

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

PRINTED: 03/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185410	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/08/2013
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NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055
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F 000	INITIAL COMMENTS A recertification survey was conducted on 03/05/13 through 03/08/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity at a "F".	F 000	F241 Criteria #1 Nursing Staff will be provided training regarding privacy and dignity of residents while providing care. The training will also specifically review that this includes ensuring that the curtain is pulled, while doing incontinent care. The training will be completed by Administrative Nursing, which includes the Director of Nursing and the Assistant Director of Nursing. This will address the deficient practice identified in relation to Resident # 6. This training will be completed by April 20, 2013, and first full day of compliance will be April 21, 2013.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 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 ensure care was provided to maintain or enhance each resident's dignity and respect, for two (2) residents (#1 and #6), in the selected sample of ten (10) residents. Staff failed to pull the privacy curtain during incontinent care for Resident #6 and failed to use a vanity bag to cover the urinary catheter drainage bag for Resident #1. The findings include: A review of the facility's policy titled "Patient Privacy", undated, revealed the facility strived to ensure patient privacy is provided during all aspects of care. An observation, on 03/06/13 at 2:00 PM, revealed	F 241	Nursing Staff will also be provided training on ensuring that all residents that have an indwelling catheter utilize a dignity bag, which includes Resident # 1. This training will be provided by Administrative Nursing, which includes the Director of Nursing and the Assistant Director of Nursing. The training will be completed by April 20, 2013, and the first full day of compliance will be April 21, 2013.	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Y. Laura Jelder, Administrator TITLE: _____ DATE: 3-22-13

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.

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F 241	<p>Continued From page 1</p> <p>incontinent care was provided to Resident #6 by Certified Nurse Aide (CNA) #1 and CNA #2 with the privacy curtains not completely pulled which exposed Resident #6 to his/her roommate during care.</p> <p>An interview with CNA #1 and CNA #2 on 03/06/13 at 2:35 PM and 2:40 PM respectively, revealed resident care and incontinent care should have been provided with the privacy curtain completely pulled and the door closed.</p> <p>An interview with the Director of Nursing (DON), on 03/07/13 at 2:21 PM, revealed she expected staff to provide resident privacy by pulling the privacy curtain as well as closing the door.</p> <p>2. A review of the facility's policy titled "Care of Indwelling Catheter", undated, revealed a cover bag should be used to provide dignity.</p> <p>A record review revealed Resident #1 was admitted to the facility on 10/30/08 with diagnosis of Neurogenic Bladder.</p> <p>An observation, on 03/05/13 at 10:00 AM, revealed Resident #1 was sitting in a reclining geri-chair in his/her room with a urinary catheter bag attached to the geri-chair and the catheter bag uncovered.</p> <p>An observation, on 03/05/13 at 11:52 AM, revealed Resident #1 was sitting in a reclining geri-chair in the dining room eating lunch with a urinary catheter bag attached to the geri-chair and the catheter bag uncovered.</p>	F 241	<p>Criteria #2 Resident #1 is currently the only resident at River's Bend Retirement Community that is being provided an indwelling catheter. In order to identify other residents that may not being provided privacy/dignity during care, the Social Services Director will interview those residents with a BIMS score (on last assessment) of 13-15 to determine if privacy and dignity is being provided with routine care. If any privacy and dignity concerns are noted, Nursing staff will be provided training on each specific resident and their concern(s) by the Social Service Director to ensure that the deficient practice does not reoccur. This will be completed by April 20, 2013 and first full day of compliance will be April 21, 2013.</p> <p>Criteria #3 Nursing Staff will be inserviced on providing privacy and dignity to residents while providing care. Training will be provided by Administrative Nursing, which includes the Director of Nursing and the Assistant Director of Nursing. The Administrator and Director of Nursing will also review the policy regarding "Patient Privacy" to include in the policy examples of care when nursing staff must ensure that privacy and dignity is maintained. The policy will specifically indicate incontinent care and the use of dignity bags with catheters. Nursing Staff will be provided training on the revised policy by the Administrator by April 20, 2013, with first full day of compliance being April 21, 2013.</p>	

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F 241	Continued From page 2 An interview with CNA #3, on 03/07/13 at 2:00 PM, revealed the facility's policy was urinary catheter bags should be covered at all times. An interview with the Registered Nurse (RN) Supervisor, on 03/07 /13 at 2:05 PM, revealed the urinary catheter bags should have a cover bag over the bag at all times. An interview with the DON, on 03/07/13 at 2:30 PM, revealed she expected the urinary catheter bags to be covered at all times because it was a dignity issue.	F 241	Criteria # 4 Two times a month Administrative Nursing , which includes the Director of Nursing and Assistant Director of Nursing will observe an act of care where dignity and privacy is a component. This will be completed for the next quarter by Administrative Nursing. Results of monitoring will be reported to the Quality Assurance Committee, which meets at least quarterly. Any issues identified during monitoring, will be corrected immediately during the monitoring.		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 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 ensure services were provided in accordance with the plan of care for one (1) resident (#5), in the selected sample of ten (10) residents. Observations on 03/06/13 revealed Resident #5's safety alarm was not functioning. Findings include: A review of the facility's policy titled	F 282	F282 Criteria # 1 On 3/8/2013 Resident #5 was provided a safety alarm that was functioning. Inservicing was implemented by the Director of Nursing immediately for that shift on ensuring that Nursing staff is checking placement and functioning of safety alarms being utilized. Inservicing was also implemented for that shift to ensure that alarms are checked on every two hours for functioning and placement. This was implemented by the Director of Nursing.	Criteria #5 4/21/2013	

