

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

PRINTED: 11/05/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185257	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GREEN HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 211 INDUSTRIAL ROAD GREENSBURG, KY 42743	
(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 on 10/20-22/15. Deficient practice was identified with the highest scope and severity at "D" level. An abbreviated survey (KY23949) was also conducted at this time. The complaint was unsubstantiated with no deficient practice identified.	F 000	<u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u>	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to provide	F 322	F 322 NG treatment/services – restore eating skills 1. Resident A was immediately assessed when alleged deficient practice occurred and no adverse outcome noted for resident. G-tube was properly in place. Immediate re-education of RN#2 regarding proper g-tube medication administration by DNS, DCE to watch skills check off of RN#2 and correct any deficient practice noted by 11/16/15. 2. Facility residents that have a g-tube have the potential to be affected. Five other residents which had g-tubes were immediately checked 10/21/15 by the DNS/ADNS for proper g-tube placement. Each of the residents were found to have the g-tube in proper placement. Facility nurses will be re-educated with regards to proper g-tube medication administration by DCE by 11/20/15. A Skills check-off to be completed with every nurse regarding	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *David Blount, Administrator* TITLE: Administrator (X8) DATE: 11/11/15

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.

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GREEN HILL	STREET ADDRESS, CITY, STATE, ZIP CODE 213 INDUSTRIAL ROAD GREENSBURG, KY 42743
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F 322	<p>Continued From page 1</p> <p>appropriate gastrostomy tube (G-Tube) care for one (1) of three (3) unsampled residents (Resident A). Observation on 10/21/15 during medication administration revealed staff was observed to administer medication per G-Tube, without checking for placement of the G-Tube prior to administration of the medication for Resident A.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Medication Administration for Enteral Feeding," (no date) revealed staff would verify G-Tube placement, by checking gastric content for residual feeding, before administering any medications.</p> <p>Observation conducted during medication administration on 10/21/15 at 12:00 PM revealed Registered Nurse (RN) #2 flushed Resident A's G-Tube with 30 cubic centimeters (cc) of water before administering medications. However, RN #2 did not verify G-tube placement by checking gastric contents prior to flushing or administering medications.</p> <p>Interview with RN #2 on 10/21/15 at 12:40 PM revealed she was trained to check for placement of the G-Tube, prior to flushing the G-Tube or administering medications. RN #2 further revealed she was nervous about being observed and forgot to verify placement of the G-tube.</p> <p>Interview with the Director of Nursing (DON) on 10/22/15 at 3:00 PM revealed the G-Tube should always be checked for placement when medications were going to be administered. She further revealed she had not identified any concerns with staff not checking placement of the</p>	F 322	<p>proper g-tube administration by DCE/ADNS by 11/20/15.</p> <p>3. The DNS/ADNS/DCE will monitor medication administration via g-tube by facility nurses X one week, then twice a week X four weeks. The DNS/ADNS/DCE will monitor the process of three nurses for proper g-tube administration weekly X one month, then once every other week X one Quarter. Thereafter, the DNS/ADNS/DCE will monitor five nurses a month for six months. Facility nurses will complete a medication administration competency twice a year.</p> <p>4. The DNS/DCE will present the findings of the monitoring summaries of the g-tube medication administration to the QAPI committee monthly meeting X six months for review until substantial compliance is achieved. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for monitoring.</p> <p>5. Completion date 11/20/2015</p>	11/20/15
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F 322 F 431 SS=0	<p>Continued From page 2</p> <p>G-Tube before administering medications.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 322 F 431	<p>F 431 Drug Records, label/store drugs & biologicals</p> <p>1. Immediate re-education of RN#2 in regards to the safe storage of medication by the DNS 10/21/15.</p> <p>2. All other facility medication carts were immediately checked 10/21/15 to ensure the safe storage of medication by the facility DNS/ADNS. Facility medication carts were found to be locked properly and medications secured.</p> <p>3. Re-education to be completed by the DCE with all nurses in regards to the safe storage of medications by 11/20/15. The DNS/ADNS/DCE will monitor the medication carts daily X 1 week through daily rounds and will immediately correct any deficient practice noted, then weekly X 1 month, then monthly X 6 months. Random audits will continue to ensure best practice. Nurses will complete a medication storage competency twice a year.</p> <p>4. The DNS/ADNS will present the results of the audits to the QAPI meeting monthly for six months until substantial compliance is achieved. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits if needed.</p> <p>5. Completion date 11/20/2015</p>	11/20/15

