

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

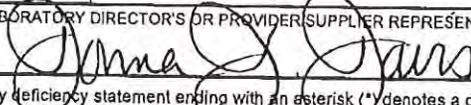
PRINTED: 11/18/2011
FORM APPROVED
OMB NO. 0938-0391

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 11/03/2011
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NAME OF PROVIDER OR SUPPLIER SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 509 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
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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review and review of the facility's policy/procedure, it was determined the facility failed to ensure services met professional standards related to physician's orders for laboratory services not being completed as ordered and the facility policy not being followed for one resident (#5), in the selected sample of fourteen (14).</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure "Care Standard, Laboratory Test, Chapter 15.1, Revised 06/08" revealed "the licensed nurse receiving the order for any laboratory test will document the order on the appropriate physician's order form, transcribe the order onto the tracking log, include the type of lab to be drawn, date of order and date draw was to be done, notify the lab for specimen pick up, and the licensed nurse working the 11 PM to 7 AM shift was to review the log for all lab draws to be done the next day and prepare requisitions as appropriate."</p> <p>A record review revealed Resident #5 was admitted to the facility on 07/13/11 with diagnoses to include Congestive Heart Failure, Osteoarthritis, Diabetes Mellitus, History of Urinary Tract Infection with Methicillin Resistant</p>	F 281	<p>The statements contained in this plan of correction are not an admission of deficient practice and do not constitute agreement with the alleged deficiencies cited within. To remain compliant with all federal and state regulations, the facility sets forth the following actions.</p> <p>F 281</p> <ol style="list-style-type: none"> 1. The ordered laboratory service for resident #5 was completed on 11/1/11. 2. A review of all laboratory service orders for the past 30 days revealed no other uncompleted labs. 3. All licensed nurses were retrained on the center policy for completion of labs and the tracking log procedures by the Director of Nursing on or before 11/29/11. A lab calendar for use by all nurses has been implemented and will be reviewed in the daily clinical meeting with the Director of Nursing. 4. All physician's orders for lab services will be reviewed daily five days per week for one month by the Director of Nursing or designee 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/28/11
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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 281	<p>Continued From page 1</p> <p>Staphylococcus Aureus (MRSA) and Urinary Retention.</p> <p>A review of the lab order, dated 10/07/11, for a repeat urinalysis (UA) was to be completed in two weeks, on 10/21/11. This lab was not obtained until 11/01/11.</p> <p>Urinalysis results for Resident #5, dated 11/01/11 at 5:07 PM, revealed trace amounts of blood, nitrites, leukocytes, an elevated white blood cell count, an elevated red blood cell count, bacteria, mucus and squamous epithelial's.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 11/02/11 at 8:30 AM, revealed a laboratory log should be updated at the time the nurse received the order for the lab. She stated she and the other unit manager usually check to ensure the orders were put in the book, but stated "I just missed this one." She stated she notified Resident #5's physician and was instructed to obtain the lab at that time and notify the physician of the results.</p> <p>An interview with the Director of Nursing (DON), on 11/02/11 at 9:15 AM, revealed the lab log was to be completed monthly and updated daily based on any new orders that were written. She verbalized the unit managers get a copy of all orders and add the labs to the log as needed. She said some nurses will update the log when orders are received, but it was ultimately the unit managers who monitor and update the lab log book. She stated she was aware of Resident #5 not getting the lab as ordered for 10/21/11 and the lab being obtained on 11/01/11; however, she could offer no explanation as to how the lab was</p>	F 281	<p>to ensure that the lab is scheduled and completed as ordered. The Director of nursing will report findings of this review to the center quality assurance committee monthly times three months to ensure continued compliance.</p>	12/01/11	

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F 281	Continued From page 2 missed.	F 281		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to provide appropriate treatment and services related to incontinent care for one resident (#3), in the selected sample of fourteen (14). Findings include: A review of the facility's policy/procedure, "Perineal Care" (undated), revealed "the staff members were to wash the resident's perineal area, starting with the urethra and working outward, using a circular motion. Continue to wash the perineal area and thoroughly rinse the perineal area in the same order, using a fresh water and clean washcloth. Gently dry the perineum in the same order. Turn the resident on their side and wash, rinse and dry the rectal area thoroughly."	F 315	F 315 1. Appropriate incontinent care was provided to resident #3 and a skin assessment was completed on 11/2/11. 2. All other residents being cared for by SRNA #2 on 11/2/11 were assessed with no findings. 3. All SRNA's were retrained on proper incontinent care by the Director of Nursing on or before 11/2/11. 4. Unit Managers will observe incontinent care on a random sampling of five residents on each unit one time daily for 2 weeks to ensure that facility policy and procedures for incontinent care are being properly followed. The Director of Nursing will report their findings to the center Quality Assurance committee monthly until resolved.	12/01/11

