

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

PRINTED: 12/28/2012  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/06/2012
NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A recertification survey was conducted on 12/04/12 through 12/06/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with deficiencies cited at the highest S/S of "D."	F 000	<p><b>DISCLAIMER:</b> This Plan of Correction is prepared, submitted and executed because it is required by the provisions of the state and federal law and not because Dawson Pointe, d/b/a Dawson Springs Health and Rehabilitation Center, agrees with the allegations and citations listed on the pages of the Statement of Deficiencies. Dawson Springs Health and Rehabilitation Center maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor is it of such character as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates stated. Dawson Springs Health and Rehabilitation Center has taken or will take the actions set forth in the following Plan of Correction.</p> <p>F tag: 167</p> <ol style="list-style-type: none"> <li><b>Corrective action:</b> In addition to the public copy on the Administrative hall, a copy of the most recent survey was placed within the resident area accessible to all persons along with a notice of the availability. Resident council was made aware of the location of the survey information on December 31, 2012. (See Exhibit #1 and 1a)</li> <li><b>ID of Other Residents at Risk:</b> All residents can be considered affected with no adverse consequences noted in a survey of interviewable residents conducted by Social Services on December 31, 2012. (See Exhibit #2)</li> </ol>	
F 167 SS-C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE  A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.  The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure results of the most recent Federal/State survey were readily accessible to the residents within the facility. On 12/04/12, the facility had a census of 57 residents. The residents were unable to review past survey results located on the administrative hall.  Findings Include:  Observations of the facility, on 12/04/12 through 12/06/12, revealed the Federal/State survey results were housed in a binder located on a table	F 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *1-4-13*

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 those 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 167	Continued From page 1 on the administrative hall.  Interview of three alert and oriented residents during the group interview, on 12/04/12 at 2:15 PM, revealed three of the five attendees expressed they were unaware that they could view past survey results. Additionally, the residents revealed they did not know the location of the survey results within the facility.  Interview with the Director of Nursing (DON), on 12/06/12 at 4:50 PM, revealed the survey results were located on the administrative hall. She acknowledged that the survey results should be accessible to the residents, and stated if a resident wanted to view the survey results, then "we would get them."	F 167	3. <b>Prevention Measures:</b> Along with the current survey information, all subsequent survey information will be made available to the public and to the residents by providing the copies in the Administrative hall and in the resident area.  4. <b>Monitor:</b> Availability of survey information will be monitored by members of the QA/PI Team that includes the Administrator, the DON, QA Nurse and the Social Services Director, and reported daily in the M-F QA Daily meetings by the Social Services Director x 1 month then monthly in the QA Committee meeting consisting of members including the Medical Director, the Administrator, the DON, QA Nurse and the Social Services Director, for a total reporting period of twelve months.	
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, and review of the facility's policy and procedure, it was determined the facility failed to promote care for residents in a manner and an environment that maintained or enhanced the resident's dignity and respect for one resident (#16), not in the selected sample.  Findings include:	F 241	5. <b>Date Corrected:</b> 1-1-13  F tag 241  1. <b>Corrective Action:</b>  Resident #16, a non-oriented resident, was taken to their room for incontinent care and CNA #1 received disciplinary	