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F 282	<p>Continued From page 3</p> <p>"COMPREHENSIVE CARE PLAN", undated, revealed residents would be provided with a comprehensive care plan and a CNA care plan that is individualized to strive to ensure that appropriate care is provided to the resident. Care plans should be followed at all times to strive to ensure all supports are being provided to residents.</p> <p>A record review revealed Resident #5 was admitted to the facility with diagnoses to include Dementia, Gait Disturbance With Falling Spells, and Unsocial Aggression. A review of the Minimum Data Set (MDS) quarterly assessment, dated 12/28/12, revealed the facility had assessed the resident as severely cognitively impaired, required extensive assistance with transfers and activities of daily living, was non ambulatory and was at risk for falls.</p> <p>A review of Resident #5's Comprehensive Care Plan titled, "AT RISK FOR FALLS", dated 07/21/11, revealed an interventions for a flat sensor alarm to bed and wheel chair and to check alarms for placement and functioning every two hours.</p> <p>A review of Resident #5's Alarm Check Off Documentation sheet, dated March 2013, revealed no documentation the alarm had been checked for placement and function on 03/01/13 from 6:30 AM through 4:30 PM, the entire day on 03/02/13 and from 12:30 AM through 6:30 AM on 03/03/13. Further review revealed the last time it was documented the alarm was checked for placement and functioning was on 03/06/13 at 8:30 AM.</p>	F 282	<p>Criteria #2</p> <p>Administrative Nursing, which consists of the Director of Nursing and Assistant Director of Nursing, will check functioning and placement of personal safety alarms being utilized by current residents to ensure functioning and placement of alarms. Any alarms that are found to be malfunctioning will be replaced immediately by Administrative Nursing. This will be completed by April 20, 2013, with first full day of compliance being April 21, 2013.</p> <p>Nursing staff will be provided training by Administrative Nursing, which includes the Director of Nursing and Assistant Director of Nursing, to ensure that alarms are checked for placement and functioning every two hours by the Certified Medication Techs., and then by Certified Nurse Aides when they are providing care.</p> <p>Certified Medication Techs. will also be provided training by Administrative Nursing that they are to be verifying placement and functioning every 2 hours, and documenting this on the alarm check off sheet every two hours. Training will also be provided by Administrative Nursing to Nursing staff that the Certified Nurse Aide Care Plan must be followed at all times.</p> <p>This will be completed by April 20, 2013, with first day of full compliance being April 21, 2013.</p>		

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F 282	<p>Continued From page 4</p> <p>Observations, on 03/06/13 at 9:00 AM, 9:30 AM and 10:00 AM, revealed Resident #5 was sitting in a wheelchair in his/her room. A safety alarm was observed in place to the resident's wheelchair but the "In Use Light" was not flashing.</p> <p>Observation, at 10:15 AM on 03/06/13 with Certified Nurse Aide (CNA) #3 and CNA #4, verified the safety alarm "In Use Light" was not flashing. CNA #3 and CNA #4 disconnected the alarm contact and the alarm failed to sound. Interviews with CNA #3 and #4 at the time revealed the alarm should have sounded when the alarm contact was disconnected. CNA ##3 stated she should have checked the alarm for functioning previously when in the room with the resident. CNA #3 gave no explanation as to why she did not check the alarm for functioning.</p> <p>An interview with Certified Medication Technician (CMT) #6, on 03/06/13 at 10:20 AM, revealed she was responsible to verify and document that the alarms were on and functioning. She stated she normally checked the alarm for functioning by unplugging the alarms so the alarm would sound. She stated she had not checked Resident #5's alarm on this date and did not know why.</p> <p>An interview with the Administrator, on 03/06/13 at 12:20 PM, revealed she expected staff to follow the residents' plans of care. She stated the CMT should have checked every alarm placement and functioning every two hours and documented the checks on the Alarm Check Off Documentation sheet. The Administrator was not aware Resident #5's placement and functioning documentation was not signed off as completed</p>	F 282	<p>Criteria # 3</p> <p>Nursing staff will be provided training by Administrative Nursing, which consists of the Director of Nursing and Assistant Director of Nursing, to ensure that alarms are checked for placement and functioning every two hours by the Certified Medication Techs., and then by Certified Nurse Aides when they are providing care. Certified Medication Techs. will also be provided training by Administrative Nursing that they are to be verifying placement and functioning every 2 hours, and documenting this on the alarm check off sheet every two hours. Training will also be provided by Administrative Nursing that the Certified Nurse Aide Care Plan must be followed at all times to ensure appropriate supports to maintain safety for residents. Administrative Nursing will also train Nursing staff to ensure that the "in use light" is working on the alarms to alert staff that alarms are functioning. This will be completed by April 20, 2013, with first day of full compliance being April 21, 2013.</p>		

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F 282 F 315 SS=D	<p>Continued From page 5 on multiple days and times.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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.</p> <p>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 ensure one (1) resident (#6), in the selected sample of ten (10) residents, who was incontinent of bladder received the appropriate treatment and services to prevent urinary tract infections. Certified Nurse Aide (CNA) #2 was observed performing improper incontinent care for Resident #6.</p> <p>Findings include: A review of the facility's policy titled, "Peri-Care", undated, revealed Peri-care should be provided by utilizing a product approved by the facility, and should be done by wiping from front to back, and always with a clean area of the product being used to provide care. A record review revealed Resident #6 was</p>	F 282 F 315	<p>Criteria # 4</p> <p>Administrative Nursing, which consists of the Director of Nursing and Assistant Director of Nursing, will check safety alarms that are being utilized by the residents one time a month to ensure that they are functioning, and are appropriately placed. Administrative Nursing will also ensure that alarm usage is appropriately marked on each residents' care plans that use alarms. Administrative Nursing will complete the above actions one time a month for one quarter.</p> <p>Administrative Nursing will also 2x's a month for the next quarter review the "alarm check off sheet" that is utilized by the Certified Medication Techs. to ensure that monitoring for placement/functioning is being completed by the Certified Medication Techs. every 2 hours. If this is not occurring appropriate training/disciplinary action will be provided to the appropriate Certified Medication Tech.</p>	Criteria #5 4/21/2013	

