

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

PRINTED: 01/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185279	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/20/2012
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NAME OF PROVIDER OR SUPPLIER  MILLS HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 BECK LANE MAYFIELD, KY 42066
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A standard health survey was conducted 12/18/12 through 12/20/12 and a Life Safety Code survey was conducted on 12/18/12. Deficiencies were cited with the highest scope and severity of an "F" with the facility having no opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
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, and facility policy review, it was determined the facility failed to maintain water temperatures of 100 to 110 degrees Fahrenheit (F.) in four (4) of eleven (11) sampled resident rooms.  The finding include:  Review of the facility's policy regarding Environment Maintenance Administrative Guidelines, dated 12/05/12, revealed the maintenance program monitored the facility's heating, cooling, plumbing, water, gas, electrical, mechanical, oxygen, painting and heavy cleaning of the facility. The policy did not capture the	F 323	<u>F-323</u> <u>483.25(h) Free of Accident Hazards/Supervision/Devices</u>  It is the practice of Mills Health and Rehab to maintain the facility in a manner that the resident environment remains as free of hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents.  <u>Corrective Measures for Resident Identified in the deficiency:</u> Resident A had a skin assessment completed by the licensed nurse on 12/18/12 with no indication of burns or trauma. Resident B had a skin assessment completed by the licensed nurse on 12/24/12 with no indications of burns or trauma. Resident C had a skin assessment completed by the licensed nurse on 12/24/12 with no indications of burns or trauma. The water heater serving residents rooms of 2102, 2104, 2117, and 2119 were adjusted to lower the water temperature. Water temperatures in those rooms were checked on 12/19/12 by the administrator and all were in normal range of between 100-110 degrees. The identified rooms were thoroughly checked for the presence of potential hazards by the Administrator and the Plant Service Director on 12/18/12. Any identified concerns or potential hazards were corrected or removed.	12/25/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X [Signature]</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 2-1-13</i>
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any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her 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 323	<p>Continued From page 1</p> <p>parameters for water temperatures in resident rooms or shower rooms.</p> <p>Observations, on 12/18/12 at 3:45 PM, revealed a water temperature of 111.3 degrees F. in Room 2102; a water temperature of 112.2 degrees F. in Room 2104; a water temperature of 111.3 degrees F. in Room 2117; and a water temperature of 110.3 degrees F. in Room 2119.</p> <p>Observations, on 12/18/12 at 5:00 PM, revealed the water temperature in Room 2102 at 116.0 degrees F.; Room 2104 at 116.9 degrees F.; Room 2117 at 114.4 degrees F.; and Room 2119 at 113.1 degrees F.</p> <p>Observations, on 12/18/12 at 5:25 PM, revealed Room 2102 water temperature at 98.6 degrees F.; Room 2104 water temperature at 98.4 degrees F.; Room 2117 water temperature at 98.7 degrees F.; and Room 2119 water temperature at 97.7 degrees F.</p> <p>Record Review of the most recent Minimum Data Set (MDS) assessments for unsampled residents A, B, and C revealed all three (3) unsampled resident had a Brief Interview for Mental Status (BIM) score of eleven (11) or above. Residents with a score of eleven (11) or above are considered interviewable.</p> <p>Interview with Unsampled Resident A, on 12/18/12 at 4:00 PM, Unsampled Resident B at 4:05 PM, and Unsampled Resident C, on 12/20/12 at 10:00 AM, revealed these residents used the bathroom sink in the room for self grooming.</p>	F 323	<p><b>F-323 (cont)</b></p> <p><u>How other residents who may have been affected by this practice were identified:</u></p> <p>All residents in rooms served by that water heater had the potential to be affected by the practice. Water temperatures in areas accessible by residents and all resident rooms in the facility were checked on 12/19/12. On the East Side Wing, rooms 1101 through 1127 and also all resident rooms on the West Side Wing rooms 2101 through 2127 were checked by the Administrator and the Plant Service Director and all of these water temperatures were found to be within acceptable range of 100-110 degrees on 12/19/12.</p> <p>The staff were informed to not use water in any resident room in the facility until further direction from the Administrator and the Plant Service Director.</p> <p>Skin assessments for all residents completed prior to 12/19/12 were checked and there was no indication of any burns or trauma. There were no resident complaints of water being too hot or burns. In addition there were no staff member complaints of any burns or injuries from water temperatures.</p> <p>The facility rooms were also assessed by the Administrator and Plant Service Director on 12/19/12. On the East Side Wing, rooms 1101 through 1127 and also all resident rooms on the West Side Wing rooms 2101 through 2127 to verify that they were as free of hazards as was possible by the Administrator and Plant Service Director</p>	