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F 315	<p>Continued From page 3</p> <p>A record review revealed Resident #3 was admitted to the facility on 11/01/04, and re-admitted on 10/15/10, with diagnoses to include Anoxic Brain Damage, Persistent Vegetative State and Neurogenic Bladder.</p> <p>A review of the quarterly assessment, dated 09/07/11, revealed the facility identified Resident #3 to be incontinent of bowel and bladder. A review of the care plan for incontinence, dated 08/08/08, revealed the resident required the extensive assistance of two staff members for incontinent care, and interventions included checking and changing the briefs during rounds and as needed. A review of the State Registered Nurse Aide (SRNA) care plan revealed the resident was to be provided perineal cleansing with the assistance of two staff members.</p> <p>An observation during the provision of incontinent care for Resident #3, on 11/02/11 at 9:45 AM, revealed SRNA #2 used the same area of the washcloth, using a circular wiping motion for the entire perineal region and a back and forth motion in the resident's groin area, using the same washcloth, which contaminated the clean area. The SRNA wiped the same area with a dry towel and turned the resident to a side-lying position and cleansed the rectal area with a back and forth motion. An interview with SRNA #2, at the time of the observation, revealed she was trained to provide incontinent care and to fold the washcloth and to avoid using a contaminated surface, but had "forgotten this."</p> <p>An interview with Licensed Practical Nurse (LPN)/ Charge Nurse (CN) #1, on 11/02/11 at 4:13 PM,</p>	F 315		
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F 315	<p>Continued From page 4</p> <p>revealed she expected the SRNAs to wash the resident "front to back and fold the washcloth before each wipe." Additionally, the SRNAs were trained about proper incontinent care upon hire, with monthly training and with yearly competency training.</p> <p>An interview with Registered Nurse (RN) #1, on 11/02/11 at 4:30 PM, revealed the CNAs were to fold the washcloth between wipes and "they knew better."</p> <p>An interview with the Director of Nursing (DON), on 11/03/11 at 9:30 AM, revealed the SRNAs were trained to provide proper perineal care and "they just got nervous."</p>	F 315		
F 332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy/procedure, it was determined the facility failed to ensure it was free of medication error rates of five percent or greater. Observations of medication passes, on 11/01/11 and 11/02/11, on three separate units revealed fifty medication opportunities with five errors, which resulted in a medication error rate of ten percent.</p> <p>Findings include:</p>	F 332	<p>F 332</p> <p>1. Residents # 16, 17, 18 were assessed no have no negative effect from the error and their physician's were notified of the errors with no new orders received.</p> <p>2. All other residents on Potassium Chloride ER and Theophylline ER were assessed and no other instances of medication crushing were found to have occurred. All other residents with orders for nasal sprays were reviewed and no other administration errors were discovered.</p>	

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F 332	<p>Continued From page 5</p> <p>A review of the facility's policy/procedure (for oral medications) "Medication Administration," dated 10/07, included "check for specific prescriber order to crush medications if required by state regulations. Crush medications if indicated for the resident only after referring to the Medications to be Crushed list. Crush in tablet crusher, mortar and pestle or with other appropriate device and clean immediately after use. For products that appear on the Medications not to be Crushed list, check with the pharmacist regarding a suitable alternative, and request a new prescriber order if appropriate."</p> <p>A review of the Medications not to be Crushed list, revised date 12/10, revealed Potassium chloride tablets were not to be crushed and listed the reason was due to being a time release formulation. Theophylline ER was also on the list and the reason indicated was due to being a time release formulation.</p> <p>1. A record review revealed Resident #16 was admitted to the facility on 08/22/11 with diagnoses to include Dementia with Behavior Disturbance, Congestive Heart Failure and Confusion.</p> <p>A review of the physician's order, dated November 2011, revealed Potassium Chloride ER was to be administered two times a day by mouth and "DO NOT CRUSH."</p> <p>An observation of a medication pass, on 11/01/11 at 3:05 PM, revealed Registered Nurse (RN) #2 administered a Potassium Chloride ER (extended release) tablet crushed, mixed with applesauce to Resident #16.</p>	F 332	<p>3. All licensed nurses have been retrained on the medications on the Do Not Crush list and the center policy and procedures for medication administration on or before 11/29/11.</p> <p>4. The Director of Nursing or designee will observe one medication pass daily five times per week for 4 weeks to ensure center policy and procedures as well as pharmacy instructions and physician's orders are followed during medication administration. The Director of Nursing will report findings to the center Quality Assurance committee monthly for continued follow-up and recommendations.</p>	12/01/11