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F 431	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of the facility's policy it was determined the facility failed to ensure medications were stored in locked carts during medication administration on 10/21/15. Observation on 10/21/15 during medication administration on the South Hall revealed staff was observed to leave the medication cart unattended and unlocked and enter Resident A's room to assess Resident A's blood sugar.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Storage of Medication," (not dated) revealed medications and biologicals were stored safely, securely, and properly, following manufacturer's recommendations.</p> <p>Observations on the South Hall on 10/21/15 at 12:00 PM revealed Registered Nurse (RN) #2 entered Resident A's room to assess Resident A's blood sugar without securing or locking the medication cart.</p> <p>Interview conducted with RN #2 on 10/21/15 revealed as long as the medication cart was in sight at all times the medication cart did not have to be locked.</p> <p>Interview with the Director of Nursing (DON) on 10/21/15 at 3:00 PM revealed any time the nurse was away from the medication cart the cart should be locked. She further revealed if the nurse could visually see the cart at all times then</p>	F 431			

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F 431	Continued From page 4 It was acceptable to leave the medication cart unlocked. However, if a nurse entered a resident's room then the medication cart should be locked. She further revealed she had not identified any concerns with the medication carts being left unsecured.	F 431	F 441 Infection control, prevent spread, linens 1. DCE immediately corrected State Registered Nurse Aide (SRNA) #4, as well as the Activities Director (AD), whom were noted in the alleged deficient practice of entering a resident room without the proper personal protective equipment. RN#2 was immediately re-educated regarding the proper cleaning procedure of the accuchecks by the ADNS 10/21/15.	
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 - (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.	F 441	2. All residents have the potential to be affected by the alleged deficient practices. If deficient practice is identified, corrective action in the form of re-education will take place with the employee involved. 3. All staff will be re-educated by the DCE/DNS/ADNS in regards to infection control procedures, to include having the proper PPE when entering isolation rooms by 11/20/15. Nursing staff will be re-educated regarding the proper cleaning of accuchecks by the DCE/ADNS by 11/20/15. The DNS/ADNS/DCE will conduct daily audits of isolation rooms during rounds to ensure staff have the proper PPE when entering isolation rooms, and that all isolation equipment is stocked properly X 1 week, then weekly X one month, then bi-weekly X two weeks, then monthly X six months until substantial compliance is achieved. The DNS/ADNS/DCE will	

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F 441	<p>Continued From page 5</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined that the facility failed to have an effective infection control program in order to prevent the spread of infections for one (1) of twenty-one (21) sampled residents (Resident #5) and one (1) of three (3)unsampled residents (Resident A). On 10/21/15, staff was observed to go into the room of Resident #5 (who was on contact precautions) and provide care without wearing the appropriate personal protective equipment (PPE). In addition, on 10/21/15 during medication pass observation staff was observed to not properly sanitize the blood glucose monitor after checking the blood glucose level for Resident A.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Isolation - Categories of Transmission Based Precautions," revised August 2012, revealed when a resident was placed on contact precautions staff should wear gloves and a disposable gown when entering the resident's room.</p> <p>1. Observation on 10/21/15 at 9:24 AM revealed that State Registered Nurse Aide (SRNA) #4 and</p>	F 441	<p>conduct daily audits of nurses performing accuchecks to ensure proper cleaning is occurring. Audits will occurring daily X 1 week, then weekly X 1 month, then monthly X 6 months until substantial compliance is achieved. . Staff will also complete infection control in-servicing annually by the facility DCE.</p> <p>4. The DNS/DCE will present the results of the audits to the QAPI committee for six months. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits.</p> <p>5. Completion date 11/20/2015</p>	11/20/15	