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F 241	<p>Continued From page 2</p> <p>A review of the facility's Dignity policy and procedure, no date, revealed the facility should 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.</p> <p>Observation during the noon meal, on 12/05/12 at 12:25 PM, revealed Certified Nurse Aide (CNA) #1 approached Resident #16, took the resident by the hand and leaned over to the resident's hip level and "sniffed." He called for another CNA to assist him to escort the resident to his/her room to provide incontinent care. There were other residents and staff on the hall at the time.</p> <p>An interview with CNA #1, on 12/06/12 at 12:55 PM, revealed he was on the hall and smelled an odor. He stated he knew incontinent care was provided to Resident #16, so he did not think the odor came from him/her, but to be sure, he leaned over and "sniffed" to determine if the odor came from the resident. He stated he did this when he was not sure where the odor was coming from. He stated he tried to make it appear as though he was checking the resident's shoes.</p> <p>An interview with the Director of Nursing (DON) and Registered Nurse (RN) #1, on 12/06/12 at 1:00 PM and 2:00 PM, respectively, revealed staff should take the resident to his/her room and assist the resident to bed to check for incontinence. The DON and RN stated the staff member who bent over on the hall to "smell the resident" was a dignity issue.</p>	F 241	<p>action and re-education from the DON regarding promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity.</p> <p>2. ID of Other Residents at Risk: All residents can be potentially be effected by the actions of a CNA with no adverse consequences noted in a survey of interviewable residents conducted by Social Services on December 31, 2012.</p> <p>3. Prevention Measures: Inservice on Resident Dignity for Nursing personnel (including NASR's and licensed staff) was conducted by the DON 12-30-12 thru 1-4-13. Inservice also conducted for Licensed nursing staff by DON 12-30-12 thru 1-4-13 regarding the monitoring of resident dignity.</p> <p>4. Monitor: Charge Nurses will monitor resident dignity on their regular shift rounds, correct any issues immediately and report any adverse actions to the DON daily. DON will report to QA/PI team consisting of the Administrator, DON,</p>	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

Dawson Pointe, LLC

#185263

Survey Completion Date: 12/06/2012

F241 continued

QA Nurse and Social Services Director in daily meetings M-F any issues identified. DON or Administrator will report to monthly QA Committee consisting of members including the Medical Director, the Administrator, the DON, the QA Nurse and the Social Services Director x 12 months and ongoing regarding dignity issues identified and corrected.

5. Date Corrected: 1-5-13

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F 315	Continued From page 3  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, and review of the facility's policy and procedure, it was determined the facility failed to ensure residents who were incontinent received the appropriate care and services to prevent urinary tract infections (UTI) for one resident (#4), in the selected sample of 15 residents, and one resident (#16), not in the selected sample. Two Certified Nurse Aides (CNAs) provided incontinent care for Resident #4 and Resident #16 as the residents were standing, which prevented the CNAs from being able to see and ensure the residents were clean in order to decrease the risk of the residents developing a UTI.  Findings include:  A review of the facility's Diarrhea and Fecal Incontinence policy and policy, last revised April 2007, revealed incontinent care should be provided with resident laying in bed. A review of a facility inservice, dated 11/16/12, revealed	F 316	F tag 315  1. Corrective Action:  Resident #4 Proper incontinent care observed by DON on 12-6-12 when made aware of improper care provided. Resident #16 Proper incontinent care observed by DON on 12-6-12 when made aware of improper care provided.  2. ID of Other Residents at Risk:  All residents can be potentially be effected by the actions of NASR's with no adverse consequences noted in a review of incontinent residents conducted by the QA Nurse beginning December 6, 2012 thru December 12, 2012.  3. Prevention Measures:  Inservice on incontinent care for Nursing personnel (including NASR's and licensed staff) was conducted by the DON 12-30-12 thru 1-4-13.  (See Exhibit #4, Inservice)		