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F 323	<p>Continued From page 2</p> <p>Interview with the Assistant Plant Service Director (APSD) on 12/18/12 at 4:10 PM, revealed the facility's policy was to keep the water temperatures in the residents' rooms between 105 to 110 degrees Fahrenheit. The APSD confirmed residents could get burned if water temperatures were greater than 110 degrees Fahrenheit.</p> <p>Interview the Administrator, on 12/18/12 at 5:05 PM, revealed the the Plant Service Technician (PST) must have turned the hot water temperature regulator dial the wrong way for the temperatures to be as high as 116.9 degrees Fahrenheit. The Administrator confirmed residents could be burned with water temperatures this high. Continued interview at 5:30 PM, revealed water temperatures between 97.7 and 98.6 degrees Fahrenheit were too low and would be uncomfortable for the residents. The Administrator confirmed the water temperatures in the residents' rooms should be between 105 to 110 degrees Fahrenheit.</p>	F 323	<p><b>F-323 (cont)</b></p> <p><u>Measures implemented or Systems altered to Prevent Re-occurrences:</u></p> <p>The policy in the facility for monitoring water was modified to include the requirement to maintain the water temperatures within state and or federal guidelines.</p> <p>The Assistant Plant Service Director and Plant Service Director and maintenance employee were re-educated by the Administrator on acceptable water temperature range according to regulatory requirements and how to properly turn and set the regulator to set the temperature on the 12/18/12. Additional thermometers were purchased on 12/18/12 by the maintenance staff to promote efficiency with the monitoring of the water temperatures.</p> <p>The water temperatures will be checked daily 5 X per week in a minimum of 6 randomly selected resident rooms on an ongoing basis by the Director or Assistant Director of Plant Services or maintenance employee and reported to the Administrator on a daily basis to verify that water temperatures are within acceptable range.</p> <p>An interdisciplinary audit tool has been developed which will be completed monthly to evaluate 26 resident rooms for any potential hazards including environmental hazards. This will be completed by Administrative Staff, Social Services, Activities, and Plant Services. The results will be reported to the Administrator and also in the monthly QA meeting and will be on-going.</p> <p>If any concerns are identified they will be reported to the Administrator and corrected immediately. The frequency or duration of the audit may be increased to validate ongoing compliance. In addition re-education/discipline will result.</p>	

F-323 (cont)

**Monitoring Measures Implemented to  
Maintain Ongoing Compliance:**

The Director or Assistant Director of Plant Services or maintenance employee will randomly audit water temperatures in 26 resident rooms throughout the facility on the East Wing and the West Wing daily for one week. This was initiated on 12/19/12.

Then 13 rooms randomly throughout the facility on the East and West Wings will have the water temperatures checked, x one week, this includes weekends and holidays.

Then water temperatures will be checked in a minimum of 6 randomly selected resident rooms throughout the facility on the East Wing and the West Wings 5 x per week on an ongoing basis by the Director or Assistant Director of Plant Services or maintenance employee and reported to the administrator on a daily basis to verify that water temperatures are within acceptable range.

The administrator will conduct unannounced rounds with the Director, Assistant Director of Plant Services or maintenance employee on a monthly basis for one year to verify ongoing compliance with water temperatures ranges. The Administrator will be responsible on an ongoing basis to review the water temperature results reported in the daily AQA meeting 5 x per week by the Director or Assistant of Plant Services to verify ongoing compliance. The Administrator will also review that the Unit Managers & Licensed Nurses are observing for hazards & care plan compliance weekly for 12 weeks, through review of the signed NADS. The results will also be reported on a monthly basis to the Quality Assessment and Assurance Committee for review for a minimum of one year. If any areas of concern are identified the frequency or duration of the audit may be increased to validate ongoing compliance. In addition re-education/discipline will result.

