

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

PRINTED: 07/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185138	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2015
NAME OF PROVIDER OR SUPPLIER NAZARETH HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 NEWBURG ROAD LOUISVILLE, KY 40205	
(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 Recertification Survey was initiated on 06/30/15 and concluded on 07/02/15 with deficiencies cited at the highest scope and severity of an "D". In addition, an Abbreviated Survey was initiated on 06/30/15 and concluded on 07/02/15 to investigate KY 23456. The Division of Health Care unsubstantiated the allegation with no deficiencies cited.	F 000	This plan of correction is submitted for the accompanied statement of deficiencies. This documented plan submitted does not constitute agreement with the statement of deficiencies nor does it document agreement with the stated conclusions from the interviews written as a part of the deficiencies.	
F 371 SS=D	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, it was determined the facility failed to ensure food was served within the required temperature range for one (1) of five (5) dining rooms and one (1) of three (3) unsampled residents, (Unsampled Resident A). Dietary Aide #1 failed to accurately temp foods and Unsampled Resident A voiced concerns regarding cold food in the Woodside Dining room. The findings include:	F 371	This plan of correction is submitted as our duty as outlined in the requirements of the law. 1. Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice: Dietary manager upon receipt of deficient practice, re-educated Dietary Aide #1 regarding calibrating thermometer process and procedure for obtaining temperature of foods on July 1, 2015. Competency form for dietary Aide #1 was completed July 1, 2015, see Attachment A.	

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

TITLE

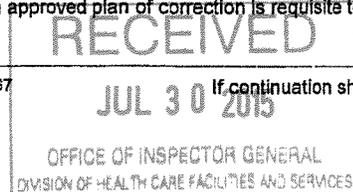
(X5) DATE

Mary Jo Arnesen

Administrator 7/30/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SM

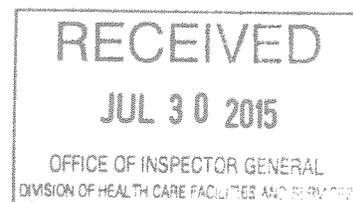


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F 371	<p>Continued From page 1</p> <p>Review of the Food Safety Serving Temperatures Policy, reviewed January 2015, revealed prior to serving, prepared foods would remain within standard temperature ranges to assure quality and avoid potential contamination resulting in food borne illness. Hot food temperatures do not fall below one hundred and forty (140) degrees (F)ahrenheit while food was held on steam equipment, in ovens, or in other equipment.</p> <p>Interview with Unsampled Resident A, during the Resident Council Meeting, on 07/01/15 at 11:00 AM, revealed he/she ate in the Woodside Dining Room and found the hot food was served too cold for him/her.</p> <p>Observation of the lunch meal in the Woodside Dining Room, on 07/01/15 at 12:15 PM, revealed Dietary Aid #1, placed ground chicken, carrots and mashed potatoes on the steam table. She then placed three thermometers in water containing a little amount of ice. Continued observation 12:30 PM, revealed Dietary Aid #1 took the temperature of food items on the steam table. The ground chicken tempted at ninety (90) degrees (F); carrots at ninety (90) degrees (F); and, mashed potatoes at 100 degrees (F). These food items were returned to the kitchen to be reheated. Additional observations at 1:02 PM, revealed the ground chicken, carrots and mashed potatoes were returned from the kitchen and Dietary Aide #1 rettempted the ground chicken at ninety (90) degrees (F); carrots at ninety (90) degrees (F); and, the mashed potatoes at 100 degrees (F).</p> <p>Observation and interview with the Team Leader during the lunch meal in the Woodside Dining Room, on 07/01/15 at 1:08 PM, revealed she</p>	F 371	<p>Dietary Aide #1 was observed by dietary manager and team leader on 7/2/2015 performing calibration of thermometers and taking of temps for breakfast and lunch meals – compliance identified and noted utilizing Attachment A. (forms are kept on file by dietary manager) Two residents on 7/1/2015 were identified by dietary manager as having been affected by the deficient practice, did not experience any untoward effects.</p> <p>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>No other residents were identified as having been impacted by the deficient practice per dietary manager based upon elders' diet orders.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>On July 1, 2015, dietary manager and team leaders began process of re-educating dietary staff (i.e., cooks, aides, dishwasher) regarding: accuracy of checking food temperature and process for calibrating thermometer.</p>	

