM 2) 05-31-13 @ 7:00 PM 3) 02-27-13 @ 7:00 PM 4) 11-30-12 @ 7:00 PM <p>Interview, on 09/26/13 at 11:12 AM, with the Director of Maintenance revealed he was</p> | K 050 | | |



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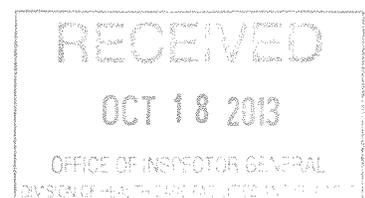
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| K 050 | Continued From page 17 unaware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible | K 050 | | | |



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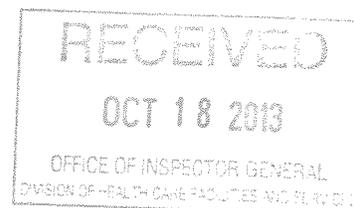
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| K 050 | Continued From page 18 alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. | K 050 | <ol style="list-style-type: none"> Maintenance Director contacted Kentuckiana Sprinkler on 9/27/13 to learn the status of new sprinkler heads ordered 6 weeks earlier. Kentuckiana Sprinkler assured Maintenance Director sprinkler heads would be installed no later than 10/31/13. Maintenance inspected all sprinkler heads on 9/27/13 and no others are out of date. Administrator re-educated Maintenance Director on 9/26/13 on regulations regarding sprinkler systems. Maintenance Director will develop a tool to track sprinkler head dates by 11/7/13. Administrator will audit tracking tool monthly and report results at QA on 11/7/13 and not quarterly thereafter. | 11/7/13 11-8-13 per Anville by PA 10-22-13 |
| K 062 SS=D | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on sprinkler testing record review and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy eight (78) beds with a census of seventy four (74) on the day of the survey. The facility failed to maintain complete sprinkler protection.</p> <p>The findings include:</p> <p>Sprinkler Testing Record Review on 09/26/13 at 11:16 AM, with the Director of Maintenance revealed the facility failed to make repairs to the sprinkler system noted on the sprinkler testing company 's quarterly report. Quarterly sprinkler testing reports dated 04/05/13 and 07/24/12 both noted expired sprinkler heads located in a bathroom. The facility failed to provide documentation that the sprinkler heads noted in the reports had been replaced.</p> | K 062 | | |



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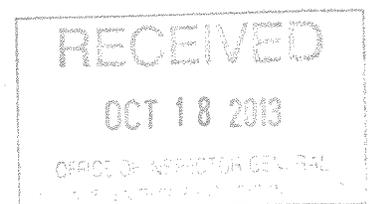
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| K 062 | Continued From page 19 Interview, on 09/26/13 at 11:16 AM, with the Director of Maintenance revealed he was aware of the reports and had planned on having the sprinkler company make the repairs. Reference: NFPA 13 (1999 Edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated In Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary | K 062 | | |



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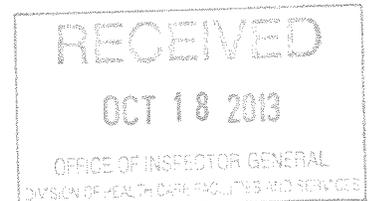
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| K 062 | Continued From page 20 temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 | K 062 | | |



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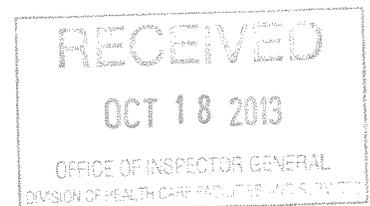
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 09/26/2013 |
| NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045 | |
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| K 062 | Continued From page 21 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction Investigation Maintenance 5 years or as needed Chapter 10 | K 062 | 1. Maintenance Director purchased metal containers with self-closing lid devises 10/16/13 and placed in all smoking areas 2. Maintenance Director purchased metal receptacles with self-closing lid devises 10/16/13 and placed in all smoking areas 3. Administrator re-educated Maintenance Director regarding all smoking regulations on 9/27/13. 4. Administrator will inspect smoking areas monthly to ensure containers are in place and function properly and will report results of inspections to QA on 11/7/13 and not less than quarterly thereafter. | 11/7/13 11-8-13 per Anable by PB 10-22-13 |
| K 066 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible materlal and safe design are provided in all areas where smoking is permitted. | K 066 | | |



