

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

PRINTED: 07/31/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2014
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NAME OF PROVIDER OR SUPPLIER SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HAYDEN AVE SALEM, KY 42078
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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
F 000	INITIAL COMMENTS	F 000	F 000 Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this time frame should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide the housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Findings include: Observation, during a tour of the facility with the Administrator and Housekeeping Supervisor, on 07/17/14 at 10:27 AM, revealed: 1. The entrance to the shower in Central Bath #3 was noted to have molding broken away from the wall exposing drywall crumbling from exposure to moisture and broken tile and grout at the entry to the shower, making an uneven surface for residents and staff walking into the shower. 2. The housekeeping closet, on the 300 Hallway, was noted to have (3) gallon jugs of bleach stored on the floor.	F 253		

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

[Handwritten Signature]

TITLE

ADMINISTRATOR

(X6) DATE

8/8/2014

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

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F 253	Continued From page 1 Interview with the Housekeeping Supervisor, on 07/17/14 at 12:55 PM, revealed a written request for repair of the shower floor and wall was placed on the Maintenance Supervisor's door. She also revealed she should have placed all the bleach on the shelves; however, she had received a new shipment of bleach and did not have room on the shelves for all the jugs. Interview with Housekeeper #1, on 07/17/14 at 12:55 PM, revealed she notified the Maintenance Supervisor about a week prior to him leaving the facility by taking him to observe the shower wall and floor. Interview with the Director of Nursing (DON), on 07/17/14 at 11:40 AM, revealed there was not a policy on the storage of items in the housekeeping closets. Interview with the Administrator, on 07/17/14 at 10:37 AM, revealed the Maintenance supervisor quit unexpectedly, but the surfaces in the shower needed to be repaired. He did not think there was any policy on the storage of items in the housekeeping closets, and he had the Housekeeping Supervisor move the jugs of bleach onto a shelf.	F 253	F 253 1.The shower in Central Bath #3 has been repaired. The (3) gallon jugs of bleach have been placed off the floor. 2.Residents that utilize the Central Bath #3 shower have the potential to be affected. Ambulatory residents have the potential to be affected by the (3) gallon jugs of bleach sitting on the floor 3.A full-time Maintenance Director has been hired and will monitor the shower to ensure it remains in good working order. Staff is aware to report necessary repairs to Maintenance Director. The Housekeeping Manager and staff have been inserviced regarding the standard of keeping chemicals stored off the floor, including those chemicals just delivered. 4.The Maintenance Director will inspect the showers 3 times a week for 4 weeks and then 1 time a week for two months. The Maintenance Director will inspect all housekeeping closets for proper storage 3 times a week for 4 weeks and then weekly for 2 months. These findings will be reported to the Quality Assurance Committee for recommendations. 5.Corrective action will be completed on F-253 on 8/25/2014.	F-253 8/25/2014	
F 371 SS=E	483.35(j) 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	F 371			

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F 371	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen revealed frozen condensation at the back of the walk-in freezer and condenser resulting in a thick grouping of icicles hanging from the condenser and broken ice was noted to the shelf and flooring. In addition, food was noted on the steam table one and one half (1-1/2) hours prior to the start of the lunch tray line. Review of the facility's census and condition, dated 07/15/14, revealed there were 55 residents in the facility and one of those residents was a tube feeder and did not eat food from the kitchen area. Additionally, food on the steamer was for the regular diets and did not include food prepared for seventeen (17) residents on mechanical and pureed diets. Findings include: Review of the facility's "Tray and Dining Room Meal Service", undated, revealed "Food is to be on the steam table no longer than 20 minutes before the resident meal service." Interview with the Dietary Manager and the Administrator revealed there was no policy for maintenance and servicing of the freezer. 1. Observation of the freezer and refrigerators, on 07/15/14 at 9:50 AM, revealed a thick frozen	F 371	F 371 1.The freezer has been repaired. Food will not be placed on the steam table more than 20 minutes prior to serving. 2.The residents that have the potential to be affected are those who eat frozen food prepared by the kitchen. The residents that have the potential to be affected by the food at the steam table for over 20 minutes are those residents who eat in the dining room. 3.The freezer has been repaired by a reputable freezer repair company to prevent condensation from forming in the freezer. The Dietary Staff were immediately inserviced by the Dietary Manager that food is to be on the steam table no longer than 20 minutes before the resident meal service as per company policy 4.The Dietary Manager will inspect the freezer for condensation 3 times per week for 4 weeks and then 1 time per week for 2 months. The Dietary Manager will monitor the steam table 3 times a week for 4 weeks and then 1 time per week for 2 months. Results will be reported to the Quality Assurance Commlltee for recommendations. 5.Corrective action will be completed on F-371 on 8/25/2014.	F-371 8/25/2014	