Mary Hayes, MA, 7/24/15

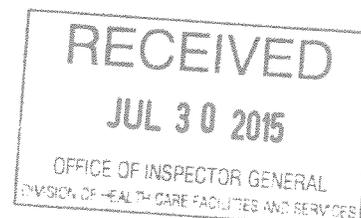


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F 371	<p>Continued From page 2</p> <p>stated the food had been sitting on the steam table and should be at the correct temperature. She then retemped the chicken and carrots at ninety (90) degrees (F) and the mashed potatoes were at one hundred (100) degrees (F). Dietary Aid #1 then removed all three (3) thermometers and stated she thought the food temperature was one hundred and forty (140) degrees (F) and then proceeded to serve the food.</p> <p>Observation of the re-calibration of the three (3) thermometers by the Team Leader, on 07/10/15 at 1:15 PM, revealed all three (3) thermometers calibrated at ten (10) and eleven (11) degrees Fahrenheit. Interview at this time with Dietary Aid #1, revealed she thought the thermometers calibrated at thirty-two (32) degrees (F). She stated if the food was served cold, the food was at risk for contamination.</p> <p>Interview with the Team Leader, on 07/01/15 at 1:20 PM, revealed food should not be served at one hundred (100) degrees (F). The Team Leader retempted the ground chicken at one hundred (100) degrees (F), carrots at one hundred and two (102) degrees (F) and mashed potatoes at one hundred and thirty (130) degrees (F) with a calibrated thermometer. The Team Leader stated if food was served cold it could cause food borne illness.</p> <p>Interview with the Dietary Manager, on 07/02/15 at 1:22 PM, revealed they tempted the food on the steam table to ensure the food temperatures were above one hundred and forty (140) degrees (F). The Dietary Manager stated she liked the food to be above one hundred and forty (140) degrees (F) so that bacteria did not get into the food. The Dietary Manager stated the</p>	F 371	<p>Re-education of dietary employees was completed by July 3, 2015 and the form to reflect education is kept on file by dietary manager. The facility's practice is to routinely obtain food temps at each meal, and this practice continued during the time frame of July 2, 2015 through July 20, 2015, utilizing Attachment Form D. All dietary employees were also required to complete educational program entitled: "Preventing Foodborne Illness in the Kitchen", with a completion date of July 22, 2015. Attached is a description of the educational program "Preventing Foodborne illnesses in the Kitchen", identifying the objectives (See Attachment B).</p> <p>To ensure deficient practice will not recur, dietary manager, team leader, and consultant registered dietician monitored dietary staff for compliance in Woodside utilizing Attachment Form C five times a week beginning July 20, 2015 through July 31, 2015 (Attachment C reflects accuracy of temp taking process and interview of at least 4 elders during meal service that food is being served at proper temperatures). All forms are kept on file by the dietary</p>	

[Handwritten Signature] 7/30/15

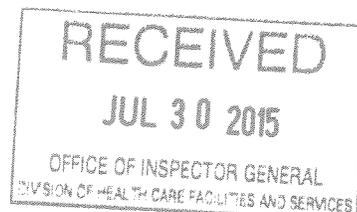


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F 371	Continued From page 3 thermometers were to be calibrated at thirty-two (32) degrees (F) before each meal was tempted. She stated she was not aware of any complaints from residents about the food being cold on Woodside Dining.	F 371	manager, and effectiveness of system is to be reviewed at Continuous Quality Improvement meeting scheduled on 8/5/15. In addition, all dietary staff were required to demonstrate competency – Attachment A was utilized for this process with a completion date of July 24, 2015 (forms to be kept on file by dietary manager and competency conducted by dietary manager, team leader, registered dietician) Ongoing, annually all dietary employees will be required to demonstrate competency during their tenure performed by either the dietary manager, team leader or consulting registered dietician utilizing Attachment A. (this form will also be kept on file by dietary manager) Also, dietary employees upon hire effective July 14, 2015, will be required to demonstrate competency utilizing Attachment A form by dietary manager or team leader during their orientation process (this form will be kept on file by dietary manager). 4. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained:	