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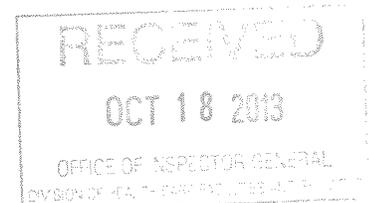
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| K 066 | <p>Continued From page 22</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff and visitors. The facility is certified for seventy eight (78) beds with a census of seventy four (74) on the day of the survey. The facility failed to ensure the smoking areas had a metal container with a self-closing lid to dump ashtrays.</p> <p>The findings include:</p> <p>Observation, on 09/26/13 at 1:44 PM, with the Director of Maintenance revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking area.</p> <p>Interview, on 09/26/13 at 1:44 PM, with the Director of Maintenance revealed he was not aware the smoking area did not have the required metal container with a self-closing lid for dumping ashtrays.</p> <p>Reference: NFPA Standard 101 (2000 Edition).</p> <p>19.7.4 Smoking (4) Metal containers with self-closing cover devices</p> | K 066 | | |



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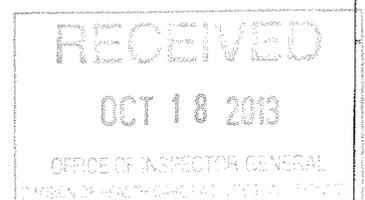
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| K 066 | Continued From page 23 into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. | K 066 | <ol style="list-style-type: none"> Maintenance Director called Hawkins Plumbing on 10/15/13 who will have water heater properly ventilated by 10/25/13. Maintenance Director inspected all water heaters on 9/27/13 and all others are properly ventilated. Regional Maintenance Director re-educated Maintenance Director on 10/15/13 regarding proper ventilation of water heaters. Maintenance Director will inspect all water heaters for proper ventilation quarterly, and will present results of inspections at QA on 11/7/13 and not less than quarterly thereafter. | 11/7/13 11-8-13 AMAV/llc jag PB 10-22-13 |
| K 068 SS=D | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, fuel fired HVAC, and water heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy eight (78) beds with a census of seventy four (74) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 09/26/13 at 1:30 PM, with the Director of Maintenance revealed the fresh air vents serving the gas fired water heater located in the Water Heater Room inside the Laundry Area was not continuous to the outside, but instead open to the attic space.</p> <p>Interview, on 09/26/13 at 1:30 PM, with the Director of Maintenance revealed he was not aware the vent had been missed when he had others in the building vented to the outside.</p> | K 068 | | |



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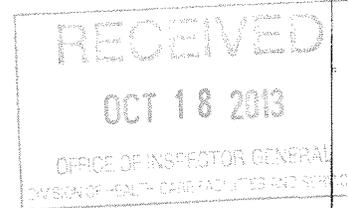
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| K 068 | Continued From page 24 Reference: NFPA 101 Life Safety Code (2000 edition) Section 19.5 Building Services 19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure. NFPA 101 LIFE SAFETY CODE STANDARD | K 068 | | |
| K 072 SS=E | Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy | K 072 | <ol style="list-style-type: none"> Maintenance Director removed equipment from Therapy Hall and West Hall on 9/27/13. Nursing Staff removed med carts from the North Nurses' Station egress and from the East Hall exit on 9/27/13. Maintenance Director inspected entire facility for any obstructed means of egress and removed equipment as necessary on 9/27/13. | 11/7/13 11-8-13 <i>Jan A. Wade</i> by PG 10-22-13 |