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F 315	Continued From page 6 admitted to the facility 03/03/10 with diagnoses to include Confusion, Acute Mental Status Change, Hypertension and Dementia. A review of a quarterly Minimum Data Set (MDS) assessment, dated 02/21/13, revealed the facility assessed Resident #6 as severely cognitively impaired and he/she required the total assist of one staff for toileting and hygiene. An observation, on 03/06/13 at 2:00 PM, revealed CNA #2 provided incontinent care using a back and forth motion with a soiled washcloth and not cleansing from front to back. An interview with CNA #2, on 03/06/13 at 2:40 PM, revealed peri-care should have been provided by cleansing from front to back with a clean cloth each swipe.	F 315	F315 Criteria # 1 On 3/13/2013 training began and was provided to Nursing Staff by Administrative Nursing, which consists of the Director of Nursing and Assistant Director of Nursing on how to provide appropriate peri-care. The training being provided addresses the deficient practice identified for Resident #6. Criteria #2 In order to identify other Residents that may be affected by the deficient practice, Administrative Nursing, which consists of the Director of Nursing and the Assistant Director of Nursing, will observe five nursing staff providing incontinent care to ensure appropriate care is being provided.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, manufacturing instructions and review of the facility's policies/procedures it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to	F 323	Any deficient practices noted will be immediately corrected and training provided to the staff providing the care. This will be completed by April 20, 2013, with first full day of compliance being April 21, 2013.	

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F 323	<p>Continued From page 7</p> <p>prevent accidents for one (1) resident (#5), in the selected sample of ten (10) residents. The facility failed to ensure Resident #5's pressure alarm was in place and functioning.</p> <p>Findings include:</p> <p>A review of the facility's policy titled, "RESIDENT SAFE ENVIRONMENT", undated, revealed all residents will be evaluated for fall risk and past interventions will be reviewed for those residents that have had a fall, and new interventions will be implemented to strive to prevent further occurrences.</p> <p>A review of the facility's policy titled, "PERSONAL SAFETY ALARMS", undated, revealed safety alarms should be checked for proper placement and functioning. Ongoing surveillance of proper device use will be done during routine care and compliance rounds.</p> <p>A review of the manufacturer's instructions for the flat sensor alarm revealed the "In-use light" notifies you at a glance that the unit is properly operating. In addition, there was a "warning" on the instructions to always verify the system is working properly before leaving the resident unattended.</p> <p>A record review revealed Resident #5 was admitted to the facility with diagnoses to include Dementia, Gait Disturbance With Falling Spells and Unsocial Aggression. A review of the Minimum Data Set (MDS) quarterly assessment, dated 12/28/12, revealed the facility had assessed Resident #5 as severely cognitively impaired, required extensive assistance with</p>	F 323	<p>Criteria # 3 Administrative Nursing, which consists of the Director of Nursing and Assistant Director of Nursing, will provide training on appropriate incontinent care to Nursing staff. This training will include appropriate techniques to be utilized to assist in prevention of urinary tract infections. This will be completed by April 20, 2013, with first full day of compliance being April 21, 2013.</p> <p>"Incontinent Care" training will also be provided at least quarterly, as part of the mandatory inservices that the facility provides to Nursing staff to ensure that incontinent care is being appropriately performed.</p> <p>Criteria # 4 Administrative Nursing, which consists of The Director of Nursing, and the Assistant Director of Nursing, will observe incontinent care at least 2 x's a month for the next quarter to ensure that appropriate incontinent care is being provided as indicated.</p>	Criteria #5 4/21/2013	

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F 323	<p>Continued From page 8</p> <p>transfers and activities of daily living, was non ambulatory and at risk for falls. A review of the Comprehensive Device Assessment, dated 03/06/13, revealed the medical symptoms for the use of the alarm sensor pads were agitation, unsteady/falls, dementia, attempts to get out of chair unassisted</p> <p>A review of Resident #5's Comprehensive Care Plan titled, "AT RISK FOR FALLS", dated 07/21/11, revealed an interventions for a flat sensor alarm to bed and wheel chair and to check alarms for placement and functioning every two hours.</p> <p>Observations on 03/05/13 at 9:00 AM, 9:30 AM and 10:00 AM revealed Resident #5 was sitting in a wheelchair in his/her room. A safety alarm was observed in place to the resident's wheelchair but the "In Use Light" was not flashing. An observation at 10:15 AM with Certified Nurse Aide (CNA) #3 and CNA #4 verified the safety alarm "In Use Light" was not flashing. CNA #3 and CNA #4 disconnected the alarm contact and the alarm failed to sound. Interview with CNA #3 and #4 at the time revealed the alarm should have sounded when the alarm contact was disconnected. CNA #3 stated she should have checked Resident #5's alarm for placement and functioning when she was previously in the room.</p> <p>A review of Resident #5's Alarm Check Off Documentation sheet, dated March 2013, revealed no documentation the alarm had been checked for placement and function on 03/01/13 from 6:30 AM through 4:30 PM, the entire day on 03/02/13 and from 12:30 AM through 6:30 AM on 03/03/13. Further review revealed the last time it</p>	F 323	<p>F323</p> <p>Criteria # 1</p> <p>On 3/6/2013 Resident #5 was provided a safety alarm that was functioning. Inservicing was implemented by the Director of Nursing immediately for that shift on ensuring that Nursing staff is checking placement and functioning of safety alarms being utilized. Inservicing was also implemented for that shift to ensure that alarms are checked on every two hours for functioning and placement. This was implemented by the Director of Nursing.</p> <p>Criteria #2</p> <p>Administrative Nursing, which consists of the Director of Nursing and Assistant Director of Nursing, will check functioning and placement of personal safety alarms being utilized by current residents to ensure functioning and placement of alarms. Any alarms that are found to be malfunctioning will be replaced immediately by Administrative Nursing. This will be completed by April 20, 2013, with first full day of compliance being April 21, 2013.</p>	