MMA, 7/30/15



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1976, 1999</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Three (3) stories, Type II (222)</p> <p>SMOKE COMPARTMENTS: Thirteen (13) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, wet sprinkler system.</p> <p>GENERATOR: Type II generator, fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 06/30/15. The facility was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred eighteen (118) beds with a census of one-hundred twelve (112) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Mary Daynes* TITLE *X Administration* (X6) DATE *8-6-15*

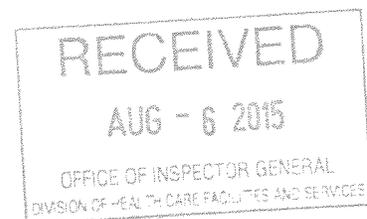
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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	This plan of correction is submitted for the accompanied statement of deficiencies. This documented plan submitted does not constitute agreement with the statement of deficiencies nor does it document conclusions from the interviews written as a part of the deficiencies. This plan of correction is submitted as our duty as outlined in the requirements of the law. 1. No residents, staff, visitors identified as affected. The condition identified as having the potential to affect residents in one of the twelve smoke compartments has been corrected. <u>Corrective Action -</u> Maintenance staff have sealed the pipe sleeve and penetration around duct pipe with a material rated equal to the partition.	7-15-15
K 025 SS=D	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of twelve (12) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred eighteen (118) beds and at the time of the survey, the census was one-hundred twelve (112). The findings include: Observation, on 06/30/15 at 10:55 AM, with the	K 025		

Mary Dwyneal, 8-6-15

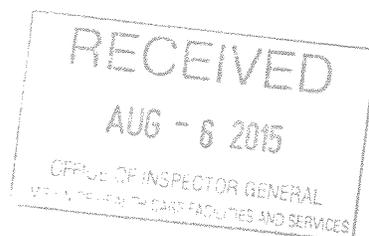


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K 025	Continued From page 3 building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining 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. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025	on agenda of Safety Committee each quarter.	
K 027	NFPA 101 LIFE SAFETY CODE STANDARD	K 027		

Mary Dwyne, 8-6-15

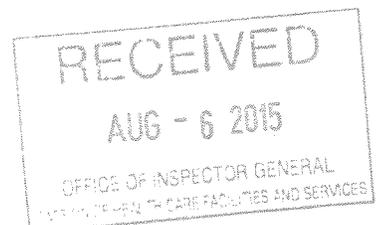


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K 027 SS=D	<p>Continued From page 4</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in a smoke barrier, would resist the passage of smoke in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of twelve (12) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred eighteen (118) beds and the census was one-hundred twelve (112) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 06/30/15 at 9:05 AM, with the Chief Financial Officer revealed the door located in the smoke barrier wall to Room #G104 did not have a self-closing device installed. Review of the blueprints confirmed the door was located in a smoke barrier.</p>	K 027	<p>1. No residents, staff, visitors identified as affected. The practice identified as having the potential to affect residents in the four (4) identified smoke compartments has been corrected. Self – closing devices have been installed on door to room #G 104 and door to room #A204. 7-10-15</p> <p>2. Other residents, staff, visitors identified as having the potential to be affected. <u>Corrective action –</u> Maintenance staff have inspected all twelve (12) smoke compartments and found all doors located in smoke barrier walls to have required self-closing devices installed. 7-16-15</p> <p>3. Systemic changes implemented to ensure the practice will not recur – maintenance staff will inspect all doors located in a smoke barrier wall quarterly for proper functioning of the required self-closing devices. CFO/Facility Management Director educated maintenance staff on 7-16-2015 regarding NFPA requirements for maintenance of smoke compartments. 7-16-15</p>