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F 371	<p>Continued From page 3</p> <p>layer of icicles hanging at the back of the walk-in freezer, extending from the condenser into a cardboard box on a shelf below. Additional icicles were noted below the box and broken icicles were noted on the shelves and frozen foods below and onto the floor.</p> <p>Interview with the Dietary Manager, on 07/15/14 at 10:00 AM, revealed the condenser had not been working properly since early spring and she made the Maintenance Director aware, as well as the Administrator. The Maintenance Director stated he would "get to this as soon as he could." However, the Administrator and Maintenance Director she reported to are no longer employed by the facility.</p> <p>Interview with the Interim Administrator, on 07/17/14 at 9:30 AM, revealed he was unaware of the problems with the condenser and would make arrangements to have this rectified.</p> <p>2. Observation of the kitchen, on 07/15/14 at 10:00 AM, revealed country fried steak and egg noodles on the steam table.</p> <p>Interview with Cook #1, on 07/15/14 at 10:05 AM, revealed she was unsure how long food was to be kept on the steam table prior to starting the tray line, and stated the last tray usually left the steam table, at approximately 12:15 PM.</p> <p>Interview with the Dietary Manager, on 07/16/14 at 11:25 AM, revealed she was aware the food should not have been on the steamer at 10:00 AM, but had an emergent physician appointment and was unable to be at the facility for the noon meal on 07/15/14. She stated she spoke with the staff, who were concerned with getting the food</p>	F 371		

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F 371	Continued From page 4 ready on time and had prepared everything ahead of time.	F 371		
F 490 SS=D	Interview with the Administrator, on 07/16/14 at 9:30 AM, revealed he interviewed the staff members and all stated they did not want to be late with meals during the survey process. 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. During the Life Safety Code (LSC) survey, conducted 07/15/14, there was a deficiency cited which was cited on the previous annual survey (08/06/13) because it had not been corrected. (Refer to K-056).	F 490	F 490 1. Additional fire sprinklers have been installed in the affected rooms 2. The residents affected by the previous Life Safety Survey, conducted 7/15/2014 and the cited deficiency was not corrected but was accepted last year within the POC, are those residents in room # 602, 604, 501, 502, 506, 505, 509, 510, 403, 404, 304, 302, 207, 211, 212, 208, 204, 103, and 101. As noted in K-056 in the Life Safety Survey. 3. The issue cited on the previous annual survey (08/06/13), and the POC was accepted, was for sprinklers in rooms which have sprinkler heads which are twelve feet away from the wardrobes with a wall blocking the wardrobes from the sprinkler spray. Additional sprinkler heads have been installed to provide coverage of the wardrobes. 4. This installation of the additional sprinklers was performed by a reputable fire sprinkler company. Regular inspections will be conducted as required by regulations. 5. Corrective action will be complete on F-490 on 8/25/2014.	F-490 8/25/2014

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1996.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1996 with 46 smoke detectors and 3 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1996.</p> <p>GENERATOR: Type II generator installed in 1996. Fuel source is Diesel.</p> <p>A standard Life Safety Code Survey was conducted on 07/15/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy-five (75) beds with a census of fifty-five (55) 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 Fire).</p>	K 000	<p>K 000</p> <p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this time frame should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

8/8/2014

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

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K 000	Continued From page 1	K 000		
K 027 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</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 National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of four (4) smoke compartments, forty-five (45) residents, staff and visitors. The facility has the capacity for seventy-five (75) beds and at the time of the survey, the census was fifty-five (55).</p> <p>The findings include:</p> <p>Observation, on 07/15/14 at 11:45 AM with the Administrator, revealed the door located in the smoke barrier at the activity room dragging the</p>	K 027	<p>K 027</p> <ol style="list-style-type: none"> 1.The door at the activity room has been repaired. 2.Residents located in this smoke barrier area have the potential to be affected. 3.The door has been adjusted and now closes according to regulation. 4.The Maintenance Director will monitor all fire doors as per regulations. 5.Corrective action will be completed on K-027 on 8/25/2014. 	K-027 8/25/2014

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K 027	Continued From page 2 floor which kept it from self-closing. Interview, on 07/15/14 at 11:46 AM with the Administrator, revealed he was unaware the door was hanging on the floor. The census of fifty-five (55) was verified by the Administrator on 07/15/14. The findings were verified by the Administrator at the exit interview on 07/15/14. Actual NFPA Standard: Reference: NFPA 101, 19.3.7.6*. (2000 Edition) Requires doors in smoke barriers to be self-closing and resist the passage of smoke. 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. 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.	K 027		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 056		