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F 323	<p>Continued From page 9</p> <p>was documented the alarm was checked for placement and functioning was on 03/06/13 at 8:30 AM.</p> <p>An interview, on 03/06/13 at 10:20 AM with Certified Medication Technician (CMT) #6, revealed she was responsible for checking to ensure the alarms were in place and functioning every two hours and should document the checks on the alarm sheets. She stated she verified the alarms were functioning by disconnecting the alarm contact. She revealed she had not checked Resident #5's on this date and did not know why.</p> <p>An interview with the Administrator, on 03/08/13 at 12:20 PM, revealed she expected the CMT to check every alarm for placement and functioning every two hours and to document it on the alarm sheet. The Administrator was not aware Resident #5's placement and functioning documentation was not signed off as completed on multiple days and times.</p>	F 323	<p>Nursing staff will be provided training by Administrative Nursing, which includes the Director of Nursing and Assistant Director of Nursing, to ensure that alarms are checked for placement and functioning every two hours by the Certified Medication Techs., and then by Certified Nurse Aides when they are providing care. Certified Medication Techs. will also be provided training by Administrative Nursing that they are to be verifying placement and functioning every 2 hours, and documenting this on the alarm check off sheet every two hours. Training will also be provided by Administrative Nursing that the Certified Nurse Aide Care Plan must be followed at all times. This will be completed by April 20, 2013, with first day of full compliance being April 21, 2013.</p> <p>Criteria # 3 Nursing staff will be provided training by Administrative Nursing, which consists of the Director of Nursing and Assistant Director of Nursing, to ensure that alarms are checked for placement and functioning every two hours by the Certified Medication Techs., and then by Certified Nurse Aides when they are providing care. Certified Medication Techs. will also be provided training by Administrative Nursing that they are to be verifying placement and functioning every 2 hours, and documenting this on the alarm check off sheet every two hours. Training will also be provided by Administrative Nursing that the Certified Nurse Aide Care Plan must be followed at all times to ensure appropriate supports to maintain safety for residents. Administrative Nursing will also train Nursing staff to ensure that the "In use light" is on to alert staff that alarms are functioning. This will be completed by April 20, 2013, with first day of full compliance being April 21, 2013.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186410	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2013
NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055	
(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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1994.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (000).</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1995, with 25 smoke detectors and 113 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1994.</p> <p>GENERATOR: Type II generator installed in 1995. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 03/05/13. River's Bend Retirement Community was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Forty (40) beds with a census of Thirty-Seven (37) 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</p>	K 000	<p>K018</p> <p>Criteria #1 The corridor doors to Rooms #206, #207, #213, #223, #226, and # 225 are going to be replaced, due to the unacceptable gap noted by Life Safety Inspector. Gary Bernot has been selected to do the replacement of the doors, and the doors have been ordered, as indicated in the attached letter. The letter was received on March 21, 2013 from contractor, and estimated completion date for replacement of the doors is April 30, 2013. Doors to rooms #208 and #219 will be repaired by the Maintenance Director to ensure that they latch by April 20, 2013, with first full day of compliance being April 21, 2013.</p> <p>Criteria #2 To ensure that no other residents' rooms' corridor doors do not have a larger gap than a 1/2 inch around the door jamb the Maintenance Director will measure each residents' corridor doors in the facility. The Maintenance Director will also ensure that all residents' corridors' doors latch as indicated per regulations. The above will be completed by April 20, 2013, with first full day of compliance being April 21, 2013.</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Sedler, Administrator TITLE: Administrator (X6) DATE: 3-22-13

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.

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NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055	
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K 000	Continued From page 1 Fire).	K 000	Criteria #3 Nursing Facility staff will be provided training by the Maintenance Director that they are to report any doors that are not latching, via the work order system.	
K 018 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms were in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for Forty (40) beds with a census of	K 018	The Administrator will provide training to the Maintenance Director on the Life Safety Code regulation regarding corridors to resident rooms and K018. The above mentioned will be completed by April 20, 2013, with first full day of compliance being April 21, 2013. Criteria #4 The Maintenance Director, as part of preventative maintenance, will ensure that all residents' doors latch as indicated. The Maintenance Director will also monitor, as part of preventative maintenance, to ensure that there are no larger gaps of a ½" of residents' rooms corridors. The Maintenance Director will do this one time a month for a quarter, and then every quarter after that. This will be completed by April 20, 2013, with first full day of compliance being April 21, 2013. K027 Criteria #1 The three sets of doors identified as having a gap of more than 1/8" where the doors meet are in the process of being replaced. River's Bend Retirement Community has hired a contractor (Gary Bernot) and purchased and ordered the doors. The facility is awaiting delivery of doors. A letter from Mr. Bernot was provided to Administrator on March 21, 2013. The estimated date of completion is April 30, 2013, per contractor.	Criteria #5 4/21/2013