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F 315	Continued From page 4 education was provided to staff which included a female resident's labia should be separated with one hand and cleansed with one hand with downward strokes.  Observation of incontinent care for Resident #4, on 12/04/12 at 9:05 AM, revealed CNA #1 and another aide were providing incontinent care to the resident while the resident stood up. When the surveyor entered the room, the CNAs and Resident #4 were behind the curtain. Resident #4 was standing and the resident's pants were down around his/her ankles. The brief was undone and pulled out from between the resident's legs. The brief contained feces and there was feces on the resident's bottom. Staff cleaned the resident's bottom with wet wipes. Observation revealed the CNAs did not clean between the resident's legs. The resident was assisted to sit in the bedside recliner, and the resident's soiled hipsters and pants were removed. Clean hipsters and pants were applied.  Observation of incontinent care for Resident #16, on 12/05/12 at 12:25 PM, revealed CNA #1 and another CNA provided incontinent care to Resident #16 while the resident was standing. The surveyor followed two CNAs and Resident #16 to his/her room. CNA #1 shut the door and pulled the curtain around the resident as he/she was standing. The CNAs proceeded to pull the resident's pants down to his/her ankles with the resident still standing. The second CNA took the brief and pulled it out from between the resident's legs. The brief contained feces and there was feces on the resident. CNA #1 provided incontinent care by using a wet wipe. He pushed the wet wipe through the resident's legs, and took	F 315	Inservice also conducted for Licensed nursing staff by DON 12-30-12 thru 1-4-13 regarding the monitoring of incontinent care.  4. Monitor: Charge Nurses will monitor resident incontinent care during their regular shift rounds, correct any issues immediately and report any adverse actions to the DON daily. DON will report to QA/PI team consisting of the Administrator, DON, QA Nurse and Social Services Director in daily meetings M-F any issues identified. DON or Administrator will report to monthly QA Committee consisting of members including the Medical Director, the Administrator, the DON, the QA Nurse and the Social Services Director x 12 months and ongoing regarding incontinent care issues identified and corrected.  5. Date Corrected:	1-5-13	

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F 315	<p>Continued From page 5</p> <p>the wet wipe out from the back while the resident was standing. CNA #1 did this several times. A clean brief was placed on the resident and the resident's pants were pulled up.</p> <p>Interview with CNA #1, on 12/06/12 at 12:55 PM, revealed if a resident was able to stand, then staff would sometimes provide incontinent care while the resident was standing. He stated Resident #4 and Resident #16 were able to stand and the residents did not "squeeze their legs together," so staff was able to provide incontinent care and clean the resident properly.</p> <p>Interview with the Director of Nursing (DON) and Registered Nurse #1, on 12/06/12 at 1:00 PM and 2:00 PM, respectively, revealed staff should lay a resident down in the bed to provide incontinent care. The DON and RN #1 stated staff would not be able to see and thoroughly clean a resident when providing incontinent care while the resident was in a standing position. The DON stated this could place the resident at risk for a UTI.</p>	F 315			

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K 000	INITIAL COMMENTS  CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1962 Remodeled: 1971 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III (211) SMOKE COMPARTMENTS: Four (4) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1962 and upgraded in 2008, with 35 smoke detectors and 32 heat detectors. SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 2007. EMERGENCY POWER: Type II Diesel Generator. A life safety code survey was initiated and concluded on 12/06/12. Dawson Pointe was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for fifty-nine (59) beds with a census of fifty-seven (57) on the day of the survey.  The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	DISCLAIMER: This Plan of Correction is prepared, submitted and executed because it is required by the provisions of the state and federal law and not because Dawson Pointe, d/b/a Dawson Springs Health and Rehabilitation Center, agrees with the allegations and citations listed on the pages of the Statement of Deficiencies. Dawson Springs Health and Rehabilitation Center maintains that the alleged deficiencies do not jeopardize the health and safety of residents, nor is it of such character as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates stated. Dawson Springs Health and Rehabilitation Center has taken or will take the actions set forth in the following Plan of Correction.	
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches	K 027		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 1-4-13

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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K 027	<p>Continued From page 1</p> <p>from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure 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 four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for fifty-nine (59) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure three (3) cross corridors doors would close properly once the fire alarm released them from the magnetic locks.</p> <p>The findings include:</p> <p>Observation, on 12/06/12 between 1:00 PM and 3:00 PM with the Maintenance Director, revealed the cross-corridor doors located in 100, 200, and 300 halls would not close completely when tested. This was due to the doors not having a coordinating device installed on the doors. The doors released properly from the magnetic locks but once closed the doors would not operate properly.</p> <p>Interview, on 12/06/12 between 1:00 PM and 3:00 PM with the Maintenance Director, revealed he</p>	K 027	<p>F tag: K 027</p> <ol style="list-style-type: none"> <li><b>Corrective action:</b> Coordinating devices for cross-corridor doors located in 100, 200, and 300 halls ordered on January 2, 2013 for installment upon arrival by Maintenance Dept.</li> <li><b>ID of others at risk:</b> All residents considered at risk in the event of a fire or emergency, however, no adverse indications identified at this time.</li> <li><b>Prevention measures:</b> Coordinating devices located on all corridor doors upon arrival.</li> <li><b>Monitor:</b> Maintenance Dept will monitor corridor door operation through Life Safety QA Tool and report monthly in QA meeting x 3 months, then quarterly.</li> <li><b>Date Corrected:</b></li> </ol>	1-3-13
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K 027	Continued From page 2 was unaware the doors needed a coordinating device to ensure the door without the astragal would always close first. .  Reference: NFPA 101 (2000 edition) 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.  Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027		
K 029 SS=E	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. NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ 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	K 029		

