

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

PRINTED: 07/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/03/2013
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NAME OF PROVIDER OR SUPPLIER  METCALFE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE EDMONTON, KY 42129
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F 00C	INITIAL COMMENTS  A Standard Recertification Survey was initiated on 07/01/13 and concluded on 07/03/13. Deficient practice was identified with the highest scope and severity of an "E".	F 000	The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure food was palatable and at proper temperature at point of service on the North Wing 300 Hall. Observation of a test tray on 07/01/13 revealed french fries were not palatable and hot food was served cold.  The findings include:  Review of the facility's policy, "Serving of Meals (Dining Room and Resident Room)", undated, revealed hot food would be served hot when the tray reached the resident and would be distributed to residents by designated personnel promptly.  Review of the facility's policy, "Minimum Temperature at Point of Service to Resident", undated, revealed minimum food temperatures at point of service (POS) to the resident should be:	F 364	1. Residents are served meals in accordance with the regulatory requirements for food temperatures as determined by test tray monitoring done daily X 1 week, then weekly X 3 weeks and then monthly thereafter by the Dietary Manager/Registered Dietician. 2. Residents are served meals in accordance with the regulatory requirements for food temperatures as determined by test tray monitoring done daily X 1 week, then weekly X 3 weeks and then monthly thereafter by the Dietary Manager/Registered Dietician. 3. A new wax pellet heating system has been purchased and is utilized for delivery of trays to the residents choosing to eat in their rooms on the North Hall. Feeding assistants are being trained and will be utilized to assist residents who choose to eat in their rooms. Dietary and nursing staff have received in-service education by the DM/DON/ADON on the use of the new wax pellet heating system and the implementation of the feeding assistant program.	8/15/13

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JUL 29 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE <i>D. Neighbors</i>	TITLE Administrator	(X6) DATE 7/29/13
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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 364	<p>Continued From page 1</p> <p>potatoes over 115 degrees Farenheit (F), and meat over 115 degrees F.</p> <p>Review of the facility's policy, "Food Distribution/Meal Service Audit", dated 03/18/13 at 12:05 PM, for the North Trays, revealed a test tray was temped forty (40) minutes after service from the tray line. The meat temperature at the POS of the test tray was 107 degrees. The Audit, dated 04/24/13 at 11:22 AM, for a test tray to the Side 2 Floor Trays revealed a test tray was temped ten (10) minutes after service from the tray line. The meat (pork chop) temperature of the test tray at POS was 100 degrees and was documented as unacceptable. The pork chop was identified as not warm enough. The test tray at POS in the Main Dining Room, dated 06/24/13 at 12:00 PM, revealed the tray was temped five (5) minutes after tray line service with all temperatures acceptable.</p> <p>Interview with Resident #2, on 07/01/13 from 3:30 PM until 4:00 PM, revealed he/she only ate breakfast and supper and the food was not hot enough at times. He/she stated he/she would have to ask the staff to warm the food.</p> <p>Observation, on 07/01/13 at 4:25 PM, revealed tray line temperatures of hamburger at 194 degrees F, ground hamburger at 175 degrees F, french fries at 143 degrees F, ground fries at 158 degrees F.</p> <p>On 07/01/13 at 4:55 PM, observation of a test tray revealed the kitchen tray line service prepared a test tray for the last hall tray cart for the North Hall. At 5:10 PM, the tray cart was delivered to the North Hall and Certified Nursing Assistant</p>	F 364	<p>4. The CQI indicator for the monitoring of food temperatures will be utilized monthly as per the established CQI calendar under the supervision of the Dietary Manager. Residents will be asked about food temps in the monthly resident council meeting to determine effectiveness of the new interventions.</p>	