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K 018	<p>Continued From page 2</p> <p>Thirty-Seven (37) on the day of the survey. The facility failed to ensure six (6) corridor doors to the resident rooms did not have a gap smaller than ½ inch around the jamb and two (2) doors latched when closed.</p> <p>The findings include:</p> <p>Observations, on 03/05/13 between 2:06 PM and 3:00 PM with the Maintenance Director, revealed the corridor doors to rooms #206, #207, #213, #223, #226, and #225 had a gap larger than ½ inch around the jamb.</p> <p>Interview, on 03/05/13 between 2:06 PM and 3:00 PM with the Maintenance Director, revealed he was unaware of the acceptable gap around the doors.</p> <p>Observations, on 03/05/13 between 2:06 PM and 3:00 PM with the Maintenance Director, revealed the doors to resident rooms #208 and #219 did not latch when closed.</p> <p>Interview, on 03/05/13 between 2:06 PM and 3:00 PM with the Maintenance Director, revealed he was unaware these two (2) doors were not latching.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood</p>	K 018	<p>Criteria #2 The Maintenance Director will asses to ensure that the other cross corridor doors located in the smoke barriers close completely and have a gap less than 1/8" where the doors meet. This will be completed by April 20, 2012, with the first full day of compliance as April 21, 2013.</p> <p>Criteria # 3 The Maintenance Director will inservice nursing staff that when the fire alarm sounds that cross corridor's doors should close without gaps. they will be provided training to alert Maintenance if they notice a gap, and to document it in the work order system for the Maintenance Director to address. The Administrator will provide training to the Maintenance Director regarding this regulation. The Maintenance Director will also assess cross corridor doors to ensure that there is no gap more than a 1/8" gap where the doors meet, when they close. This inspection will be done one time a month as preventative maintenance, and documented on the preventative maintenance documentation sheet, by the Maintenance director. This will be completed by April 20, 2013, with first full day of compliance being April 21, 2013.</p>	

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K 018	<p>Continued From page 3</p> <p>or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.</p>	K 018	<p>Criteria # 4 The Maintenance Director, one time a month, will assess cross corridor doors to ensure a gap of less than 1/8," one time a month, as part of the Maintenance Director's preventative maintenance program. This will be completed and documented on the Preventative maintenance sheet that is documented on monthly by the Maintenance Director.</p> <p>Criteria #5 4/21/2013.</p> <p>K029 Criteria #1 Closers will be added to the Assistant Director of Nursing's office, the storage room in the kitchen, the Dietary Office, and the Medical Record Director's office. This will be completed by the Maintenance Director by April 20, 2013, with first full day of compliance being April 21, 2013.</p> <p>Criteria #2 The Maintenance Director will conduct a walk-through of the facility to ensure that rooms within the facility are properly protected due to the storage in the room. This will be completed by April 20, 2013, with first full day of compliance being April 21, 2013.</p>	
K 027 SS=F	<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 1 1/2-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.</p>	K 027	<p>Criteria #3 The Maintenance Director will, every quarter, complete a walk-through to ensure that closers are on doors to ensure that they are properly protected due to the storage in the rooms. This assessment will be documented on the Maintenance Director's preventative maintenance form, which is reviewed monthly by the Administrator.</p>	

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K 027	<p>Continued From page 4</p> <p>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 cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for Forty (40) beds with a census of Thirty-Seven (37) on the day of the survey. The facility failed to ensure three (3) sets of doors in the smoke barriers had a gap less than 1/8 inch where the doors meet.</p> <p>The findings include:</p> <p>Observation, on 03/05/13 at 1:34 PM with the Maintenance Director, revealed the cross-corridor doors located throughout the facility except at the media room would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke.</p> <p>Interview, on 03/05/13 at 1:34 PM with the Maintenance Director, revealed he was unaware the doors would not close all the way leaving a gap between the doors in the closed position.</p>	K 027	<p>Criteria #4 The Maintenance Director will, every quarter, complete a walk through to ensure that closers are on doors to ensure that the area is properly protected due to the storage in the rooms. This assessment will be documented on the Maintenance Director's preventative maintenance sheet, which is reviewed monthly by the Administrator.</p> <p>Criteria # 5 4/21/2013</p> <p>K038 Criteria #1 The Maintenance Director placed an emergency crash bar on the egress doors in the service hall, and removed the slide locks on 3/18/2013.</p> <p>Criteria #2 The Maintenance Director will ensure that egress doors and exits are maintained as indicated in NFPA standards. This will be completed as a one time walk-through to identify any further deficient practices. The Maintenance Director will check each egress door to ensure that it is in good working order. This includes ensuring that egress doors with push bars are in good functioning repair. This will be completed by April 20, 2013, with first full day of compliance being April 21, 2013.</p>		

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K 027	Continued From page 5 Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027	Criteria # 3 The Administrator will provide training to the Maintenance Director that any device or alarm installed to restrict the improper use of a means of egress shall be designed and installed so that it cannot, even in case of failure impede or prevent emergency use of such means of egress, unless otherwise provided in 7.2.1.6, and chapters 18, 19, 22, and 23. This training will be completed by April 20, 2013, with first full day of compliance being April 21, 2013.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 1/2 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The	K 029	Criteria # 4 One time a quarter the Maintenance Director will assess egress doors with push bars to ensure that they are in good working order. Documentation of this inspection will be noted on preventative maintenance sheet that is reviewed by the Administrator, monthly. Criteria # 5 4/21/2013	

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K 029	Continued From page 6 deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for Forty (40) beds with a census of Thirty-Seven (37) on the day of the survey. The facility failed to ensure four (4) rooms were properly protected due to the storage in the rooms. The findings include: Observation, on 03/05/13 between 2:00 PM and 3:00 PM with the Maintenance Director, revealed the Assistant Director of Nursing office, the dry storage room in the kitchen, the Dietary Office, and the Medical Records office did not have a closer added to the door. This requirement is due to the storage of combustible items inside the areas. Interview, on 03/05/13 between 2:00 PM and 3:00 PM with the Maintenance Director, revealed he was unaware the storage in a room determined whether the room was a hazardous storage area or not. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated	K 029	K045 Criteria #1 The Maintenance Director repaired the emergency lights on 3/18/2013 at exit, identified during Life Safety Code Survey. The emergency light currently has more than one bulb for emergency lighting. Criteria #2 The Maintenance Director will do an one-time audit to ensure that all emergency lighting at exits has more than one bulb, and is appropriately illuminated. This will be completed by April 20, 2013, with first full day of compliance being April 21, 2013. Criteria #3 The Maintenance Director, one time a month, will ensure that emergency lights at exits have more than one bulb and are appropriately illuminated. This will be documented on the Maintenance Director's preventative maintenance sheet that is turned into the Administrator once a month. Criteria #4 The Maintenance Director, one time a Month, will ensure that emergency lights at exits have more than one bulb and are appropriately illuminated. This will documented on the Maintenance Director's preventative maintenance sheet that is turned into the Administrator one time a month. Criteria # 5 4/21/2013	