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F 441	<p>Continued From page 6</p> <p>the facility Activities Director (AD) entered the room of Resident #5 and did not apply a disposable gown or gloves when entering the room. Continued observation revealed SRNA #4 and the facility AD made contact with Resident #5's bed and bed linens as they repositioned Resident #5 in the bed so that he/she could be fed. Further observation revealed SRNA #4 sat down next to Resident #5 and fed the resident without a disposable gown or gloves.</p> <p>Review of Resident #5's medical record revealed the facility admitted Resident #5 on 10/15/13 with diagnoses including Urinary Tract Infection, Flatulence Eructation (Belching) and Gas Pain, and Skin Infection. Further review of Resident #5's record revealed that on 09/14/15 Resident #5 had several loose stools that were light brown in color with yellow mucus present. Further review of Resident #5's medical record revealed on 09/15/15 a stool sample was obtained from Resident #5 and sent to the lab to check for a Clostridium difficile (C. diff) infection. Resident #5's medical record revealed that on 09/18/15 Resident #5 was diagnosed with a C. diff infection and was placed on contact isolation precautions.</p> <p>Interview with State Registered Nurse Aide (SRNA) #4 on 10/21/15 at 3:27 PM revealed she had been trained to put on gloves and a gown before entering the room of a resident on contact precautions. Continued interview with SRNA #4 revealed she knew to wear gloves and a gown, but forgot because she was "nervous."</p> <p>Interview with the facility AD on 10/21/15 at 3:46 PM revealed she had been trained to wear gloves and a gown when entering the room of a resident that was on contact precautions. Continued</p>	F 441			

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F 441	<p>Continued From page 7</p> <p>interview with the facility AD revealed she "just forgot" to put on her PPE when she entered Resident #5's room.</p> <p>Interview with the facility Director of Clinical Education (DCE) on 10/22/15 at 5:30 PM revealed all staff had been trained to wear a gown, gloves, and possibly a facemask when providing care for a resident that had been placed on contact precautions. Continued interview with the facility DCE revealed she had trained all staff on contact isolation precautions upon hire, annually, and as needed. Further interview with the facility DCE revealed she conducted weekly infection control observations that she reported to the Administration. The facility DCE revealed she had conducted daily observations to ensure isolation precautions were being followed and had identified a concern with the staff not following the isolation precautions last month and as a result had conducted an In-service in September 2015 to reeducate facility staff on the proper use of PPE.</p> <p>Interview with the facility Director of Nursing (DON) on 10/22/15 at 6:15 PM revealed all staff had been trained on contact isolation precautions at least twice a year and as needed. Continued interview with the facility DON revealed staff should have put on gloves, gown, and possibly a facemask when entering a room where a resident had been placed on contact precautions. Further interview with the facility DON revealed she conducted daily rounds to audit the PPE carts and to observe for staff following isolation precautions and had not identified any concerns related to contact isolation precautions to date.</p> <p>2. Review of the facility's policy titled "Blood</p>	F 441			