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F 364	<p>Continued From page 2</p> <p>(CNA) #1 began to pass meal trays to resident rooms, with the last tray delivered at 5:28 PM. The test tray temperatures at POS, at 5:29 PM, revealed the hamburger was 90 degrees F, ground hamburger was 112 degrees F, the french fries were 97 degrees F, and the ground fries were 100 degrees F. Taste of the French fries on the test tray revealed they were cold.</p> <p>On 07/01/13 at 5:29 PM and on 07/3/13 at 4:05 PM, interview with the Dietary Manager (DM) revealed a test tray was audited once a month at POS; however, hamburger had not been previously tested. The DM stated there had been problems with POS food temperatures in the past and the facility obtained plate warmers about one (1) year ago. She stated the kitchen was responsible to set a timer on the tray cart for twenty (20) minutes, when the last tray was put on the tray cart. The DM tasted the French fries and stated they were cold.</p> <p>Interview, on 07/01/13 at 6:00 PM, with Certified Nursing Assistant (CNA) #1 revealed usually one CNA would pass trays to resident rooms. The CNA stated other staff for the North Hall were assisting other residents in the dining rooms. CNA #1 further stated she would not always be notified from the kitchen when the tray cart was delivered to the unit. She stated there was a timer on top of the cart that was to be set by the kitchen staff; however, it had not been turned on. The CNA stated residents had complained of cold food, including Resident #2 who was usually served last from the tray cart. She stated Resident #2's food would often have to be warmed up.</p>	F 364		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=LI	Continued From page 3 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.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	1. Resident #8 was assessed by the APRN on 7/23/13 and determined to be free of any current signs/symptoms of UTI at that time. Resident #8 is provided peri-care in accordance with infection control standards of care which includes changing of gloves between peri-care proceeding from the rectal to vaginal areas and washing of hands between glove changes as determined by care observations performed by the DON/ADON/Staff Development Coordinator. 2. Residents are provided peri-care and in accordance with infection control standards of care which includes changing of gloves between peri-care proceeding from the rectal to vaginal areas and washing of hands between glove changes as determined by care observation performed by the DON/ADON/Staff Development Coordinator. No other residents were determined to be affected during the observations completed by the survey team during the annual survey, or by the facility during the care observations. 3. LPN #1 received individual in-service education on peri-care in accordance with infection control standards of practice performed by the ADON on 7/16/13. Facility nursing staff have received in-service education on the provision of peri-care in accordance with infection control standards of care which included but was not limited to: changing of gloves between peri-care proceeding from the rectal to	8/12/13

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F 44	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to maintain an effective infection control program in order to prevent the development and transmission of disease and infection within the facility for one (1) of fifteen (15) sampled residents (Resident #8). Observation of perineal care for Resident #8 revealed poor infection control technique.</p> <p>The findings include:</p> <p>Review of the facility's "Giving Female Perineal Care", policy, undated, revealed staff should apply soap to a washcloth, separate the labia, clean downward from front to back with one stroke, repeat until the area is clean, use a clean part of the washcloth for each stroke, rinse the perineum with a clean washcloth, separate the labia, stroke downward from front to back, pat the area dry with a towel, assist the resident to turn on to the side, wash from the vagina to the anus with one stroke, rinse and pat dry, remove gloves, and wash hands.</p> <p>Observation of perineal care for Resident #8, on 07/02/13 at 1:30 PM, performed by Licensed Practical Nurse (LPN) #1, revealed the LPN cleansed stool from the resident's anal area and buttocks with several wet wipes, placed a brief under the resident's hips, and with the same soiled gloves, wiped the resident's vaginal area from front to back with a wet wipe.</p> <p>Interview, on 07/02/13 at 1:50 PM with LPN #1,</p>	F 441	<p>vaginal areas, and washing of hands between glove changes, as provided by the DON/ADON/Staff Development Coordinator.</p> <p>4. Peri-care observations were performed for facility nursing staff by the DON/ADON/Staff Development Coordinator to determine that they are providing this in accordance with infection control standards of care. Peri-care observations will be performed by the ADON/Staff Development Coordinator with the Wound Nurse monthly X 2, and then with randomly chosen nursing staff on a quarterly basis thereafter.</p> <p>The CQI indicator for the monitoring of peri-care in accordance with infection control standards of care will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the DON.</p>	
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F 441	Continued From page 5 revealed she should have washed her hands and donned new gloves after cleansing the resident's anal area and prior to performing perineal care to prevent the spread of infection.  Interview, on 07/03/13 at 2:20 PM, with the Director of Nursing and Assistant Director of Nursing, revealed they were constantly watching and teaching staff. Further interview revealed LPN #1 should have washed hands after cleansing the stool and prior to cleansing the vaginal area.	F 441			
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.  Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 520	1. Residents are served meals in accordance with the regulatory requirements for food temperatures as determined by test tray monitoring done daily X 1 week then weekly X 3 weeks and then monthly thereafter by the Dietary Manager/Registered Dietician. 2. Residents are served meals in accordance with the regulatory requirements for food temperatures as determined by test tray monitoring done daily X 1 week then weekly X 3 weeks and then monthly thereafter by the Dietary Manager/Registered Dietician. 3. A wax pellet heating system has been purchased and is utilized for delivery of trays to the residents choosing to eat in their rooms on the North Hall. Feeding assistants are being trained and will be utilized to assist residents who choose to eat in their rooms. Dietary and nursing staff have received in-service education by the DM/DON/ADON on the use of the new wax pellet heating	8/15/13	