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K 029	Continued From page 7 from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029	K050 Criteria #1 A fire drill will be held at an unexpected time on second and third shift by the Maintenance Director by April 20, 2013, with first full day of compliance being April 21, 2013. Criteria #2 A fire drill will be held at an unexpected time on second and third shift by the Maintenance Director by April 20, 2013, with first full day of compliance being April 21, 2013. Criteria #3 The Maintenance Director will receive training from the Administrator that fire drills are to be completed quarterly on each shift at random times, with varying conditions. The Maintenance Director will complete one drill for one shift each month to ensure that all three shifts have been provided a fire drill within the quarter. This training will be completed by April 20, 2013, with first full day of compliance being April 21, 2013. Criteria #4 One time a quarter the Maintenance Director will audit fire drill forms to ensure that a fire drill has been completed for each shift quarterly.	
K 038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	Criteria #5 4/21/2013	

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NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055		
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K 038	<p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, fifteen (15) residents, staff and visitors. The facility is certified for Forty (40) beds with a census of Thirty-Seven (37) on the day of the survey. The facility failed to ensure one egress door would open with the push bar installed on the door.</p> <p>The findings include:</p> <p>Observation, on 03/05/13 at 3:00 PM with the Maintenance Director, revealed the egress doors in the service hall had a push bar installed on the door which no longer worked. The facility added a lock over four (4) feet from the floor. A slide bolt was also added to the egress door.</p> <p>Interview, on 03/05/13 at 3:00 PM with the Maintenance Director, revealed he had installed the new latch instead of repairing the push bar hardware on the door.</p> <p>Reference: NFPA 101 (2000 ed.) 7.1.9 Impediments to Egress. Any device or alarm installed to restrict the improper use of a means of egress shall be designed and installed so that it cannot, even in case of failure, impede or prevent emergency use of such means of egress unless otherwise provided in 7.2.1.6 and Chapters 18, 19, 22, and 23.</p>	K 038	<p>K056</p> <p>Criteria # 1 The sprinkler heads located in Residents' rooms' #216, #215, #217, #224, #226, #225, corridor in front of #215, clean linen side of laundry, and the Dietary lounge that were blocked by light fixtures and speakers within one foot of sprinkler heads, extending below the sprinkler heads have been repaired. The Maintenance Director corrected issue by removing light fixtures and speakers to meet regulations. This was completed on 3/8/2013. All sprinkler heads that were identified as being blocked have been repaired. This was completed by March 8, 2013. On March 11, 2013 Premier Fire Protection was at the facility completing repairs regarding the sprinkler system. Premier completed work to ensure that the sprinkler heads matched and met regulations. Two sprinkler heads were replaced in the kitchen, two sprinkler heads were replaced in the hallway beside the call light, and in one bathroom beside the kitchen.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186410	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2013
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NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42056
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K 045 SS=E **NFPA 101 LIFE SAFETY CODE STANDARD**

Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, fifteen (15) residents, staff and visitors. The facility is certified for Forty (40) beds with a census of Thirty-Seven (37) on the day of the survey. The facility failed to ensure the emergency lights had two (2) bulbs at one (1) exit.

The findings include:

Observation, on 03/05/13 at 2:09 PM with the Maintenance Director, revealed the exterior exit at room # 211 only had a single light for illumination of the outside of the exit.

Interview, on 03/05/13 at 2:09 PM with the Maintenance Director, revealed he was unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path.

Reference: NFPA 101 (2000 edition)

K 045

Criteria #2
The Maintenance Director will complete a one time facility walkthrough to ensure that sprinkler heads are not blocked by ceiling fixtures, and that the sprinklers have the same engagement heads located in the same compartment. This will be occur one time, by April 20, 2013, with first full day of compliance being April 21, 2013.

Criteria #3
Premier Fire will complete annual visits to ensure that sprinkler heads are not blocked and that the same engagement heads are located in the same compartment. This will be coordinated annually by the Maintenance Director. Premier Fire was at the facility on 3-11-2013. The Maintenance Director will do a sprinkler head check every quarter to ensure that the heads are not blocked and that same heads are located in the same compartments. The Maintenance Director will document his findings on a log for every quarter. Any findings that violate regulations will be identified and arrangements made for repair. The Maintenance Director will be inserviced on this system by the Administrator by April 20, 2013, with first full day of compliance being on April 21, 2013.

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K 045	Continued From page 10 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	Criteria # 4 Premier Fire will complete annual visits to ensure that sprinkler heads are not blocked, and that the same engagement heads are located in the same compartment. Premier Fire was at the facility on 3-11-2013 to complete repairs to the sprinkler system, and to ensure matching heads within the same compartment.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for Forty (40) beds with a census of Thirty-Seven (37) on the day of the survey. The facility failed to complete a fire drill on a shift for two quarters in 2012. The findings include: Fire Drill review, on 03/05/13 at 12:05 PM with the	K 050	The Maintenance Director will do a sprinkler head check, every quarter, to ensure that the heads are not blocked and that same heads are located in the same compartments. The Maintenance Director will document his findings on a log every quarter. Any findings that violate regulations will be identified and arrangements made for repair.	Criteria # 5 4/21/2013