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K 000	Continued From page 1 Fire).	K 000	Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.	
K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>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 three (3) of six (6) smoke compartments, seventy-eight residents, staff and visitors. The facility is certified for Ninety-Eight (98) beds with a</p>	K 018	<p>K-018</p> <p>It is the normal practice of Mills Health and Rehab Center to ensure doors to resident rooms are in accordance with NFPA standards.</p> <p><u>Corrective Measures for Residents Identified in the Deficiency:</u></p> <p>No residents were identified in this deficiency.</p> <p><u>How Other Residents were Identified that may have been affected by the practice:</u></p> <p>Residents in 3 of the 6 smoke compartments have the potential to be affected by the practice.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>All remaining resident doors in the facility were checked by the Director and Assistant Director of Plant Operations and the maintenance employee on 12/19/12 to verify that no other door frames had greater than a 1/8 inch gap. The Director and Assistant Director of Plant Operations and the maintenance employee were in-serviced on 12/19/12 by the Administrator of the requirement of no greater than a 1/8 inch between the frame and door jamb.</p> <p>The contracting company was contacted and came to facility on 12/27/12 and assessed the door frames and a quote was obtained to correct the identified rooms that have greater than a</p>	1/17/13

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K 018 Continued From page 2  
census of Eighty-Three (83) on the day of the survey. The facility failed to ensure seven (7) corridor doors to the resident rooms did not have a gap smaller than 1/2 inch around the jamb.

The findings include:

Observations, on 12/18/12 between 1:10 PM and 4:00 PM, with the Director and Assistant Director of Plant Operations revealed the corridor doors to rooms 1118, 1104, 1121, 1126, 2106, 2105, and 2111 had a gap larger than 1/2 inch around the jamb.

Interview, on 12/18/12 between 1:10 PM and 4:00 PM, with the Director and Assistant Director of Plant Operations revealed they were unaware of the acceptable gap around the doors.

Reference:  
NFPA 101 (2000 edition)

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 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.

Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar

K 018  
K-018 (cont)

1/2 inch gap. Rooms identified are: 1118, 1104, 1121, 1126, 2106, 2105, and 2111. The contractor began corrections on identified doors in the facility on 1/15/13 and was completed on 1/16/13.

Monitoring Measure to Maintain Ongoing Compliance:

The Plant Operations Director, Assistant Director or the maintenance employee will audit all the corridor doors to the residents rooms once every quarter to verify a gap has not become greater than 1/2 inch around the jamb. The results of this audit will be reported to the administrator and to the Quality Assessment and Assurance Meeting on a quarterly basis to validate ongoing compliance for a minimum of one year.

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K 018 Continued From page 3  
auxillary spaces that do not contain flammable or combustible materials.  
Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.6.2, 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.  
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.

K 018

K 029 SS=E 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 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

K 029

K-029

1/10/13

It is the normal practice of Mills Health and Rehab Center to meet Protection of Hazards in accordance with NFPA Standards.

Corrective Measures for Residents Identified in the Deficiency:

No residents were identified in this deficiency.

How Other Residents were Identified that may have been affected by the practice:

Residents in 4 of the 6 smoke departments have the potential to be affected by the practice. On 12/21/12 The Director and Assistant Director of Plant Operations conducted a review of the facility to verify that rooms over 50 square feet with combustible materials had a self closing device present on the door.

This STANDARD is not met as evidenced by:

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K 029 | Continued From page 4

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 four (4) of six (6) smoke compartments, seventy-four (74) residents, staff and visitors. The facility is certified for Ninety-Eight (98) beds with a census of Eighty-Three (83) on the day of the survey. The facility failed to ensure five (5) rooms with hazardous storage had the proper door closer for separation.

The findings include:

Observation, on 12/18/12 between 1:10 PM and 4:00 PM, with the Director and Assistant Director of Plant Operations revealed:

- 1) The Therapy Office did not have a door closer installed.
- 2) The Medical Records Office did not have a door closer installed.
- 3) The East Linen Closet did not have a door closer installed.
- 4) The West Linen Closet did not have a door closer installed.
- 5) The Director of Nursing Office did not have a door closer installed.

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.

K 029

K-29 (cont)

Measures Implemented or Systems Altered to Prevent Re-occurrence:

Universal door closers were ordered on 12/21/12 by the Director of Plant Operations. A self closing device was installed on the Therapy Office door and the Director of Nursing door on 1/9/13 by the Assistant Director of Plant Operations and maintenance employee.