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F 521)	Continued From page 6 a basis for sanctions.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's policies A, it was determined the facility failed to maintain a Quality Assessment and Assurance Program that developed and implemented appropriate plans of action to correct quality deficiencies. This was evidenced by repeated deficiencies related to the facility's failure to ensure food was palatable and served at proper temperatures.  The findings include:  Review of the facility's policy "Continuous Quality Improvement Program Policy", undated, revealed monitoring and evaluation were the fundamental activities of any quality improvement process. The policy stated, data collected about aspects of care and services through the use of indicators were monitored and assessed regularly to determine whether desired outcomes were reached. Further review revealed, information obtained from other sources assists in identifying quality projects which would include regulatory surveys.  Review of the facility's policy, "Dietary Department Audit", not dated, revealed the Dietary Department Audit Form would be included in the facility quality assurance program.  Review of the facility's "Minimum Temperature at	F 520	system and the implementation of the feeding assistant program. 4. The QUI indicator for the monitoring of food temperatures will be utilized monthly as per the established CQI calendar under the supervision of the Dietary Manager. Residents will be asked about food temps in the monthly resident council meeting to determine effectiveness of the new interventions. CQI indicator results and resident interview findings will be reviewed in the CQI meetings on a quarterly basis to monitor ongoing meal temp compliance and to address any identified issues.	

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F 520	<p>Continued From page 7</p> <p>Point of Service to Resident" Policy, undated, revealed the minimum temperature of the food at point of service to the residents should be: meat-greater than 115-125 degrees.</p> <p>Review of the facility's Plan of Correction, with a compliance date of 06/28/12, revealed staff would audit food temperatures at point of service for two (2) months. However, based on observation, interview, record review, and review of the facility's Quality Assurance Audits, it was determined the facility failed to ensure food was palatable and and at proper temperatures at point of service during this survey. This was a repeat deficiency for the facility which was cited 06/07/12 for deficiencies related to food not being palatable and not being served at proper temperatures.</p> <p>Interview with Resident #2, on 07/01/13 from 3:30 PM until 4:00 PM, revealed he/she only ate breakfast and supper and the food was not hot enough at times. He/she stated he/she would have to ask the staff to warm the food.</p> <p>On 07/01/13 at 4:55 PM, observation of a test tray revealed the kitchen tray line service prepared a test tray for the last hall tray cart for the North Hall. At 5:10 PM, the tray cart was delivered to the North Hall and Certified Nursing Assistant (CNA) #1 began to pass meal trays to resident rooms, with the last tray delivered at 5:28 PM. The test tray temperatures at Point of Service (POS), at 5:29 PM, revealed the hamburger was 90 degrees, ground hamburger was 112 degrees, the french fries were 97 degrees, and the ground fries were 100 degrees. The French fries on the test tray were cold when tasted.</p>	F 520			

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F 520	<p>Continued From page 8</p> <p>Interview, on 07/01/13 at 6:00 PM, with CNA #1 revealed usually one CNA would pass trays to resident rooms. The aide stated other staff for the North Hall were assisting other residents in the dining rooms. The aide stated she would not always be notified from the kitchen when the tray cart was delivered to the unit. She stated there was a timer on top of the cart that was to be set by the kitchen staff however it had not been turned on. The CNA stated residents had complained of cold food, including Resident #2 who was served last from the tray cart. She stated Resident #2's food would have to be warmed up often.</p> <p>On 07/01/13 at 5:29 PM and on 07/3/13 at 4:05 PM, interview with the Dietary Manager (DM) revealed a test tray was audited once a month at POS; however, hamburger had not been previously tested. The DM stated there had been problems with POS food temperatures in the past and the facility obtained plate warmers about one (1) year ago. She stated the kitchen was responsible to set a timer on the tray cart for twenty (20) minutes when the last tray was put on the tray cart. The DM tasted the french fries and stated they were cold. She stated during the audits, it was found that the food on the tray carts would hold temperature for a maximum of twenty (20) minutes. The DM stated she was still conducting monthly audits as was determined in the previous survey Plan of Correction (POC) as problems continued. She also stated during the audits, at times, all of the resident trays were not passed before the timer sounded and the remaining trays had to be disposed of and replaced. The DM stated the facility had been considering an insulated tray cart or using</p>	F 520		

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F 520	Continued From page 9 multiple tray carts to help maintain food temperatures at POS.  Interview with the Staff Development Coordinator (SDC)/ Quality Assurance Nurse, on 07/03/13 at 4:05 PM, revealed she was a member of the Quality Assurance (QA) committee, as was the DM, and the committee met once a month. She stated if a problem was identified, the committee would complete an action plan and audits would be done monthly for two (2) months to verify the action plan worked. Further interview revealed, if during those two (2) month audits the problem was found to be resolved, then the issue would be placed back into the rotation of standard audits. If the issue was found to continue, the QA committee would begin additional interventions. The SDC/QA Nurse stated the QA committee had discussed additional staff to assist with passing meal trays or adding facility feeding assistants. She stated the 200-300 hall was the location of concern with cold food temperatures at POS. Continued interview revealed the QA Committee had not identified until this survey that there was still a concern with food temperatures at point of service.	F 520		