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K 050	Continued From page 11 Maintenance Director, revealed there was no fire drill completed in the 2nd quarter of 2012 on 2nd shift and in the 4th quarter of 2012 on 3rd shift. Interview, on 03/05/13 at 12:05 PM with the Maintenance Director, revealed he was unaware the fire drills were not being conducted as required. He was aware of the requirements on fire drills but he must have missed doing the drills on all shifts. Reference: NFPA 101 (2000 edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	K066 Criteria #1 River's Bend Retirement Community staff will be provided training that only approved ash trays may be used for smoking, and where approved smoking areas are located on facility grounds that contains approved ashtrays. Training will be provided that ashtrays must be of a noncombustible material, and of a safe design. Staff will also be provided training that metal containers with self-closing cover devices into which ash trays can be emptied may only be used. This training will be provided to staff by the Maintenance Director by April 20, 2013, with first full day of compliance being April 21, 2013.	
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 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 This STANDARD is not met as evidenced by: Based on observations and interview, it was	K 056	Criteria #2 River's Bend Retirement Community staff will be provided training that only approved ash trays may be used for smoking, and where approved smoking areas are located on facility grounds that contains approved ashtrays. Training will be provided that ashtrays must be of a noncombustible material and of a safe design, and that metal containers with self-closing cover devices into which ash trays can be emptied may only be used. The facility will purchase approved ash trays as indicated in the regulations. This will be completed by the Maintenance Director by April 20, 2013, with first full day of compliance being April 21, 2013. This training will be provided to staff by the Maintenance Director by April 20, 2013, with first full day of compliance being April 21, 2013.	

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K 056	<p>Continued From page 12</p> <p>determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for Forty (40) beds with a census of Thirty-Seven (37) on the day of the survey. The facility failed to ensure twelve (12) sprinkler heads were not blocked by fixtures on the ceiling and that all sprinkler heads matched in a compartment.</p> <p>The findings include:</p> <p>Observations, on 03/05/13 between 1:05 PM and 3:00 PM with the Maintenance Director, revealed the sprinkler heads located in resident rooms #210, #215, #217, #224, #226, #225, corridor in front of #215, clean linen side of laundry, and dietary lounge bathroom were blocked by light fixtures and speakers, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observation revealed the sprinklers were also blocked by fixtures in the closets of rooms #217, #225, and #219.</p> <p>Interview, on 03/05/13 between 1:05 PM and 3:00 PM with the Maintenance Director, revealed he was unaware that the light fixtures could block the spray pattern of the sprinkler head.</p> <p>Observations, on 03/05/13 between 1:05 PM and 3:00 PM with the Maintenance Director, revealed standard response sprinkler heads, a quick response sprinkler head, and high temperature heads in the same compartment located in the kitchen area.</p>	K 056	<p>Criteria #3 A sign will be placed at the employee time clock indicating where approved smoking areas are at for the facility. Ash trays that are of non-combustible material and safe design will be provided at the approved smoking area for the facility. This will be completed by the Maintenance Director by April 20, 2012, with first full day of compliance being April 21, 2013.</p> <p>Criteria #4 The Maintenance Director will, one time a month, check facility's grounds to inspect for butts that may indicate that employees are smoking in non-approved areas. If there is an evidence of this, immediate training will be provided by the Maintenance Director. One time a month the Maintenance Director will ensure that approved ash trays in approved smoking areas are emptied.</p> <p>Criteria #5 4/21/2013</p>	

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K 056	<p>Continued From page 13</p> <p>Interview, on 03/05/13 between 1:05 PM and 3:00 PM with the Maintenance Director, revealed he was not aware that the sprinklers had to have the same engagement heat if the sprinkler heads are located in the same compartment.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <thead> <tr> <th style="text-align: left;">Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th style="text-align: left;">Maximum Allowable Distance of Deflector Obstruction (in.) (B)</th> </tr> </thead> <tbody> <tr><td>Less than 1 ft</td><td>0</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>2 1/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>3 1/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>5 1/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>7 1/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>9 1/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>16 1/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </tbody> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 056	<p>K076</p> <p>Criteria #1 On 3/6/2013 the Director of Nursing contacted Med Source to remove six oxygen tanks from oxygen storage room. The oxygen room currently has 12 tanks in the oxygen room. Med Source representative came to the Facility, and tanks have been removed to ensure compliance. The Administrator also spoke with representative, Ocia Reed, on 3/8/2013, to discuss and review regulation with her, as indicated per Life Safety Code.</p> <p>Criteria #2 On 3/21/2013 the Assistant Director of Nursing inspected oxygen storage room to ensure that there continued to be a max of 12 oxygen tanks in the oxygen room, and that the facility was meeting regulations regarding cubic feet for the amount of the oxygen tanks. The Administrator and Maintenance Director also contacted the Life Safety Code Surveyor on March 21, 2013 to ensure that the facility understood the regulation.</p> <p>Criteria #3 One time a month, Administrative Nursing (which consists of the Director of Nursing and the Assistant Director of Nursing) will inspect the oxygen storage room to ensure that there are no more than 12 tanks in the oxygen room at any given time. Administrative Nursing will provide training to Licensed Nurses to ensure that at any time the oxygen storage room does not need to exceed 12 tanks. This training will be completed by April 20, 2013, with first full day of compliance being April 21, 2013.</p>	
Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)																									
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5 ft and greater	18																									

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K 056	Continued From page 14 Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall. Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. NFPA 101 LIFE SAFETY CODE STANDARD	K 056	Criteria #4 One time a month, Administrative Nursing (which consists of the Director of Nursing and the Assistant Director of Nursing) will inspect the oxygen storage room to ensure that there are no more than 12 tanks in the oxygen room at any given time. Administrative Nursing will provide training to Licensed Nurses to ensure that at any time the oxygen storage room does not need to exceed 12 tanks. This training will be completed by April 20, 2013, with first full day of compliance being April 21, 2013. Criteria #5 4/21/2013	
K 068 SS=E		K 066		