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F 441	<p>Continued From page 8</p> <p>Glucose Monitor Decontamination," (not dated) revealed the facility would use a wipe that was Environmental Protection Agency (EPA) registered as tuberculocidal and effective against Human Immunodeficiency Virus (HIV), Hepatitis B (HBV), and a broad spectrum of bacteria to clean the blood glucose monitor.</p> <p>Observation during the medication pass on 10/21/15 at 12:00 PM revealed after Registered Nurse (RN) #2 checked Resident A's blood sugar with the facility's glucometer, she cleaned the glucometer with an alcohol pad.</p> <p>Interview with RN #2 on 10/21/15 at 12:40 PM revealed she was trained to clean the glucometer with an alcohol pad.</p> <p>Interview with the Director of Clinical Education revealed the glucometers were to be cleaned with a 1:10 bleach solution. She further revealed she did spot checks at different times and needed to watch the nurses clean the glucometers more often.</p> <p>Interview with the Director of Nursing (DON) on 10/21/15 at 3:00 PM revealed the glucometer should be cleaned with bleach wipes. She stated she had not identified any concerns with sanitizing the glucometer.</p>	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: 1979</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111(000)</p> <p>SMOKE COMPARTMENTS: Nine 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. Fuel source is diesel.</p> <p>A life safety code survey was initiated and concluded on 10/20/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "D" level.</p>	K 000	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>K 038</p> <p>1. The "stop sign" with Velcro, along with the wreath hanging on the outside of the door, were immediately removed from the front door by the assistant maintenance director. The gate in the courtyard was immediately assessed by the assistant maintenance director and by the maintenance director. The maintenance director contacted David Storm and associates 10/21/15 to equip the courtyard gate with a functional delayed egress. The courtyard gate will be equipped with delayed egress by David Storm and associates by 11/27/15.</p> <p>2. The Maintenance director walked through the building and checked each of the egress doors to ensure they were free from obstructions and equipped with delayed egress by 10/21/15. All facility doors were found to be in compliance.</p>	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>L. J. Administrator</i>	TITLE	(X6) DATE 11/11/15
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186257	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-GREEN HILL			STREET ADDRESS, CITY, STATE, ZIP CODE 213 INDUSTRIAL ROAD GREENSBURG, KY 42743	
(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 038	<p>Continued From page 1</p> <p>Exit access is arranged so that exits are readily 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, the facility failed to maintain exits in accordance with National Fire Protection Agency (NFPA) standards. This deficient practice affected two (2) of nine (9) smoke compartments, staff, and approximately sixteen (16) residents. The facility has the capacity for 108 beds with a census of 99 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 10/20/15, at 10:30 AM, with the Assistant Maintenance Staff (AMS), an exit door leading from the front entrance of the facility was observed to have a stop sign attached with Velcro across the door. There should be no obstructions on egress doors. Delayed egress signage was not clearly visible due to a wreath hanging on the outside of the door. Exit signage must be clearly visible at all times. An interview with the AMS on 10/20/15, at 10:30 AM revealed he was not aware that there should not be any obstruction across an exit door. The AMS also stated he was not aware the delayed egress exit signage was not visible. At 10:40 AM on 10/20/15, a gate in the courtyard</p>	K 038	<p>3. The facility staff will be re-educated regarding keeping the egress doors free from obstructions and the delayed egress functionality of the courtyard gate by 11/27/15. The maintenance director will audit the facility egress doors weekly X 1 month, then monthly X 6 months to ensure they continue to be free of obstructions and the delayed egress function works properly.</p> <p>4. The maintenance director will present the findings of the audits related to the egress doors to the QAPI committee monthly meeting for six months for review until substantial compliance is achieved. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for monitoring.</p> <p>5. Completion date 11/27/2015</p>	11/27/15

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K 038	<p>Continued From page 2</p> <p>was observed to have a magnetic locking device with no obvious method of operation to release the lock. Access to exits must be readily available at all times. An interview with the AMS on 10/20/15, at 10:40 AM revealed he was not aware the gate should be accessible at all times.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.1.10.1*</p> <p>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.</p> <p>7.10.1.7* Visibility.</p> <p>Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted.</p> <p>7.2.1.6.1 Delayed-Egress Locks.</p> <p>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</p>	K 038		

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K 038	<p>Continued From page 3</p> <p>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.</p> <p>(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 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.</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:</p> <p>PUSH UNTIL ALARM SOUNDS</p> <p>DOOR CAN BE OPENED IN 15 SECONDS</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30</p>	K 038		

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K 038	Continued From page 4 seconds shall be permitted.	K 038			