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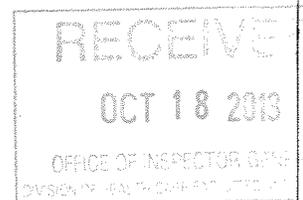
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| K 072 | Continued From page 25 eight (78) beds with a census of seventy four (74) on the day of the survey. The facility failed to ensure the means of egress was free of all obstructions or impediments. The findings include: Observations, on 09/26/13 between 10:30 AM and 2:30 PM, with the Director of Maintenance revealed four (4) chairs, one (1) table, one (1) floor scrubber, one (1) lift, two (2) carts, two (2) walkers, and one (1) dolly, stored in the egress path located in the Therapy Hall. Further observation revealed three (3) wheelchairs, and one (1) chair stored in the egress path located in the West Hall by Room #8. Further observation revealed Med Carts stored in the egress path located by the North Nurses' Station, and by the East Hall Exit. Interview, on 09/26/13 between 10:30 AM and 2:30 PM, with the Director of Maintenance revealed the items were routinely stored in these areas. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. | K 072 | 3. Administrator, Director of Nursing, and Maintenance Director will re-educate all Facility Staff on 11/7/13 regarding the need to keep corridors and exit door free from obstructions. 4. Maintenance Director or Assistant will inspect facility daily Monday through Friday to ensure corridors and exit doors remain free of obstruction. Weekend Supervising Nurse will inspect each Saturday and Sunday. Results of inspections will be reported at QA on 11/7/13 and not less than quarterly thereafter. | |
| 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 | K 076 | | |



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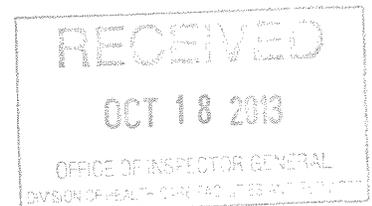
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| K 076 | Continued From page 26 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for seventy eight (78) beds with a census of seventy four (74) on the day of the survey. The findings include: Observation, on 09/26/13 at 2:25 PM, with the Director of Maintenance revealed thirty one (31) oxygen tanks stored in the oxygen storage room with an ignition source located below five (5) feet from the floor. The ignition sources were two (2) plugs and one (1) light switch. Interview, on 09/26/13 at 2:25 PM, with the Director of Maintenance revealed he was not aware of the requirements for oxygen storage. Reference: NFPA 99 (1999 edition) 8-3.1.11.2 | K 076 | 1. Maintenance Director will raise both electrical outlets and the one light switch to a minimum height of 5 feet above the floor by 11/7/13. 2. Maintenance Director will raise both electrical outlets and the one light switch to a minimum height of 5 feet above the floor by 11/7/13. 3. Regional Maintenance Director re-educated facility Maintenance Director on 10/15/13 regarding medical gas storage. 4. Maintenance Director or Assistant will inspect South med room weekly to ensure no combustibles or ignition sources are within five feet of medical gas and report results of inspections at QA on 11/7/13 and not less than quarterly thereafter. | 11/7/13 11-8-13 M.A.W.D.C. by PB 10.27.13 |



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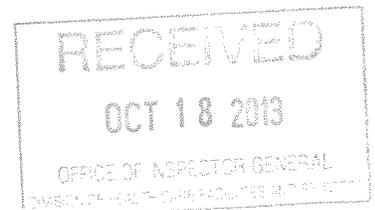
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| K 076 | Continued From page 27 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible 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 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 | K 076 | | |