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K 029	<p>Continued From page 3</p> <p>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</p> <p>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 deficiency had the potential to affect three (3) of four (4) smoke compartments, thirty-nine (39) residents, staff and visitors. The facility is certified for fifty-nine (59) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure six (6) rooms with hazardous storage had the proper door closer for separation.</p> <p>The findings include:</p> <p>Observation, on 12/06/12 between 1:00 PM and 3:00 PM with the Maintenance Director, revealed:</p> <ol style="list-style-type: none"> <li>1) The business office did not have a door closer installed due to the excess combustible storage in the room.</li> <li>2) The MDS office did not have a door closer installed due to the excess combustible storage in the room.</li> <li>3) The computer room did not have a two (2) door closers installed due to the excess combustible storage in the room.</li> <li>4) Room # 107 did not have a door closer installed due to the excess combustible storage in</li> </ol>	K 029	<p>F tag: K 029</p> <ol style="list-style-type: none"> <li>1. <b>Corrective action:</b> Proper, self-closing devices for doors in rooms containing hazardous storage including             <ol style="list-style-type: none"> <li>1) Business Office</li> <li>2) MDS Office</li> <li>3) Computer/IT Room x 2</li> <li>4) Room #107/Activities</li> <li>5) Room #112/Financial</li> <li>6) Linen Room on 300 hall ordered on January 2, 2013 for installment upon arrival by Maintenance Dept.</li> </ol> </li> <li>2. <b>ID of others at risk:</b> All residents considered at risk in the event of a fire or emergency, however, no adverse indications identified at this time.</li> <li>3. <b>Prevention measures:</b> Proper self-closing devices located on all doors to room containing hazardous storage.</li> <li>4. <b>Monitor:</b> Maintenance Dept will monitor door operations including rooms with hazardous storage through Life Safety QA Tool and report monthly in QA meeting x 3 months, then quarterly.</li> <li>5. <b>Date Corrected:</b></li> </ol>	1-3-13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186263	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/06/2012
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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408
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K 029	<p>Continued From page 4 the room. 5) Room # 112 did not have a door closer installed due to the excess combustible storage in the room. 6) The linen room on 300 hall did not have a door closer installed due to the excess combustible storage in the room and the door swung open into the corridor.</p> <p>Any room larger than 50 square feet with substantial combustible material must have a door that resists the passage of smoke and a closing device.</p> <p>Interview, on 12/06/12 between 1:00 PM and 3:00 PM with the Maintenance Director, revealed he was not aware the areas listed above were considered hazardous storage thus requiring a door, a self-closer, and separation.</p> <p>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 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</p>	K 029		
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K 029	Continued From page 5 (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	F tag: K 056  1. <b>Corrective action:</b> Nurse Station sprinkler head ordered on January 2, 2013 for installment upon arrival by Armor Fire Protection Company.  Kitchen quick response sprinkler heads ordered thru Armor on January 2, 2013 for coordination of the sprinkler heads in the same compartment.  2. <b>ID of others at risk:</b> All residents considered at risk in the event of a fire or emergency, however, no adverse indications identified at this time.  3. <b>Prevention measures:</b> Coordinating sprinkler heads are located in the same compartments throughout the building with installation of the kitchen quick response heads upon arrival.  4. <b>Monitor:</b> Maintenance Dept will monitor sprinkler head operation throughout the building utilizing the Life Safety QA Tool and report monthly in QA meeting x 3 months, then quarterly.  5. <b>Date Corrected:</b>	
K 056 SS=E	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	K 056		