Mary Dwyer, 8-6-15

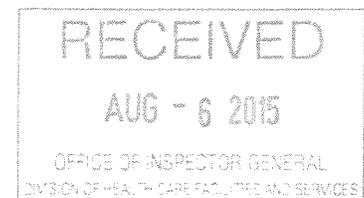


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K 027	<p>Continued From page 5</p> <p>Interview, on 06/30/15 at 9:06 AM, with the Chief Financial Officer revealed he was not aware the door was part of a smoke barrier.</p> <p>2. Observation, on 06/30/15 at 11:20 AM, with the Chief Financial Officer revealed the door located in the smoke barrier wall to Room #A204 did not have a self-closing device installed. Review of the blueprints confirmed the door was located in a smoke barrier.</p> <p>Interview, on 06/30/15 at 11:21 AM, with the Chief Financial Officer revealed he was not aware the door was part of a smoke barrier.</p> <p>The census of one-hundred twelve (112) was verified by the Administrator on 06/30/15. The findings were acknowledged by the Administrator and verified by the Chief Financial Officer at the exit interview on 06/30/15.</p> <p>Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition), 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and</p>	K 027	<p>Documentation will be kept on file in the maintenance department.</p> <p>4. Results of maintenance inspections will be reported by CFO/Facility Management Director at each quarterly Safety Committee Meeting from a quality assurance perspective beginning at next scheduled meeting on 10-1-2015 continuing as recurring item on agenda of Safety Committee each quarter.</p>	7-17-15

Mary Daynes, 8-6-15

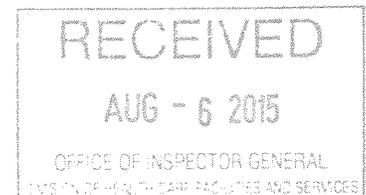


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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 6 latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027		
K 029 SS=D	Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors. 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 for Protection of Hazards, in accordance with the National Fire Protection	K 029	1. No residents, staff, visitors identified as affected. The practice identified as having the potential to affect residents in the four (4) identified smoke compartments has been corrected. <u>Corrective actions:</u> Maintenance staff sealed the identified 6 inch x 6 inch opening in the storage room with a material rated equal to the partition. Maintenance staff installed self-closing device on Medical records room door.	7-15-15 7-7-15

Mary Dwyer, 8-6-15

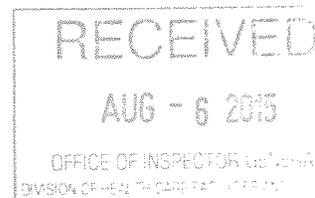


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K 029	Continued From page 7 Agency (NFPA) standards. The deficiency had the potential to affect four (4) of twelve (12) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred eighteen (118) beds and at the time of the survey, the census was one-hundred twelve (112). The findings include: 1. Observation, on 06/30/15 at 9:25 AM, with the Chief Financial Officer revealed the ground floor storage room had a six (6) inch by six (6) inch penetration in the wall. The penetration in the hazardous storage room wall was for the HVAC to return air which was not ducted but using the space between the suspended ceiling and the floor above as a plenum. The opening in the hazard room wall did not have a fire damper installed. Interview, on 06/30/15 at 9:26 AM, with the Chief Financial Officer revealed he was not aware of the opening in the wall. 2. Observation, on 06/30/15 at 9:55 AM, with the Chief Financial Officer revealed hazardous amounts of paper medical records stored in the Medical Records Room. The door was not equipped with a self-closing device. Interview, on 06/30/15 at 9:56 AM, with the Chief Financial Officer revealed he was not aware of the requirements for protection from hazards. 3. Observation, on 06/30/15 at 10:05 AM, with the Chief Financial Officer revealed hazardous amounts of paper and combustible storage located in the Environmental Storage Room. The	K 029	Maintenance staff installed self-closing device on Environmental Storage Room door. Combustible hazardous amounts of paper and cardboard boxes have been removed from Human Resources conference room area and stored in Ground Floor Storage Room. Combustible hazardous amounts Of paper and cardboard boxes have been removed from the Director of Nursing Offices and Stored in Ground Floor Storage Room. 2. Other residents, staff, visitors identified as having the potential to be affected – Self-closing devices have been installed as required per applicable NFPA standards for hazardous storage rooms. Entire facility has been inspected for compliance by maintenance staff with applicable standards for hazardous storage rooms and facility was identified to be in compliance.	7-9-15 7-14-15 7-14-15 7-16-15 7-14-15

Mary Dwyer, 8-6-15

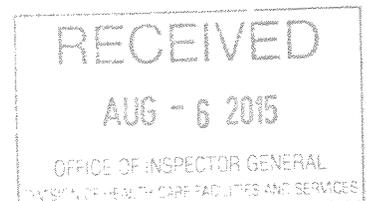


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K 029	Continued From page 9 Protection from Hazards. Reference: NFPA 101 (2000 Edition) 9.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		