A self closing device was installed on the Medical Records door, the East Linen Closet door, and the West Linen Closet door on 12/27/12 by the Assistant Director of Plant Operations and maintenance employee. The Director and Assistant Director of Plant Operations were re-educated by the Administrator on 12/19/12 that rooms with combustible material larger than 50 square feet must have a closing device.

Monitoring Measure to Maintain Ongoing Compliance:

Rooms that are 50 square feet or more that contain combustibles will be monitored to ensure they have self door closers. This was added to the maintenance audit tool and will be conducted monthly by the Plant Operations Director, Assistant Director or the maintenance employee. The results of the findings will be presented to the administrator and the Quality Assessment and Assurance Committee on a monthly basis to validate ongoing compliance for a minimum of one year.

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K 029 Continued From page 5

K 029

Interview, on 12/18/12 between 1:10 PM and 4:00 PM, with the Director and Assistant Director of Plant Operations revealed they were not aware the areas listed above were considered hazardous storage thus requiring a door, a self-closer, and separation.

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
  - (2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)
  - (3) Paint shops
  - (4) Repair shops
  - (5) Soiled linen rooms
  - (6) Trash collection rooms
  - (7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), 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

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K 029	Continued From page 6 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.	K 029		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  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 six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for Ninety-Eight (98) beds with a census of Eighty-Three (83) on the day of the survey. The facility failed to ensure all egress doors had a code posted at the door.  The findings include:  Observation, on 12/18/12 at 2:00 PM, with the Director and Assistant Director of Plant Operations revealed all egress doors in the facility were locked and did not have a code posted to	K 038	K-038 It is the normal practice of Mills Health and Rehab to have means of egress according to NFPA code.  <u>Corrective Measures for Residents Identified in the Deficiency:</u>  No residents were identified in the deficiency.  <u>How Other Residents were Identified that may have been affected by the practice:</u>  Residents in 6 of 6 smoke compartments have the potential to be affected by the practice.  <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u>  Codes were posted on all locked egress doors on 12/19/12. This was completed by the Director and Assistant Plant Director of Operations. The Director and Assistant Director of Operations were re-educated on 12/19/12 by the Administrator that a door code must be posted on egress doors that are locked and was completed on 1/17/13.  Education for all facility staff was initiated on 12/19/12 by the Administrator on the code location of all locked egress doors and will continue until all facility staff are educated. This will be conducted by the Administrator and Plant Service Director.	1/18/13

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NAME OF PROVIDER OR SUPPLIER  MILLS HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 BECK LANE MAYFIELD, KY 42066
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 038 Continued From page 7  
exit the building.

Interview, on 12/18/12 at 2:00 PM, with the Director and Assistant Director of Plant Operations revealed they were unaware the doors were required to have a door code posted if the doors were locked.

Reference:  
NFPA 101 (2000 Edition)  
19.2.2.2.4

Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.

Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.)

Exception No. 2\*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.

Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.

7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic

K 038: K-038 (cont)

Monitoring Measure to Maintain Ongoing Compliance:

Auditing of the locked egress doors will be added to the maintenance audit tool and be conducted by the Plant Service Director, Assistant Director of Plant Operations or maintenance employee on a monthly basis to verify presence of code. The findings of the audit will be reported to the Administrator and the Quality Assessment and Assurance Committee on a monthly basis to verify ongoing compliance for a minimum of one year. If any areas of concern are identified, the frequency and or duration of the audit may be increased.

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K 038 Continued From page 8  
fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.

(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.

(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.

(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual

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K 038 Continued From page 9  
means only.  
Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.

K 038

(d) \*On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows:  
PUSH UNTIL ALARM SOUNDS  
DOOR CAN BE OPENED IN 15 SECONDS

K 056 NFPA 101 LIFE SAFETY CODE STANDARD  
SS-E

K 056

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 1/13/13

It is the normal practice of Mills Health and Rehab to ensure sprinkler coverage in accordance with NFPA standards.

Corrective Measures for Residents Identified in the Deficiency:

No residents were identified in the deficiency.

How Other Residents were Identified that may have been affected by the practice:

Residents in 4 of the 6 smoke compartments have the potential to be affected. A complete walk through of the facility was completed on 1/12/13 and it was determined by the fire protection company that all areas are properly protected by the automatic sprinkler system.