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K 056	<p>Continued From page 6</p> <p>This STANDARD Is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, twenty (20) residents, staff and visitors. The facility is certified for fifty-nine (59) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure all areas of the building had proper sprinkler coverage.</p> <p>The findings include:</p> <p>Observation, on 12/06/12 at 2:10 PM with the Maintenance Director, revealed the nurses ' station on 300 hall did not have sprinkler protection in the new part of the station.</p> <p>Interview, on 12/06/12 at 2:10 PM with the Maintenance Director, revealed he was not aware the nurses ' station did not have proper sprinkler protection.</p> <p>Observations, on 12/06/12 between 1:00 PM and 3:00 PM with the Maintenance Director, revealed a standard response sprinkler head and a quick response sprinkler head in the same compartment, located in the Kitchen, the kitchen cooking area, and room # 204. This deficiency would not allow both sprinkler heads to engage at the same heat level.</p> <p>Interview, on 12/06/12 between 1:00 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</p>	K 056			

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K 056	Continued From page 7 located in the same compartment.  Reference: NFPA 13 (1999 Edition)  5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.  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	K 056		

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K 056	Continued From page 8 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.	K 056	F tag: K 062  1. <b>Corrective action:</b> Replacement sprinkler heads for the financial bathroom, women's bath on 200 hall, kitchenette, rooms 316, 313, 311, and 306 ordered on January 2, 2013 for installment upon arrival by Armor Fire Protection Company.  2. <b>ID of others at risk:</b> All residents considered at risk in the event of a fire or emergency, however, no adverse indications identified at this time.  5. <b>Prevention measures:</b> Sprinkler heads free from corrosion, foreign materials, paint and physical damage are located throughout the building with installation of the new heads upon arrival.  6. <b>Monitor:</b> Maintenance Dept will monitor sprinkler heads throughout the building utilizing the Life Safety QA Tool and report monthly in QA meeting x 3 months, then quarterly.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.6  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler	K 062	5. <b>Date Corrected:</b>	1-3-13

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K 062	Continued From page 9 heads were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for fifty-nine (59) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure sprinkler heads were free from paint and corrosion.  The findings include:  Observations, on 12/06/12 between 1:00 PM and 3:00 PM with the Maintenance Director, revealed the sprinkler heads in the financial bathroom, women ' s bath on 200 hall, kitchenette, rooms# 316, 313, 311, and 306 had paint on the sprinkler head.  Interview, on 12/06/12 between 1:00 PM and 3:00 PM with the Maintenance Director, revealed he was aware the sprinkler heads could not have paint on them. The facility was in the process of changing a few of the sprinkler heads at a time.  Reference: NFPA 25 (1998 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062			
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10	K 064			

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K 064	Continued From page 10  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the installation of portable fire extinguishers per NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, sixteen (16) residents, staff and visitors. The facility is certified for fifty-nine (59) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure two (2) fire extinguishers in the facility were mounted below five (5) feet above the surface of the floor.  Findings include:  Observations, on 12/06/12 at 2:30 PM with the Maintenance Director, revealed the wall mounted, portable fire extinguishers located on 300 hall were mounted above the maximum allowable height of five (5) feet above the finish floor.  Interview, on 12/06/12 at 2:30 PM with the Maintenance Director, revealed that he was unaware of the height limitations for wall mounted portable fire extinguishers and acknowledged that they were mounted above the height of five (5) feet above the finish floor.  Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m)	K 064	F tag: K 064  1. <b>Corrective action:</b> Portable fire extinguishers located on 300 hall were re-mounted and lowered to comply with the maximum allowed height of 5 ft above the finish floor by the Maintenance Department on 12-31-12.  2. <b>ID of others at risk:</b> All residents considered at risk in the event of a fire or emergency, however, no adverse indications identified at this time.  3. <b>Prevention measures:</b> All portable fire extinguishers are mounted to comply with the maximum allowed height of 5 ft above the finish floor.  4. <b>Monitor:</b> Maintenance Dept will monitor the location of portable fire extinguishers throughout the building utilizing the Life Safety QA Tool and report monthly in QA meeting x 3 months, then quarterly.  5. <b>Date Corrected:</b>	1-3-13