Mary Dwyer, 8-6-15

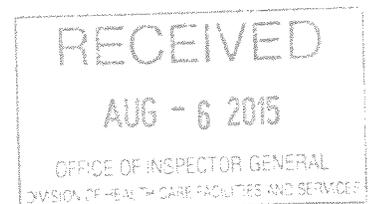


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K 029	Continued From page 10 Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices. Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2. Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily	K 038		

Mary Daynes, 8-6-15

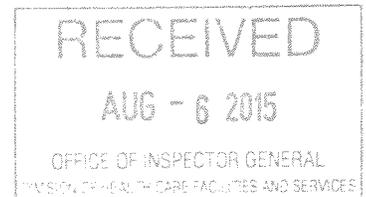


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K 038	<p>Continued From page 11 accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors equipped with delayed egress had a readily visible sign in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect three (3) of twelve (12) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred eighteen (118) beds and at the time of the survey, the census was one-hundred twelve (112).</p> <p>The findings include:</p> <p>1. Observation, on 06/30/15 at 2:44 PM, with the Chief Financial Officer revealed the ground level exit door located in the North Maria Hall Stairwell was equipped with delayed egress; however the door did not have signage to indicate the door would open in fifteen (15) seconds.</p> <p>Interview, on 06/30/15 at 2:45 PM, with the Plant Operations Manager revealed he was not aware of the requirements for delayed egress signage.</p> <p>2. Observation, on 06/30/15 at 2:49 PM, with the Chief Financial Officer revealed the South Maria</p>	K 038	<p>1. No residents, staff, visitors identified as affected. The practice identified as having the potential to affect residents in the three (3) identified smoke compartments has been corrected.</p> <p><u>Corrective Actions:</u> Required delayed egress signage has been installed on ground level north Maria Hall stairwell exit door.</p> <p>Required delayed egress signage has been installed on south Maria Hall stairwell exit door.</p>	<p>7-3-15</p> <p>7-3-15</p>

Mary Dwyer, 8-6-15

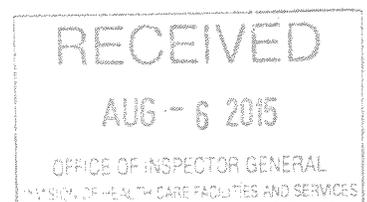


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K 038	<p>Continued From page 12</p> <p>Hall exit door was equipped with delayed egress; however the door did not have signage to indicate the door would open in fifteen (15) seconds.</p> <p>Interview, on 06/30/15 at 2:50 PM, with the Plant Operations Manager revealed he was not aware of the requirements for delayed egress signage.</p> <p>3. Observation, on 06/30/15 at 3:45 PM, with the Chief Financial Officer revealed the Second (2nd) Floor North Maria Hall exit door was equipped with delayed egress; however, the door did not have signage to indicate the door would open in fifteen (15) seconds.</p> <p>Interview, on 06/30/15 at 3:46 PM, with the Plant Operations Manager revealed he was not aware of the requirements for delayed egress signage.</p> <p>4. Observation, on 06/30/15 at 4:00 PM, with the Chief Financial Officer revealed the Second (2nd) Floor South Maria Hall exit door was equipped with delayed egress which failed to operate when tested; however, the door was equipped with a keypad that did release the door when tested. Further observation revealed the exit door had signage indicating the door had delayed egress and would open in thirty (30) seconds; however the facility did not have documented approval from an Authority having Jurisdiction to increase the delay from fifteen (15) seconds to thirty (30) seconds on the day of the survey.</p> <p>Interview, on 06/30/15 at 4:01 PM, with the Plant Operations Manager revealed he was not aware the delayed egress would not function or that the facility needed approval to increase the delay to thirty (30) seconds.</p>	K 038	<p>Required delayed egress signage has been installed on the second (2nd) floor Maria Hall stairwell exit door.</p> <p>Required delayed egress signage has been installed on the second (2nd) floor South Maria Hall stairwell exit door. The second (2nd) floor south Maria Hall delayed egress door feature was tested and door released upon fifteen (15) second delay.</p> <p>Signage on door has been corrected to reflect a fifteen (15) second delay. The magnetic lock was repaired, on date of inspection 6/30/15 and tested for proper operation.</p> <p>2. Other residents, staff, visitors identified as having the potential to be affected – corrective action.</p> <ul style="list-style-type: none"> - Maintenance staff have inspected all egress doors and exits in facility for compliance with NFPA standards, facility was in compliance. <p>3. Systemic measures implemented to ensure deficient practice will not recur CFO/Facility Management Director educated maintenance staff on July 16, 2015 regarding NFPA requirement for maintenance of delayed egress locks. Maintenance staff will inspect all egress doors and exits monthly for</p>	<p>7-3-15</p> <p>7-16-15</p> <p>7-16-15</p>