Measures Implemented or Systems Altered to Prevent Re-occurrence:

A quote was received from the fire protection Company on 12/21/12 for the sprinkler installation in the 5 identified porch areas located by rooms 1127, 2127, 2112, the equipment room, and the kitchen.

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect four (4) of six (6) smoke compartments, all

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K 056 Continued From page 10  
residents, staff and visitors. The facility is certified for Ninety-Eight (98) beds with a census of Eighty-Three (83) on the day of the survey. The facility failed to ensure five (5) porches had proper sprinkler protection.

The findings include:

Observation, on 12/18/12 between 1:52 pm and 3:30 pm, with the Director and Assistant Director of Plant Operations revealed five (5) overhangs that were seven (7) feet wide that did not have sprinkler protection. The seven (7) exits were located by rooms 1127, 2127, 2112, the equipment room, and the kitchen.

Interview, on 12/18/12 between 1:52 pm and 3:30 pm, with the Director and Assistant Director of Plant Operations revealed they were unaware the porches were combustible therefore requiring sprinkler protection.

Observation, on 12/18/12 at 2:22 PM, with the Director and Assistant Director of Plant Operations revealed the clean linen closet in the laundry was not sprinkler protected.

Interview, on 12/18/12 at 2:22 PM, with the Director and Assistant Director of Plant Operations revealed they were unaware the closet did not have proper sprinkler protection.

Reference: NFPA 13 (1999 edition)  
5-13.8.1. Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width.  
Exception: Sprinklers are permitted to be omitted

K 056 K-056 (cont)

The sprinkler company installed the sprinklers in these five overhang areas on 1/12/13. In addition, a sprinkler was installed in the clean linen closet in the laundry room on 1/12/13. The Director and Assistant Director of Plant Operations were re-educated by the Administrator on 12/19/12 that sprinklers are required in overhangs that are combustible and also in the laundry clean linen closet.

Monitoring Measure to Maintain Ongoing Compliance:

The overhang areas and the laundry clean linen closet will be added to the maintenance audit tool and checked quarterly by the Plant Service Director, Assistant Director of Plant Operations or maintenance employee to verify sprinkler placement. The findings will be reported to the Administrator and the Quality Assessment and Assurance Committee on a quarterly basis to verify ongoing compliance for a minimum of one year.

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K 056	<p>Continued From page 11 where the canopy or roof is of noncombustible or limited combustible construction.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.3.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>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.</p> <p>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.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(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.</p>	K 056		
K 069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.8, NFPA 96</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was</p>	K 069	<p>K-069</p> <p>It is the normal practice of Mills Health and Rehab Center to maintain the cooking facilities are protected in accordance with NFPA standards.</p> <p><u>Corrective Measures for Residents Identified in the Deficiency:</u></p> <p>No residents were identified in the deficiency.</p>	1/9/13

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K 069 Continued From page 12  
determined the facility failed to ensure the kitchen hood extinguishing system was in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, twenty-four (24) residents, staff and visitors. The facility is certified for Ninety-Eight (98) beds with a census of Eighty-Three (83) on the day of the survey. The facility failed to ensure the kitchen hood suppression system was connected to the fire alarm.

The findings include:

Record Review, on 12/18/12 at 11:36 AM, with the Director and Assistant Director of Plant Operations revealed the kitchen hood suppression system was not connected to the facilities fire alarm.

Interview, on 12/18/12 at 11:36 AM, with the Director and Assistant Director of Plant Operations revealed they were unaware of the requirement for the hood suppression system to be connected to the fire alarm.

NFPA 1998 (1998 ed.)  
7-6.2 Where a fire alarm signaling system is serving the occupancy where the extinguishing system is located, the activation shall activate the fire alarm signaling system.

K 076 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D  
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

K 069: K-069 (cont)

How Other Residents were Identified that may have been affected by the practice:

Residents in One of Six smoke compartments have the potential to be affected by the practice.

Measures Implemented or Systems Altered to Prevent Re-occurrence:

Fire alarm company was contacted and was at the facility on 12/19/12 to inspect/evaluate the kitchen hood suppression system being connected to fire alarm in order to obtain a quote.  
A quote was obtained from the fire alarm company on 12/31/12. The kitchen hood suppression system was connected to the fire alarm on 1/8/13 by the fire alarm company. The Director and Assistant Director of Plant Operations were educated on 12/19/12 by the Administrator on the requirement for the Kitchen Hood Suppression System to be connected to the fire alarm.