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408
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K 064	Continued From page 11 above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064		
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:  (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.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.  (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  This STANDARD is not met as evidenced by:	K 066		

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K 066	Continued From page 12 Based on observation and interview, it was determined the facility failed to ensure the use of ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, twenty (20) residents, staff and visitors. The facility is certified for fifty-nine (59) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure they had a self-closing metal container to dump ashtrays into.  The findings include:  Observation, on 12/06/12 between 1:50 PM and 3:00 PM with the Maintenance Director, revealed the ashtrays located at the resident smoking area and the employee smoking area did not have a metal container with a self-closing lid to dispose of the cigarette butts.  Interview, on 12/06/12 between 1:50 PM and 3:00 PM with the Maintenance Director, revealed he was not aware of the requirement for self-closing metal bucket to empty the ashtrays into.  Reference: NFPA Standard 101 (2000 Edition), 19.7.4 Smoking (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	F tag: K 066  1. <b>Corrective action:</b> Obtained and placed metal self-closing containers for ashes and cigarette butts in smoking areas on 12-30-12.  2. <b>ID of others at risk:</b> All residents considered at risk in the event of a fire or emergency, however, no adverse indications identified at this time.  3. <b>Prevention measures:</b> Metal self-closing containers for ashes and cigarette butts are in all smoking areas on 12-30-12.  4. <b>Monitor:</b> Maintenance Dept will monitor the location of self-closing metal ash containers throughout the building utilizing the Life Safety QA Tool and report monthly in QA meeting x 3 months, then quarterly.  5. <b>Date Corrected:</b>	
K 068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2	K 068		12-31-12

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408	
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K 068	Continued From page 13  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure combustion air and ventilation for boilers, incinerators, and heater rooms were installed in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, one (1) resident, staff and visitors. The facility is certified for fifty-nine (59) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure the gas fired hot water heater in the kitchen was taking air directly from the outside.  The findings include:  Observation, on 12/06/12 between 1:00 PM and 3:00 PM with the Maintenance Director, revealed the gas fired hot water heater in the kitchen did not have a vent to the outside of the facility to ensure the hot water heater could take air from the outside.  Interview, on 12/06/12 between 1:00 PM and 3:00 PM with the Maintenance Director, revealed he was unaware the gas fired hot water heater must have an air supply directly from the outside of the facility.  Reference: NFPA 101 Life Safety Code (2000 edition)  Section 19.5 Building Services	K 068	F tag: K 068  1. <b>Corrective action:</b> McGregor Plumbing placed a vent to the outside of the kitchen's gas fired hot water heater on 12-30-12 so as to accommodate the intake of air from the outside.  2. <b>ID of others at risk:</b> All residents considered at risk in the event of a fire or emergency, however, no adverse indications identified at this time.  3. <b>Prevention measures:</b> Vent is now located for the kitchen's gas fired hot water heater so as to accommodate the intake of air from the outside.  4. <b>Monitor:</b> Maintenance Dept will monitor air intake for the kitchen's gas fired hot water heater utilizing the Life Safety QA Tool and report any issues monthly in QA meeting x 3 months, then quarterly.  5. <b>Date Corrected:</b>	12-31-12