Mary Dwyer, 8-6-15

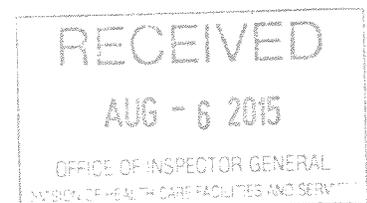


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K 038	Continued From page 13 The census of one-hundred twelve (112) was verified by the Administrator on 06/30/15. The findings were acknowledged by the Administrator and verified by the Chief Financial Officer at the exit interview on 06/30/15. Actual NFPA Standard: 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. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire	K 038	proper function in accordance with NFPA standards. Documentation will be kept on file in Maintenance Department. 4. Results of maintenance inspections will be reported by CFO/Facility Management Director at each quarterly Safety Committee meeting from a Quality Assurance perspective beginning at next scheduled meeting on 10-1-2015 continuing as recurring item on agenda of Safety Committee each quarter.	7/17/15

Mary Haynes, 8-6-15

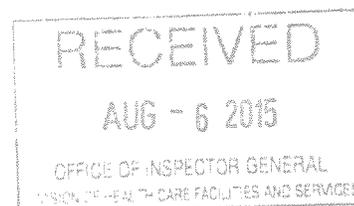


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K 038	<p>Continued From page 14 detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily</p>	K 038		

Mary D. Hynes, 8-6-15

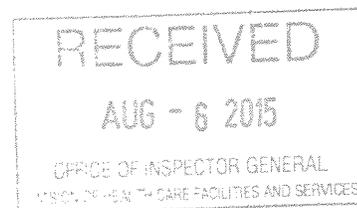


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K 038	Continued From page 15 from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED (c) The locking device is of a type that is readily distinguishable as locked. (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.	K 038		
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within	K 075	1. No residents, staff, visitors identified as affected. The practice identified as having the potential to affect residents in the one (1) smoke compartment has been corrected.	

Mary Dwyer, 8-6-15

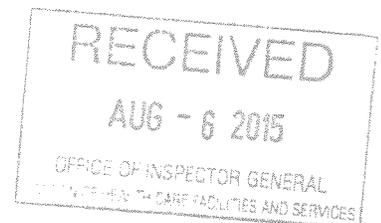


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K 075	Continued From page 16 any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure linen or trash collection receptacles with capacities greater than 32 gallon were stored in accordance with National Fire Protection Association (NFPA) standards. The deficient practice had the potential to affect one (1) of twelve (12) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred eighteen (118) beds and at the time of the survey, the census was one-hundred twelve (112). The findings include: 1. Observation, on 06/30/15 at 9:15 AM, with the Chief Financial Officer revealed a trash container with a capacity of forty-four (44) gallons was being stored in the egress path located outside Room #G103. Interview, on 06/30/15 at 9:15 AM, with the Chief Financial Officer revealed he was not aware of the requirement for trash receptacles with capacities greater than thirty two (32) gallons. 2. Observation, on 06/30/15 at 9:32 AM, with the Chief Financial Officer revealed a trash container	K 075	<u>Corrective Action:</u> The forty – four (44) gallon trash container in egress path located outside Room # G 103 has been removed and replaced with a trash collecting receptacle in accordance with NFPA standards. The forty-four (44) gallon trash container in staff lunch room has been removed and replaced with a trash collection receptacle in accordance with NFPA standards. 2. Other residents, staff, visitors identified as having the potential to be affected – Environmental Service Supervisor inspected entire facility for compliance with the NFPA standards for trash collection receptacles. 3. Systemic measure to ensure deficient practice will not recur – CFO/Facility Management Director Completed education with maintenance staff and Environmental Service Supervisor on 7-16-2015. Environmental Service Supervisor will verify compliance during the monthly room inspection rounds. Documentation will be kept on file in the maintenance department.	7-3-15 7-3-15 7-16-15 7-16-15	

