

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

PRINTED: 06/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445017	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2014
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NAME OF PROVIDER OR SUPPLIER ASBURY PLACE AT MARYVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2648 SEVIERVILLE RD MARYVILLE, TN 37804
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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 027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. 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 testing, it was confirmed that the facility failed to ensure corridor fire doors would close to a positive latch.</p> <p>The findings include:</p> <p>Observation and testing on March 19, 2014 between 10:25 a.m. and 1:50 p.m. revealed the following corridor fire doors did not close and latch within their frame:</p> <ol style="list-style-type: none"> 1. Fire doors by room 314. 2. Fire doors by room 210. 3. Fire doors by room 216. 4. Fire doors by room 113. <p>These findings were verified by the maintenance assistant and acknowledged by the administrator during the exit conference on March 19, 2014.</p>	K 027	<p>K-027 – The fire doors by room 314, 210, 216 and 113 have all been repaired to latch within their time frame.</p> <p>All remaining fire doors have been checked to ensure they latch within the proper time frame.</p> <p>The maintenance tech will conduct random audits throughout the building weekly for 4 weeks, then monthly for 3 months to check the fire doors to ensure that they latch within the proper time frame.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.</p>	4/11/14
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1</p>	K 029	<p>K-029 – The 3rd floor dining room and 2nd floor south day room closet doors has been provided with self-closing doors.</p>	4/11/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Vera L. B... ADMINISTRATOR TITLE
Not submitted (X6) DATE 6/11/14

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 029	<p>Continued From page 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</p> <p>This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to have self-closing doors in hazardous areas.</p> <p>The findings include:</p> <p>Observation on March 19, 2014 at 10:45 a.m. and 1:20 p.m. revealed the 3rd floor dining room and the 2nd floor south day room closet are over 50 square feet and have combustible storage and are not provided with self-closing doors.</p> <p>This finding was verified by the maintenance assistant and acknowledged by the administrator during the exit conference on March 19, 2014.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 029	<p>The remaining facility was checked for any self-closing door needs. None were identified.</p> <p>The maintenance tech will conduct random audits on the two doors monthly for 3 months to ensure that the newly installed self-closing apparatus is working properly.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.</p>	
K 056 SS=F	<p>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</p>	K 056		

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K 056	<p>Continued From page 2 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</p> <p>This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to install the automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation on March 19, 2014 at 10:50 a.m. revealed 12 of 14 3rd floor resident rooms have been renovated and the new framed in closets are not provided with sprinkler coverage. 2. Observation on March 19, 2014 at 1:35 p.m. revealed that room 231 has 2 sprinkler heads that are not installed at least 6 feet away from each other. <p>These findings were verified by the maintenance assistant and acknowledged by the administrator during the exit conference on March 19, 2014.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 056	<p>K-056 – The sprinkler installation company has been contacted to add the needed sprinkler heads. They will also correct the proper spacing for the sprinkler head for room 231.</p> <p>We anticipate work to start on the new sprinkler head addition by May 4th.</p>	5/4/14
K 061 SS=D	<p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p>	K 061	<p>K-061 – The OS&Y valve on the sprinkler risers in the north boiler room will be updated to have electronic supervision.</p>	4/18/14

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K 061	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to have control valves electronically supervised so that at least a local alarm will sound when the valves are closed. The findings include: Observation on March 19, 2014 at 3:10 p.m. revealed the north boiler room sprinkler riser's OS&Y valve is not electronically supervised. This finding was verified by the maintenance assistant and acknowledged by the administrator during the exit conference on March 19, 2014. NFPA 101 LIFE SAFETY CODE STANDARD	K'061	The maintenance tech will conduct random audits on the OS&Y valve monthly for 3 months to ensure that the newly installed electronic supervision is working properly. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.	
K 211 SS=F	Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623	K 211	K - 211 - The Alcohol Based Hand Rub dispensers in the 3 rd floor rooms and the 2 nd floor south soiled linen room have been moved. An audit as done facility wide to ensure that no Alcohol Based Hand Rub dispensers are installed directly over the light switches.	4/11/14

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K 211	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to install Alcohol Based Hand Rub dispensers installed away from ignition sources.</p> <p>The findings include:</p> <p>Observation on March 19, 2014 at 10:52 revealed that 12 out of 14 3rd floor resident rooms and the 2nd floor south soiled linen room has Alcohol Based Hand Rubs (ABHR) dispensers installed directly over the light switches.</p> <p>This finding was verified by the maintenance assistant and acknowledged by the administrator during the exit conference on March 19, 2014.</p>	K 211	<p>The maintenance tech will conduct random audits on the Alcohol Based Hand Rub dispensers to ensure proper placement monthly for 3 months.</p> <p>The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.</p>	
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