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408	
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K 068	Continued From page 14 19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtenances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure. NFPA 101 LIFE SAFETY CODE STANDARD	K 068	F tag: K 147	
K 147 SS=D	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	<ol style="list-style-type: none"> <li><b>Corrective action:</b> <ol style="list-style-type: none"> <li>1) Extension cord removed from Business Office calculator.</li> <li>2) Refrigerator was relocated and plugged into a wall outlet.</li> <li>3) GFI plug installed for the dishwasher hot water heater booster located in the kitchen and standard plug removed.</li> <li>4) Maintenance Office moved to 100 hall allowing clearance of at least 3 ft for electrical panels.</li> </ol> </li> <li><b>ID of others at risk:</b> All residents considered at risk in the event of a fire or emergency, however, no adverse indications identified at this time.</li> <li><b>Prevention measures:</b> The extension cord was removed from the Business Office calculator. The refrigerator in PT was relocated and plugged into a wall outlet. A GFI plug was installed for dishwasher hot water heater booster located in the kitchen and standard plug removed. The Maintenance Office relocated to 100 hall allowing clearance of at least 3 ft for existing electrical panels.</li> </ol>	
	<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 four (4) smoke compartments, one (1) resident, staff and visitors. The facility is certified for fifty-nine (59) beds with a census of fifty-seven (57) on the day of the survey. The facility failed to ensure there were no extension cords in use, one (1) electrical plug was the proper type, and electrical panels were clear by three (3) feet</p> <p>The findings include:</p>			

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K 147	<p>Continued From page 15</p> <p>Observations, on 12/06/12 between 1:00 PM and 3:00 PM with the Maintenance Director, revealed:</p> <ol style="list-style-type: none"> <li>1) A calculator was plugged into an extension cord in the business office.</li> <li>2) A refrigerator was plugged into an extension cord that was plugged into a power strip in the therapy area.</li> <li>3) A small hot water heater in the kitchen was plugged into a standard outlet above the sink.</li> <li>4) Three (3) electrical panels in the maintenance office did not have three (3) feet of clearance around them.</li> </ol> <p>Interview, on 12/06/12 between 1:00 PM and 3:00 PM with the Maintenance Director, revealed he was unaware of the extension cords in the offices. Further interview revealed he was unaware of the clearance for the electrical panels and the plug in the kitchen was not the proper plug.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>NFPA 70 400-8 ( Extensions Cords) Uses Not Permitted.</p>	K 147	<ol style="list-style-type: none"> <li>4. <b>Monitor:</b> Maintenance Dept will monitor for extension cords, the need for GFI plugs and the clearance of electrical panels, utilizing the Life Safety QA Tool and report any issues monthly in QA meeting x 3 months, then quarterly.</li> <li>5. <b>Date Corrected:</b></li> </ol>	1-3-13	

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408	
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K 147	<p>Continued From page 16</p> <p>Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <p>(1) As a substitute for the fixed wiring of a structure</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(4) Where attached to building surfaces</p> <p>National Electric Code, relating to ground fault protection for electric outlets near sinks in resident rooms. NFPA: 70 210.8 Receptacles installed under the exceptions to 210.8(A)(5) shall not be considered as meeting the requirements of 210.52(G).</p> <p>(6) Kitchens - where the receptacles are installed to serve the countertop surfaces</p> <p>(7) Wet bar sinks - where the receptacles are installed to serve the countertop surfaces and are located within 1.8 m (6 ft) of the outside edge of the wet bar sink.</p> <p>Reference NFPA 70 (1999 edition) 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel. FPN: See 215.9 for ground-fault circuit-interrupter protection for personnel on feeders. (A) Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in (1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Garages, and also accessory buildings that</p>	K 147		