Monitoring Measure to Maintain Ongoing Compliance:

The Kitchen Hood Suppression System will be inspected quarterly by the Plant Service Director, Assistant Director of Plant Operations or maintenance employee to verify the system is connected to the fire alarm. This will be added to the Maintenance audit tool. The findings will be reported to the Administrator and the Quality Assessment and Assurance committee on a quarterly basis to verify ongoing compliance for a minimum of one year.

K-076  
12/21/12  
It is the normal practice of Mills Health and

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K 076 Continued From page 13  
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 to affect two (2) of six (6) smoke compartments, fifty-six (56) residents, staff and visitors. The facility is certified for Ninety-Eight (98) beds with a census of Eighty-Three (83) 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.

The findings include:

Observation, on 12/18/12 at 1:48 PM, with the Director and Assistant Director of Plant Operations revealed eighteen (18) oxygen tanks in the east hall med room and west hall med room. The oxygen tanks were being stored within five (5) feet of combustible items and ignition sources were not located over five (5) feet from the floor.

K 076 K-076 (cont)  
Rehab to store oxygen tanks in accordance with NFPA standards.  
  
Corrective Measures for Residents Identified in the Deficiency:  
No residents were identified in this deficiency.  
  
How Other Residents were Identified that may have been affected by the practice:  
Residents in 2 of the 6 smoke compartments have the potential to be affected by the practice.  
  
Measures Implemented or Systems Altered to Prevent Re-occurrence:  
6 of the 18 oxygen tanks were removed from the East Hall Medication Room and 6 from the West Hall Medication Room to reduce the storage to only 12 tanks in each medication room. This was completed by the oxygen company on 12/20/12. The Director and Assistant Director of Plant Operations were educated by the Administrator on 12/19/12 on proper oxygen storage.  
  
Monitoring Measure to Maintain Ongoing Compliance:  
The Plant Service Director, Assistant Director of Plant Operations or maintenance employee will audit the oxygen storage areas weekly X one month then monthly thereafter to verify storage of the proper number of oxygen tanks in the East Hall Medication Room and the West Hall Medication Room. This will be added to the Maintenance Audit Tool. The findings will be reported to the Administrator and the Quality Assessment and Assurance Committee on a monthly basis to verify ongoing compliance for a minimum of one year.

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K 076 Continued From page 14

Interview, on 12/18/12 at 1:48 PM, with the Director and Assistant Director of Plant Operations revealed they were 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.

Reference:  
NFPA 101 (2000 edition)  
8-3.1.11.2  
Storage for nonflammable gases greater than 8.5 m<sup>3</sup> (300 ft<sup>3</sup>) but less than 85 m<sup>3</sup> (3000 ft<sup>3</sup>)  
(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 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 ½ 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

K 076

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K 076 Continued From page 15  
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 144 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=F  
Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.

K 144

K-144 1/11/13

It is the normal practice of Mills Health and Rehab to ensure the emergency generator is maintained in accordance with NFPA standards.

Corrective Measures for Residents Identified in the Deficiency:

No residents were identified in this deficiency.

How Other Residents were Identified that may have been affected by the practice:

Residents in 6 of the 6 smoke compartments have the potential to be affected by the practice.

Measures Implemented or Systems Altered to Prevent Re-occurrence:

An initial battery charger was purchased by the Administrator on 12/20/12. Further evaluation was initiated by contacting the supply company, at which point a second battery charger was purchased.

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure the emergency generator was maintained in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, all residents, staff and visitors. The facility is certified for Ninety-Eight (98) beds with a census of Eighty-Three (83) on the day of the survey. The facility failed to ensure the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185279	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  12/18/2012
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NAME OF PROVIDER OR SUPPLIER  MILLS HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 BECK LANE MAYFIELD, KY 42068
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 144 Continued From page 16  
generator had a permanently connected battery charger.

The findings include:

Observation, on 12/18/12 at 1:48 PM, with the Director and Assistant Director of Plant Operations revealed the generator did not have a battery charger installed on the unit.