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F 332	<p>Continued From page 6</p> <p>2. A record review revealed Resident #17 was admitted to the facility on 04/05/09 with diagnoses to include Altered Mental Status, Anemia and Congestive Heart Failure.</p> <p>A review of the physician's orders, dated November 2011, revealed Deep Sea 0.65% Nose Spray, one spray each nostril four times daily and Flonase 0.05% Nasal Spray, one spray each nostril at bedtime. Hydrochlorothiazide 12.5 mg was ordered for 9:00 AM every day.</p> <p>An observation of a medication pass, on 11/02/11 at 8:07 AM, revealed Licensed Practical Nurse (LPN) #3 administered Flonase 0.05% nasal spray to Resident #17 instead of the Deep Sea 0.6% nasal spray. Additionally, Hydrochlorothiazide 12.5 mg was not administered.</p> <p>3. A record review revealed Resident #18 was admitted to the facility on 04/03/09 with diagnoses to include Congestive Heart Failure, Chronic Obstructive Pulmonary Disease and Non Organic Psychosis.</p> <p>An observation of a medication pass, on 11/02/11 at 9:00 AM, revealed LPN #3 administered Theophylline ER 200 mg crushed and Potassium Chloride ER 20 meq dissolved in water.</p> <p>An interview with the Director of Nursing (DON), on 11/02/11 at 10:10 AM, revealed she expected the nurses not to crush Potassium chloride ER, but felt dissolving in water was acceptable. The nasal spray was given in error and the Hydrochlorothiazide should have been given and was missed.</p>	F 332		
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F 332	Continued From page 7 An interview with the Pharmacist, on 11/02/11 at 10:45 AM and 2:10 PM, revealed administering Potassium chloride ER or Theophylline ER crushed or dissolved in water was not acceptable. The Pharmacist revealed crushing or dissolving destroyed the integrity and design of the medications. Extended release meant allowing for the medication's intended effects be delivered over a time period and not all at once. Potassium chloride was a gastrointestinal irritant. Theophylline had side effects of tachycardia, heart flutter, restlessness, headache and nausea. The side effects of these medications could be more intense if the integrity of the medications had been destroyed by crushing or dissolving.	F 332		
F 371 SS=E	483.35(i) 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 review of the facility's policy/procedure, it was determined the facility failed to ensure food was prepared, distributed and served under sanitary conditions. Observations of the meal service, on 11/01/11, revealed some of the food items served were not	F 371	F 371 1. A hands free trash can was placed in the hand sink area. The broom and dustpan were hung on their bracket. The milk that was not at proper temperature was discarded and milk at appropriate temperature was served. The pureed macaroni was brought to temperature prior to it being served to a resident. The individual containers were removed from the steam table. 2. No residents were negatively impacted as a result of the alleged deficient practice. 3. All dietary staff were retrained on the center policy and procedure for obtaining food temperatures and dietary department sanitation policy and procedures by the registered dietician on or before 11/29/11.	

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F 371	Continued From page 8 checked for temperature prior to preparing resident food trays for service and some of the food items that were checked were at improper temperatures. Additionally, improper sanitation practices were observed. Findings include: A review of the facility's policy/procedure for food temperatures, undated, revealed "The temperatures of all foods on the serving line will be measured prior to resident service and recorded at every meal." The policy/procedure also revealed "Cold food should be 40 degrees Fahrenheit or less when the temperature is taken in the kitchen, at the time of service." The initial observation of the kitchen area, on 11/01/11 at 9:15 AM, revealed the trash can located at the handwashing sink did not have a hands' free lid and required touching the lid to place dirty paper towels in it. Also, a broom and a dustpan were sitting directly on the floor, instead of the proper wall hanging bracket. An observation of the lunch meal service, on 11/01/11 at 11:20 AM, revealed kitchen staff #1 obtained temperatures of all the food on the steam table, except for the alternative meat (chicken) and containers of pureed hot dog and cream of chicken soup, which were observed sitting directly on top of the macaroni. An observation, on 11/01/11 at 12:20 PM, revealed the temperature of the pureed macaroni was 130 degrees Fahrenheit. The temperature of a glass of buttermilk was 49 degrees Fahrenheit, pudding thick milk had a temperature of 48	F 371	4. The Certified Dietary Manager or designee will complete a kitchen sanitation audit daily times two weeks and will observe food temperatures at each meal times two weeks to ensure continued compliance. The Certified Dietary Manager will report findings to the center Quality assurance committee for follow-up and recommendations.	12/01/11