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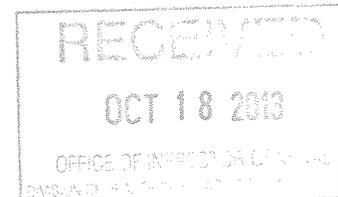
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| K 076 | Continued From page 28 storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14. | K 076 | 1. Maintenance Director will perform a 30 minute test under load on 10/18/13 to ensure generator working properly. Nixon Power contacted and will perform a load bank test by 11/7/13. | 11/7/13 11-8-13 per A.W.H.C. DyPB 11-22-13 |
| K 144 SS=F | 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 NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on generator testing record review and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, seventy four (74) residents, staff and visitors. The facility is certified for seventy eight (78) beds with a census of seventy four (74) on the day of the survey. The findings include: | K 144 | 2. Maintenance Director will perform a 30 minute test under load on 10/18/13 to ensure generator working properly. Nixon Power contacted and will perform a load bank test by 11/7/13. 3. Regional Maintenance Director re-educated facility Maintenance Director on 10/15/13 regarding generator regulations and the proper procedures for testing and documenting results. 4. Administrator will audit monthly and annual tests quarterly to ensure tests are being performed and equipment working properly and report results of audit to QA on 11/7/13 and not less than quarterly thereafter. | |



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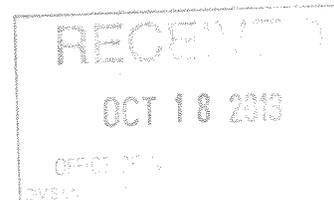
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| K 144 | Continued From page 29 Generator testing record review, on 09/26/13 at 11:05 AM, with the Director of Maintenance revealed the generator was not being exercised under load monthly. Further record review revealed that when power was transferred to the generator the load on the generator was under 25% of the nameplate rating for the generator which would require the facility to perform an annual load bank test. The last load bank test was performed on 02-23-11. Since the facility did not transfer power monthly, the time it takes for the generator to transfer power in an emergency situation is unknown. Interview, on 9/26/13 at 11:05 AM, with the Director of Maintenance revealed the generator was run monthly but did not know power had to be transferred or documentation of the transfer time was to be kept. Further interview revealed he was not aware the annual load bank test was required. Reference: NFPA 110 (1999 Edition). 6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established 6-4.1* Level 1 and Level 2 EPSSs, including all | K 144 | | |



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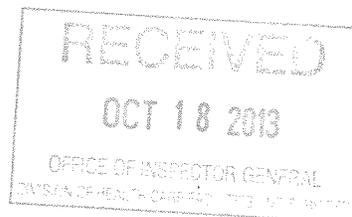
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| K 144 | Continued From page 30 appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. | K 144 | | |
| K 147 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff, and visitors. The facility is certified for seventy eight (78) beds with a census of seventy four (74) on the day of the survey. The facility failed to ensure power strips were not misused. The findings include: Observations, on 09/26/13 between 10:30 AM and 2:30 PM, with the Director of Maintenance revealed; | K 147 | <ol style="list-style-type: none"> Maintenance Director removed power strips from the North Unit Coordinator's office and the East Hall med room on 9/26/13. Maintenance Director inspected entire facility for power strips and removed them as appropriate on 9/27/13. Administrator will re-educate Nursing Staff regarding use of power cords on 11/7/13. Maintenance Director will inspect the facility weekly for three months, then monthly, for the inappropriate use of power strips. Maintenance Director will report results of audit at QA on 11/7/13 and not less than quarterly thereafter. | 11-7-13 11-8-13 per Audit by PB 10/22/13 |



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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 09/26/2013 |
| NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045 | |
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| K 147 | <p>Continued From page 31</p> <p>1) A refrigerator was plugged into a power strip located in the North Unit Managers Office.</p> <p>2) Medical equipment was plugged into a power strip located in the East Hall Med Room.</p> <p>Interview, on 09/26/13 between 10:30 AM and 2:30 PM, with the Director of Maintenance revealed he was not aware of the misuse of power strips.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric.</p> <p>Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or</p> | K 147 | | |



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| K 147 | Continued From page 32 floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces | K 147 | | | |