Mary Dayneal, 8-6-15

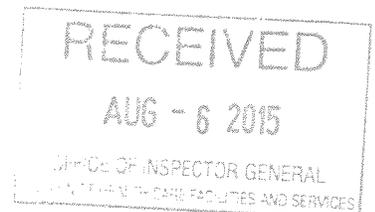


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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185138	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2015
NAME OF PROVIDER OR SUPPLIER NAZARETH HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 NEWBURG ROAD LOUISVILLE, KY 40205	
(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 075	Continued From page 17 with a capacity of forty-four (44) gallons was being stored in the Staff Lunch Room which was open to the egress path. Interview, on 06/30/15 at 9:33 AM, with the Chief Financial Officer revealed he was not aware of the requirement for trash receptacles with capacities greater than thirty two (32) gallons. The census of one-hundred twelve (112) was verified by the Administrator on 06/30/15. The findings were acknowledged by the Administrator and verified by the Chief Financial Officer at the exit interview on 06/30/15. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition) 19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft ² (20.4 L/m ²). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft ² (5.9-m ²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas.	K 075	4. Results of Environmental Service inspections will be reported by CFO/Facility Management Director at each quarterly Safety Committee meeting from a Quality Assurance perspective beginning at next scheduled meeting 10-1-2015 continuing as recurring item on agenda of Safety Committee each quarter.	7/17/15
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	1. No residents, staff, visitors identified as affected. The practice identified as having the potential to affect residents in one (1) identified smoke compartment has been corrected.	

Mary Doyne, 8-6-15

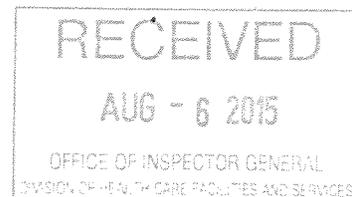


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K 076	<p>Continued From page 18</p> <p>3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as 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 twelve (12) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred eighteen (118) beds and at the time of the survey, the census was one-hundred twelve (112).</p> <p>The findings include:</p> <p>Observation, on 06/30/15 at 3:50 PM, with the Chief Financial Officer revealed two (2) light switches and one (1) receptacle were installed below five (5) feet from the floor and combustible storage was located within five (5) feet of the oxygen tanks located in the Second (2nd) Floor Maria Hall Oxygen Storage Room. At the time of the observation, there were eighteen (18) (E type) oxygen cylinders being stored in the oxygen storage room.</p> <p>Interview, on 06/30/15 at 3:51 PM, with the Chief</p>	K 076	<p><u>Corrective action:</u> The second (2nd) floor Maria Hall oxygen storage room Storage room has been modified to be in compliance with Medical Gas Storage and administration areas as required by NFPA 101 Life Safety Code Standards per NFPA 99.</p> <p>2. Other residents, staff, visitors, identified as having the potential to be affected – maintenance staff inspected all oxygen storage areas in facility and found to be in compliance with NFPA 99 standards.</p> <p>3. Systemic measures Implemented to ensure deficient practice will not recur – CFO/Facility Management Director Completed Education on 7/16/2015 with maintenance staff on NFPA 99 requirements for oxygen storage. Maintenance staff will complete quarterly inspections of oxygen storage areas for compliance with NFPA 99 standards.</p> <p>Documentation will be kept on file in the maintenance department.</p>	7-15-15 7-16-15 7-16-15

Mary Dwyer, 8-6-15

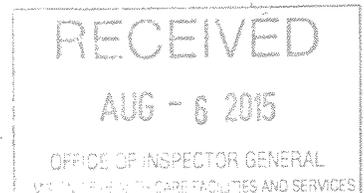


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K 076	Continued From page 19 Financial Officer revealed he was not aware of the requirements for oxygen storage. The census of one-hundred twelve (112) was verified by the Administrator, on 06/30/15. The findings were acknowledged by the Administrator and verified by the Chief Financial Officer at the exit interview on 06/30/15. 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.	K 076	4. Results of maintenance inspections will be reported by CFO/Facility Management Director at each quarterly Safety Committee meeting from a quality assurance perspective beginning at next scheduled meeting on 10-1-15 continuing as recurring item on agenda of Safety Committee each quarter.	7/17/15

Mary Haynes, 8-6-15

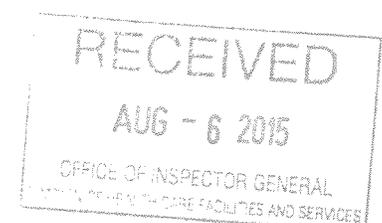


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K 076	Continued From page 20 (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical 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 storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076		
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.	K 144	1. No residents, staff, visitors identified as affected. The practice identified as having the potential to affect residents in the twelve (12) identified smoke compartments has been corrected.	