Interview, on 12/18/12 at 1:48 PM, with the Director and Assistant Director of Plant Operations revealed they were unaware the generator was required to have a charger and stated the battery charged by the alternator when the unit was running.

Observation, on 12/18/12 at 1:48 PM, with the Director and Assistant Director of Plant Operations revealed the facility did not have any battery-powered lighting installed in the room where the generator and transfer switch were located.

Interview, on 12/18/12 at 1:48 PM, with the Director and Assistant Director of Plant Operations revealed they were not aware of the requirement for the battery backup lighting.

Reference: NFPA 110 (1999 Edition).

5-12.6  
The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and

K 144 K-144 (cont)

The electric company was contacted on 1/9/13 to install the permanent battery charger and it was installed on 1/10/13 by the electrical company.

A order was placed for the battery powered light on 12/19/12 by Director of Plant Operations. The battery powered light was installed in the room where the generator and transfer switch are located by the contracted company on 12/28/12.

The Director and Assistant Director of Plant Services were educated on 12/19/12 by the Administrator on requirements for battery back up lighting and generator requirements in regards to battery charging.

Monitoring Measure to Maintain Ongoing Compliance:

The generator will be checked weekly to include the permanent battery charger connected to the generator. The battery powered lighting installed in the generator room will also be audited weekly. These audits will be added to the Maintenance Audit Tool.

These audits will be conducted by the Plant Service Director, Assistant Director of Plant Operations or maintenance employee. The findings will be reported to the Administrator and the Quality Assessment and Assurance Committee on a monthly basis to verify ongoing compliance for a minimum of one year.

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NAME OF PROVIDER OR SUPPLIER  MILLS HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 800 BECK LANE MAYFIELD, KY 42066
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K 144 Continued From page 17  
accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.

K 144

Reference: NFPA 110 (1999 Edition).

6-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.

K 147 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D  
Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

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K-147

12/20/12

It is the normal practice of Mills Health and Rehab to ensure that electrical wiring and equipment is in accordance with NFPA standards.

Corrective Measures for Residents Identified in the Deficiency:

No residents were identified in the deficiency.

How Other Residents were Identified that may have been affected by the practice:

Residents in 2 of the 6 smoke compartments have the potential to be affected by the practice.

Measures Implemented or Systems Altered to Prevent Re-occurrence:

The storage was removed from within 3 feet of the electrical panel in the Salon and the custodial closet in the Kitchen area on 12/19/12. This was completed by the Director of:

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NAME OF PROVIDER OR SUPPLIER  MILLS HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 BECK LANE MAYFIELD, KY 42088
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The findings include:

Observations, on 12/18/12 between 2:35 PM and 4:03 PM, with the Director and Assistant Director of Plant Operations revealed the electrical panels in the Salon and the custodial closet in the kitchen area had storage within three (3) feet of the electrical panels.

Interview, on 12/18/12 between 2:35 PM and 4:03 PM, with the Director and Assistant Director of Plant Operations revealed they were unaware there could not be storage within 3 feet of electrical panels.

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 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),

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K-147 (cont)

Plant Operations. The Director of Plant Operations was re-educated on the requirement that storage cannot be within 3 feet of an electrical panel. This was conducted by the Administrator on 12/19/12

Monitoring Measure to Maintain Ongoing Compliance:

The Salon area and the custodial closet in the kitchen will be audited monthly by the Director or Assistant Director of Plant Operations to verify that no storage is within 3 feet of an electrical panel. This will be added to the Maintenance Audit Tool.

The finding of the audits will be reported to the Administrator and the Quality Assessment and Assurance committee on a monthly basis to verify ongoing compliance for a minimum of one year.

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NAME OF PROVIDER OR SUPPLIER  MILLS HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 BECK LANE MAYFIELD, KY 42068
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(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 110.28(A)(1) Working Spaces

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Nominal Voltage to Ground	Minimum Clear Distance		
	Condition 1	Condition 2	Condition 3
0-150 mm (3 ft)	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 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 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.

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(b) Low Voltage. By special permission, smaller working spaces shall be permitted where all un-insulated 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, 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.

(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.

(C) Entrance to Working Space.

(1) Minimum Required. At least one entrance of

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sufficient area shall be provided to give access to working space about electrical equipment.

(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.

(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.

(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.

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