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F 371	Continued From page 9 degrees Fahrenheit, and Nectar thick milk was 46 degrees Fahrenheit. An interview with the Dietary Manager, on 11/02/11 at 8:00 AM, revealed she was aware the kitchen staff did not obtain temperatures on all of the different foods served and it was her responsibility to ensure all the temperatures were obtained. She stated individual containers of food should not be placed in other food while on the steam table. Additionally, brooms, mops and dustpans were not to be left sitting directly on the floor.	F 371		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure lab services were obtained timely for one resident (#5), in the selected sample of fourteen (14). Findings include: A record review revealed Resident #5 was admitted to the facility on 07/13/11 with diagnoses to include Congestive Heart Failure, Osteoarthritis, Diabetes Mellitus, History of Urinary Tract Infection with Methicillin Resistant Staphylococcus Aureus (MRSA) and Urinary Retention.	F 502	F 502 1. The ordered laboratory service for resident #5 was completed on 11/01/11. 2. A review of all laboratory service orders for the past 30 days revealed no other uncompleted labs. 3. All licensed nurses were retrained on the center policy for completion of labs and the tracking log procedures by the Director of Nursing on 11/29/11. 4. All physician's orders for lab services will be reviewed daily five days per week for one month by the center unit managers to ensure that the lab is scheduled and	

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F 502	<p>Continued From page 10</p> <p>A review of the lab order, dated 10/07/11, for a repeat urinalysis (UA) was to be completed in two weeks, on 10/21/11. This lab was not obtained until 11/01/11.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 11/02/11 at 8:30 AM, revealed a laboratory log should be updated at the time the nurse received the order for the lab. She stated she and the other unit manager usually check to ensure the orders were put in the book, but stated "I just missed this one." She stated she notified Resident #5's physician and was instructed to obtain the lab at that time and notify the physician of the results.</p> <p>An interview with the Director of Nursing (DON), on 11/02/11 at 9:15 AM, revealed the lab log was to be completed monthly and updated daily based on any new orders that were written. She verbalized the unit managers get a copy of all orders and add the labs to the log as needed. She said some nurses will update the log when orders are received, but it was ultimately the unit managers who monitor and update the lab log book. She stated she was aware of Resident #5 not getting the lab as ordered for 10/21/11 and the lab being obtained on 11/01/11; however, she could offer no explanation as to how the lab was missed.</p>	F 502	<p>completed as ordered. The Director of nursing will report findings of this review to the center quality assurance committee monthly times three months to ensure continued compliance.</p>	12/01/11	

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

PRINTED: 11/18/2011
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 11/03/2011
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1996 Survey under: NFPA 101 (2000 edition) Chapter 19 Facility type: SNF/NF Type of structure: Type II (000) Smoke Compartment: 4 Fire Alarm: Complete fire alarm installed 1996. Smoke detectors located in corridors and heat detectors located in Kitchen and Main Mechanical Room. Sprinkler System: Complete automatic sprinkler system (wet) installed in 1996. An antifreeze loop was installed for the front canopy in 2008. Generator: Type II, Diesel, installed in 1996. A standard Life Safety Code survey was conducted on 11/03/2011 Salem Springlake Health and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was fifty nine (59). The facility is licensed for seventy five (75). The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	K038 The center has obtained and approved a bid for the construction of a concrete walkway to connect the 200 Hall exit door to the sidewalk that connects to the paved parking lot. This walkway will provide a hard surface that will ensure the exit can be used in all weather conditions. The construction company has agreed to complete the walkway as soon as weather permits, and the center will place weather resistant wood panels on the path to use in the event of an evacuation until the concrete walkway can be poured. A waiver has been requested to allow time for completion of the project.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		01/05/12



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
[Signature]
TITLE Administrator (X6) DATE 12/1/11

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 038	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, twenty (20) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 11/03/2011 at 2:13 PM, revealed the outside exit for the 200 Hall did not have a hard surface leading to a public way. Exits must have a hard surface leading to a public way to ensure the exits can be used in all weather conditions. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 11/03/2011 at 2:13 PM, with the Maintenance Director, revealed the exit never had a hard surface leading to a public way.</p> <p>Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open</p>	K 038		

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K 038	<p>Continued From page 2</p> <p>spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.</p> <p>Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2.</p> <p>Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6.</p> <p>Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.</p> <p>CMS SEC letter 5-38</p>	K 038		