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K 147	<p>Continued From page 17</p> <p>have a floor located at or below grade level not intended as habitable rooms and limited to storage areas, work areas, and areas of similar use</p> <p>Exception No. 1: Receptacles that are not readily accessible.</p> <p>Exception No. 2: A single receptacle or a duplex receptacle for two appliances located within dedicated space for each appliance that, in normal use, is not easily moved from one place to another and that is cord-and-plug connected in accordance with 400.7(A)(6), (A)(7), or (A)(8). Receptacles installed under the exceptions to 210.8(A)(2) shall not be considered as meeting the requirements of 210.52(G).</p> <p>(3) Outdoors Exception: Receptacles that are not readily accessible and are supplied by a dedicated branch circuit for electric snow-melting or deicing equipment shall be permitted to be installed in accordance with the applicable provisions of Article 426.</p> <p>(4) Crawl spaces - at or below grade level (5) Unfinished basements - for purposes of this section, unfinished basements are defined as portions or areas of the basement not intended as habitable rooms and limited to storage areas, work areas, and the like</p> <p>Exception No. 1: Receptacles that are not readily accessible.</p> <p>Exception No. 2: A single receptacle or a duplex receptacle for two appliances located within dedicated space for each appliance that, in normal use, is not easily moved from one place to another and that is cord-and-plug connected in accordance with 400.7(A)(6), (A)(7), or (A)(8).</p> <p>Exception No. 3: A receptacle supplying only a permanently installed fire alarm or burglar alarm</p>	K 147		

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K 147	Continued From page 18 system shall not be required to have ground-fault circuit-interrupter protection. Receptacles installed under the exceptions to 210.8(A)(5) shall not be considered as meeting the requirements of 210.52(G). (6) Kitchens - where the receptacles are installed to serve the countertop surfaces (7) Wet bar sinks - where the receptacles are installed to serve the countertop surfaces and are located within 1.8 m (6 ft) of the outside edge of the wet bar sink. (8) Boathouses (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in (1), (2), and (3) shall have ground-fault circuit-interrupter protection for personnel: (1) Bathrooms (2) Rooftops Exception: Receptacles that are not readily accessible and are supplied from a dedicated branch circuit for electric snow-melting or deicing equipment shall be permitted to be installed in accordance with the applicable provisions of Article 426. (408.8 Receptacles in Damp or Wet Locations. (A) Damp Locations. A receptacle installed outdoors in a location protected from the weather or in other damp locations shall have an enclosure for the receptacle that is weatherproof when the receptacle is covered (attachment plug cap not inserted and receptacle covers closed). An installation suitable for wet locations shall also be considered suitable for damp locations. A receptacle shall be considered to be in a location protected from the weather where located under roofed open porches, canopies, marquees, and the like, and will not be subjected	K 147			

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K 147	Continued From page 19 to a beating rain or water runoff. (B) Wet Locations. (1) 15- and 20-Ampere Outdoor Receptacles. 15- and 20-ampere, 125- and 250-volt receptacles installed outdoors in a wet location shall have an enclosure that is weatherproof whether or not the attachment plug cap is inserted. (2) Other Receptacles. All other receptacles installed in a wet location shall comply with (a) or (b): (a) A receptacle installed in a wet location where the product intended to be plugged into it is not attended while in use (e.g., sprinkler system controller, landscape lighting, holiday lights, and so forth) shall have an enclosure that is weatherproof with the attachment plug cap inserted or removed. (b) A receptacle installed in a wet location where the product intended to be plugged into it will be attended while in use (e.g., portable tools, and so forth) shall have an enclosure that is weatherproof when the attachment plug is removed. (C) Bathtub and Shower Space. A receptacle shall not be installed within a bathtub or shower space.  3) Kitchens  Reference: NFPA 99 (1999 edition) 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	K 147		

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K 147	<p>Continued From page 20</p> <p>lock and key shall be considered accessible to qualified persons.</p> <p>(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.</p> <p>(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.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="3">Minimum Clear Distance</th> </tr> <tr> <th></th> <th>Condition 1</th> <th>Condition 2</th> <th>Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td></td> <td>900 mm (3 ft)</td> <td>1 m (3½ ft)</td> </tr> <tr> <td></td> <td></td> <td></td> <td>1.2 m (4 ft)</td> </tr> </tbody> </table> <p>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 effectively guarded by suitable wood or 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</p>	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)	K 147		
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)																					

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408
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K 147	Continued From page 21 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 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. (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,	K 147		
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K 147	<p>Continued From page 22</p> <p>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 a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted.</p> <p>(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</p>	K 147		
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K 147	Continued From page 23 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		
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