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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a)  BUILDING: 01  PLAN APPROVAL: 1991  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type 111 (211)  SMOKE COMPARTMENTS: 5  FIRE ALARM: Complete automatic fire alarm system.  SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.  GENERATOR: Type II diesel generator.  A life safety code survey was initiated and concluded on 07/03/13, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.	K 000	The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
K 052 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. <b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance	K 052	1. The facility contracted vendor for our fire alarm system has corrected the exit door magnetic lock system noted during the survey to assure the system will not re-engage until	8/12/13

RECEIVED  
JUL 29 2013  
BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *D. J. Neighbors* TITLE *Administrator* (X6) DATE *7/29/13*

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

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

PRINTED: 07/18/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  07/03/2013
NAME OF PROVIDER OR SUPPLIER  METCALFE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE EDMONTON, KY 42129		
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K 052	<p>Continued From page 1 and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire alarm system was being maintained according to National Fire Protection Association (NFPA) standards. This deficient practice affected five (5) of five (5) smoke compartments, staff and all the residents. The facility has the capacity for 101 beds with a census of 88 the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour conducted on 07/03/13 at 09:50 AM, with the Director of Maintenance (DOM), a test of the fire alarm system initiated by a pull station near the nursing station revealed the exit door magnetic locks would release on the activation of the fire alarm system; however, after the fire alarm system was silenced the locks would reengage and lock the exit doors. The magnetic locks must stay released until the fire alarm system is reset and showing normal conditions.</p>	K 052	<p>the system is reset and not under the silent mode. The fire zones have been checked, verified, and properly labeled on the fire alarm panel and also on the facility map. The fire alarm vendor has corrected the system to assure it will re-activate after testing in a different zone.</p> <p>2. The facility contracted vendor for our fire alarm panel along with our Director of Environmental Services has checked all the exit doors to assure all exit doors will not re-engage when the fire alarm panel is under the silent mode. The fire alarm panel has been programmed to dis-engage the magnetic locks when the fire alarm is activated and will not re-engage until the fire alarm panel has been reset. All zones have been identified by our fire alarm vendor and are correctly labeled on the fire alarm panel and on the facility map. The fire alarm vendor has corrected the system to assure it will re-activate after testing in a different zone.</p> <p>3. The Director of Environmental Services and the maintenance staff have been in-serviced by the Administrator to assure they understand these requirements.</p> <p>4. The Director of Environmental Services, under the supervision of the Administrator, shall complete the CQI tool ES-3 on a monthly basis X 2 and then quarterly thereafter to assure compliance with this requirement.</p>	

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K 052	<p>Continued From page 2</p> <p>Further testing of the fire alarm system revealed a pull station in the zone three (3) smoke compartment did not reactivate the fire alarm system after the initial testing. The fire alarm panel facility lay out map showed zone three (3) to be duct detectors. This type of testing represents fire conditions spreading from one zone or smoke compartment to another zone or smoke compartment and should reactivate the fire alarm system as required.</p> <p>Further observation revealed the fire alarm panel showed twelve (12) zones. The facility lay out map showed only seven (7) zones.</p> <p>An interview with the DOM, on 07/03/13 at 10:00 AM, revealed he was not aware the exit doors or the fire alarm system was not operating properly. The DOM stated he did not know how many zones the facility had and the zone layout map should be clearer.</p> <p>The findings were revealed to the Administrator on exit.</p> <p>Reference: NFPA 72 1999 edition</p> <p>3-9.6.3 All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2.</p> <p>1-5.7.1.1 The primary purpose of fire alarm system annunciation is to enable responding personnel to identify the location of a fire quickly and accurately and to indicate the status of</p>	K 052		

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K 052	<p>Continued From page 3</p> <p>emergency equipment or fire safety functions that might affect the safety of occupants in a fire situation. All required annunciation means shall be readily accessible to responding personnel and shall be located as required by the authority having jurisdiction to facilitate an efficient response to the fire situation.</p> <p>1-5.7.3 For the purpose of alarm annunciation, each floor of the building shall be considered as a separate zone. If a floor is subdivided by fire or smoke barriers and the fire plan for the protected premises allows relocation of occupants from the zone of origin to another zone on the same floor, each zone on the floor shall be annunciated separately for purposes of alarm location.</p> <p>3-8.4.1 Occupant Notification. Fire alarm systems provided for evacuation or relocation of occupants shall have one or more notification appliances listed for the purpose on each floor of the building and so located such that they have the characteristics described in Chapter 4 for public mode or private mode, as required. Notification zones shall be consistent with the emergency response or evacuation plan for the protected premises. The boundaries of notification zones shall be coincident with building outer walls, building fire or smoke compartment boundaries, floor separations, or other fire safety subdivisions.</p>	K 052		