Mary Daynes, 8-6-15

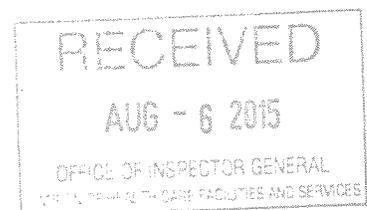


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K 144	<p>Continued From page 21</p> <p>This STANDARD is not met as evidenced by: Based on generator testing record review and interview, the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect twelve (12) of twelve (12) smoke compartments, all residents, staff and visitors. The facility has the capacity for one-hundred eighteen (118) beds with a census of one-hundred twelve (112) on the day of the survey.</p> <p>The findings include:</p> <p>Review of the Generator testing records, on 06/30/15 at 2:10 PM, with the Chief Financial Officer revealed the facility did not document the transfer times monthly when the power was transferred during the monthly testing of the generator transfer switch.</p> <p>Interview, on 06/30/15 at 2:11 PM, with the Chief Financial Officer revealed he was not aware of the requirements for generator testing.</p> <p>The census of one-hundred twelve (112) was verified by the Administrator on 06/30/15. The findings were acknowledged by the Administrator and verified by the Chief Financial Officer at the exit interview on 06/30/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 99 (1999 Edition) 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source</p>	K 144	<p><u>Corrective Action -</u></p> <p>Maintenance staff will document the transfer times monthly when the power is transferred during the monthly testing of the generator transfer switch.</p> <p>2. Other residents, staff, visitors, identified as having the potential to be affected – all residents, staff and visitors had potential to be affected.</p> <p>3. Systemic measures implemented to ensure deficient practice will not recur. CFO/Facility Management Director completed education on the NFPA Generator Testing Standards with the Maintenance staff on 7/16/2015. CFO/Facility Management Director will review documentation for compliance monthly.</p> <p>Documentation will be kept on file in the maintenance office.</p> <p>4. Results of maintenance staff monthly documentation of generator testing will be reported by CFO/Facility Management Director at Safety Committee Meetings from a Quality Assurance perspective</p>	<p>7-16-15</p> <p>7-16-15</p> <p>7-16-15</p>

Mary Daynes, 8-6-15

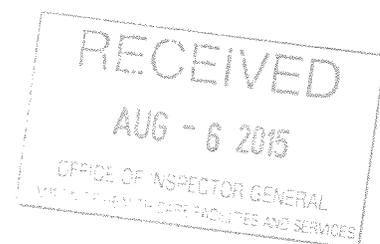


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K 144	Continued From page 22 and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1. (b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b). Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. (b) Inspection and Testing. 1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.	K 144	beginning at next scheduled meeting 10-1-2015 continuing as recurring item on agenda of Safety Committee each quarter.	7/17/15	

Mary Daynes, 8-6-15

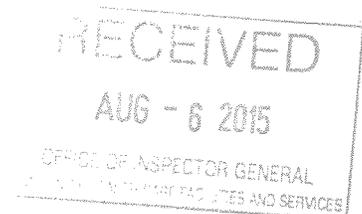


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K 144	<p>Continued From page 23</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p> <p>Reference: NFPA 99 (1999 Edition) 6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>Reference: NFPA 99 (1999 Edition) 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established</p> <p>Reference: NFPA 99 (1999 Edition) 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>Reference: NFPA 99 (1999 Edition) 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer</p>	K 144			

Mary Daynes, 8-6-15



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K 144	Continued From page 24 switch from the standard position to the alternate position and then a return to the standard position. Reference: NFPA 101 (2000 edition) 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted.	K 144			

Mary Daynes, 8-6-15