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K 056	<p>Continued From page 3</p> <p>Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with National Fire Protection Association (NFPA) Standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, all residents, staff, and visitors. The facility has the capacity for seventy-five (75) beds and at the time of the survey, the census was fifty-five (55). This deficiency was cited on the previous survey on 08/06/13. According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with major problems.</p> <p>The findings include:</p> <p>Observation, on 07/15/14 at 10:00 AM with the Administrator, revealed the wardrobes located in room #602, 604, 501, 502, 506, 505, 509, 510, 403, 404, 304, 302, 207, 211, 212, 208, 204, 103, and 101 did not have proper sprinkler coverage. The rooms were equipped with a sprinkler on the side of the wall and the wardrobes were twelve (12) feet away from the sprinkler head with a wall blocking the wardrobes from the sprinkler spray pattern.</p>	K 056	<p>K 056</p> <p>1. Additional fire sprinklers have been installed in the affected rooms All ceiling tiles in facility are now in place.</p> <p>2. The residents potentially affected by the previous Life Safety Survey, conducted 7/15/2014 and the cited deficiency was not corrected but was accepted last year within the POC, are those residents in room # 602, 604, 501, 502, 506, 505, 509, 510, 403, 404, 304, 302, 207, 211, 212, 208, 204, 103, and 101.</p> <p>The residents potentially affected are the ones in the areas where ceiling tiles had been removed.</p> <p>3. The issue cited on the previous annual survey (08/06/13), and the POC was accepted, was for sprinklers in rooms which have sprinkler heads which are twelve feet away from the wardrobes with a wall blocking the wardrobes from the sprinkler spray. Additional sprinkler heads have been installed to provide coverage of the wardrobes.</p> <p>All ceiling tiles have been replaced in the areas cited.</p>		

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K 056	<p>Continued From page 4</p> <p>Interview, on 07/15/14 at 10:05 AM with the Administrator, revealed he was new to the facility and was unaware the sprinkler protection for the wardrobes had not been addressed from the previous survey.</p> <p>Observation, on 07/15/14 at 10:40 AM with the Administrator, revealed the drop ceiling tiles had been removed in the nursing storage outside of the Director of Nursing office, the corridor of the 500 hall, vacant room by the kitchen, the woman's bathroom by the kitchen, and the director of support services office.</p> <p>Interview, on 07/15/14 at 10:45 AM with the Administrator, revealed he was new to the facility and was unaware the drop ceiling tiles being removed could affect the response time of the sprinkler heads located in the areas..</p> <p>The census of fifty-five (55) was verified by the Administrator on 07/15/14. The findings were verified by the Administrator at the exit interview on 07/15/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p>	K 056	<p>4.This installation of the additional sprinklers was performed by a reputable fire sprinkler company. Regular inspections will be conducted as required by regulations. Ceiling tiles will be monitored by the maintenance director during regular rounds. Staff is also aware that they are to report to the maintenance director any needed repairs.</p> <p>5.Corrective action will be completed on K-056 on 8/25/2014.</p>	K-056 8/25/2014

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/15/2014
NAME OF PROVIDER OR SUPPLIER SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HAYDEN AVE. SALEM, KY 42078		
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K 056	<p>Continued From page 5</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>S&C letter stating all facilities must be fully sprinkler protected by August 2013 Reference: NFPA 13 (1999 Edition) 5-6.4.1.2 Under obstructed construction, the sprinkler deflector shall be located within the horizontal planes of 1 in. to 6 in. (25.4 mm to 152 mm) below the structural members and a maximum distance of 22 in. (559 mm) below the ceiling/roof deck. Exception No. 1: Sprinklers shall be permitted to be installed with the deflector at or above the bottom of the structural member to a maximum of 22 in. (559 mm) below the ceiling/roof deck where the sprinkler is installed in conformance with 5-6.5.1.2. Exception No. 2: Where sprinklers are installed in each bay of obstructed construction, deflectors shall be permitted to be a minimum of 1 in. (25.4 mm) and a maximum of 12 in. (305</p>	K 056			

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K 056	Continued From page 6 mm) below the ceiling. Exception No. 3: Sprinkler deflectors shall be permitted to be 1 in. to 6 in. below composite wood joists to a maximum distance of 22 in. below the ceiling/roof deck only where joist channels are fire-stopped to the full depth of the joists with material equivalent to the web construction so that individual channel areas do not exceed 300 ft ² (27.9 m ²). Exception No. 4: *Deflectors of sprinklers under concrete tee construction with stems spaced less than 7 1/2 ft (2.3 m) but more than 3 ft (0.9 m) on centers shall, regardless of the depth of the tee, be permitted to be located at or above a horizontal plane 1 in. (25.4 mm) below the bottom of the stems of the tees and shall comply with Table 5-6.5.1.2.	K 056			