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K 066	<p>Continued From page 15</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays at an entrance, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for Forty (40) beds with a census of Thirty-Seven (37) on the day of the survey. The facility failed to ensure ashtrays were provided at all smoking areas.</p>	K 066	<p>K104</p> <p>Criteria #1 The Maintenance Director will remove fusible links, and ensure that all dampers fully close and latch. The Maintenance Director will also ensure that all moving parts are lubricated, as necessary. Inspection of the damper system will be completed by April 20, 2013, with the first full day of compliance being April 21, 2013.</p> <p>Criteria #2 The Maintenance Director will remove fusible links, and ensure that all dampers fully close and latch. The Maintenance Director will also ensure that all moving parts are lubricated, as necessary. Inspection of the damper system will be completed by April 20, 2013, with the first full day of compliance being April 21, 2013.</p> <p>Criteria #3 The Maintenance Director will inspect the damper system every 2 years. The Maintenance Director will be inserviced of this expectation by the Administrator. Inspection of the damper system will also be documented on the preventative maintenance sheet that is completed by the Maintenance Director, and reviewed monthly by the Administrator. This will be completed by April 20, 2013, with first full day of compliance being April 21, 2013.</p>	

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K 066	Continued From page 17 prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066	K147 Criteria #1 The electrical panel in the biohazard room, and the dietary janitor closet currently has at least 3 feet clearance. The Maintenance Director removed all storage from these areas that was within 3 feet on 3/6/2013. Criteria #2 On 3/21/2013 the Maintenance Director Verified, through a walk through, that there is no storage within 3 feet of electrical panels at the facility. Criteria #3 The Maintenance Director will inservice Nursing staff and Dietary Staff on not having storage within 3 feet of electrical panels in the closet. This will be done by April 20, 2013, with first full day of compliance on April 21, 2013. Criteria #4 The Maintenance Director will do inspection of electrical panel areas, one time a month, to ensure no storage within 3- feet of the electrical panel. If the Maintenance Director finds issues in audit they will be addressed immediately, and training will occur with responsible party. Inspections will be documented on preventative maintenance form by the Maintenance Director. This form is then turned into the Administrator for review one time a month. Any issues identified will be presented to the Quality Assurance Committee that meets at least quarterly.	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential	K 076	Criteria # 5 4/21/2013	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185410	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2013
NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055		
(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 076	<p>Continued From page 18</p> <p>to affect one (1) of two (2) smoke compartments, fifteen (15) residents, staff and visitors. The facility is certified for Forty (40) beds with a census of Thirty-Seven (37) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu ft. was stored 5 feet away from any combustibles and ignition sources located five (5) feet from the floor.</p> <p>The findings include:</p> <p>Observation, on 03/05/13 at 1:56 PM with the Maintenance Director, revealed eighteen (18) oxygen tanks in the oxygen storage room. The oxygen tanks were being stored within five (5) feet of combustible items.</p> <p>Interview, on 03/05/13 at 1:56 PM with the Maintenance Director, revealed he was unaware oxygen tanks could not be stored within five (5) feet of combustible materials once the storage equals over 300 cubic feet in a smoke compartment.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous</p>	K 076			

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NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055		
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K 076	Continued From page 19 oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ¼ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076			
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.	K 104			

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NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055	
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K 104	Continued From page 20 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for Forty (40) beds with a census of Thirty-Seven (37) on the day of the survey. The facility failed to ensure smoke dampers in the hvac system were being inspected. The findings include: Observation, on 03/05/13 at 12:15 PM with the Maintenance Director, revealed no documentation for fire/smoke damper testing. Interview, on 03/05/13 at 12:15 PM with the Maintenance Director, revealed that no maintenance documentation was kept on the fire/smoke dampers. He stated he has worked for the facility for (4) four years and they have been inspected while he has been there. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 104		

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NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST, KUTTAWA, KY 42055
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K 147 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for Forty (40) beds with a census of Thirty-Seven (37) on the day of the survey. The facility failed to ensure electrical panels maintained three (3) feet of clearance around them.</p> <p>The findings include:</p> <p>Observations, on 03/05/13 between 2:15 PM and 3:00 PM with the Maintenance Director, revealed the electrical panel in the biohazard room and the dietary janitor closet had storage within 3 feet of the electrical panels.</p> <p>Interview, on 03/05/13 between 2:15 PM and 3:00 PM with the Maintenance Director, revealed he was unaware there could not be storage within 3 feet of electrical panels.</p> <p>Reference: NFPA 99 (1999 edition)</p>	K 147		
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NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42055	
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K 147	Continued From page 22 110-26. Spaces 10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed. Table 110.26(A)(1) Working Spaces Nominal Voltage to Ground Minimum Clear Distance Condition 1 Condition 2 Condition 3 0-150 900 mm (3 ft) 900 mm (3 ft) 900 mm (3 ft) 151-600 900 mm (3 ft) 1 m (3½ ft) 1.2 m (4 ft) Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides affectively guarded by suitable wood or	K 147		

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NAME OF PROVIDER OR SUPPLIER RIVER'S BEND RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 300 BEECH ST. KUTTAWA, KY 42065	
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K 147	Continued From page 23 other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between. (a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided. (b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc. (c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation. (2) Width of Working Space. The width of the working space in front of the electric equipment	K 147		

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K 147	<p>Continued From page 24</p> <p>shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels.</p> <p>(3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment.</p> <p>(B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded.</p> <p>(C) Entrance to Working Space.</p> <p>(1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment.</p> <p>(2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met.</p> <p>(a) Unobstructed Exit. Where the location permits</p>	K 147		
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K 147	Continued From page 25 a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted. (b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition. (D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.	K 147			