

2015-07-01 15:25 Dept of Health-HCF  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

8655945739 >>

P 9/16

PRINTED: 06/18/2015  
FORM APPROVED  
OMB NO. 0938-0391

45th 8/01/15

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  06/16/2015
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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	(X5) COMPLETION DATE
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**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, testing and interview, the facility failed to provide the means of egress readily accessible at all times.

The findings include:

Observation, testing and interview with staff on 6/16/15 between 10:30 AM and 12:00 PM revealed the following:

1. 1 south delayed egress door going into the stairwell has 15 seconds and 30 seconds on the signage. The door when tested, released in 15 seconds.
2. Delayed egress door in the sun room, the signage blends in with the door and is not on a contrasting background.
3. Delayed egress door in memory care leading into the service hall is not provided with any signage.
4. Delayed egress door leading into the memory care courtyard has a 30 second delayed egress sign but when tested the door released in 15 seconds.
5. Delayed egress door in the memory care activity room that leads into the courtyard is not provided with any signage.
6. 1 north exit door leading directly outside is not provided with any signage.
7. 2 north service hall delayed egress door has

**K 038** LIFE SAFETY CODE- EXITS

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Items 1- 7 each egress door listed now have accurate and visible signage to reflect the true operation of each delayed egress door.  
Item 8, a designated exit from the courtyard will be clearly defined and exit sign installed.  
Item 9, pad lock removed from patio gate outside of the physical therapy department.  
All items will be completed by 7/31/2015.

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All delayed egress doors in the facility will be checked to insure proper signage and operation is in place by July 31, 2015.

7/31/15

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Adrian R. Hat* TITLE Administrator (X6) DATE 7/19/15

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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 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  443017	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  06/16/2015
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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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K 038 Continued From page 1  
 a 30 second delayed time, when tested, the release time was greater than 30 seconds.  
 8. Memory care courtyard does not have a designated exit that is readily accessible out of the courtyard and away from the building without reentry into the facility.  
 9. Physical therapy has a designated exit out to a small patio area outside. The gate for the patio is pad locked. Interview with the physical therapy staff revealed no one has a key or knows where a key is at for the lock.

K 038 3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.  
  
 Maintenance staff will be in-serviced on delayed egress, inappropriate use of pad locks, and proper signage by the Facilities Director by July 31, 2015.

7/31/15

These findings were verified by maintenance and acknowledged by the administrator during the exit conference on 6/16/16.  
 NFPA 101 7.2.1.6.1 & 7.10.1.2\*

K 052 SS=D NFPA 101 LIFE SAFETY CODE STANDARD  
 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4

K 052 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.  
  
 Maintenance staff to include visible and operational check of all delayed egress door when doing monthly safety check.

7/31/15

This STANDARD is not met as evidenced by:  
 Based on observation, the facility failed to maintain the fire alarm system.

The findings include:

K 052 NFPA 101- LIFE SAFETY CODE- NFPA 70 NATIONAL ELECTRICAL CODES AND NFPA 72  
 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

7/31/15

New back- up batteries were installed 6/18/2015 in the 3<sup>rd</sup> and 2<sup>nd</sup> floor North fire alarm control panels.

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K 052 Continued From page 2

Observation 6/16/15 at 10:30 AM revealed the annunciator panels on 3rd floor north and 2nd floor north for the fire alarm control panel shows a trouble signal due to back up batteries having a low charge.

This finding was verified by the maintenance and acknowledged by the administrator during the exit conference on 6/16/15.  
NFFPA 72 1-5.4.6.3.3\*, 7-1.1.1, 7-1.1.2  
NFFPA 101 LIFE SAFETY CODE STANDARD

K 061 SS=F  
Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFFPA 72, 9.7.2.1

This STANDARD is not met as evidenced by:  
Based on record review, the facility failed to have all control valves for the sprinkler system electronically supervised.

The findings include:  
Record review of the sprinkler documentation revealed that not all control valves are electronically supervised to provide a signal that sounds and is displayed at a continuously attended location when the sprinkler system is impaired.

This finding was verified by the maintenance and acknowledged by the administrator during the exit

K 052

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

All fire alarm control panels have been evaluated to ensure that they are working properly and have charged batteries.

K 061

3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.

The Facilities Director will educate staff on the proper operation of annunciator panels and trouble signals by July 31, 2105.

7/31/15

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.

The maintenance staff will document dates of when batteries are replaced to aid in determining age of battery and when it should be systematically changed.

Facility Director and or maintenance staff will inspect and monitor all annunciator panels and fire panels during monthly safety inspection of the facility.

K-061 - See Additional pages. *Official*

K-061

**K 061 NFPA 101 LIFE SAFETY CODE-  
VALVES- NFPA 72,  
9.7.2.1AUTOMATIC SPRINKLER  
CONTROL**

- 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**

SimplexGrinnell Alarm Company has been contracted with to install electronic supervisory devices to all sprinkler valves not currently supervised. The work is to be completed by 7/31/2015

- 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**

Director of Facility and SimplexGrinnell technician to inspect all sprinkler valves thru-out the facility to identify all sprinkler valves are electronically supervised by July 31, 2015.

- 3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.**

The Facilities Director will ensure that the Maintenance staff is properly educated as to the proper supervisory devices; how they work; and what to observe for during inspections by July 31, 2015.

DATE  
7/31/15

K-061  
Cont.

DA  
7/31

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.

Director of Facilities and/or the maintenance staff will inspect all sprinkler valves while doing monthly safety checks. Morristown Sprinkler Company is contracted to complete quarterly system inspections, which the Facilities Director and/or maintenance staff will ensure are completed and documented.

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K 061 Continued From page 3  
 conference on 6/16/15.  
 K 064 NFPA 101 LIFE SAFETY CODE STANDARD  
 SS=E  
 Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFPA 10

This STANDARD is not met as evidenced by:  
 Based on observation, the facility failed to have the 6 year maintenance on fire extinguishers conducted.

The findings include:

Observation on 6/16/15 at 2:30 PM revealed 10lbs fire extinguishers on the 2nd and 3rd floor have not had the 6 year maintenance conducted. No metallic label or verification of service collar was on the fire extinguishers. The date of manufacture on the fire extinguishers is 2008.

This finding was verified by the maintenance and acknowledged by the administrator during the exit conference on 6/16/15.  
 NFPA 10 4-4.4.1\* & 4-4.4.2\*

K 069 NFPA 101 LIFE SAFETY CODE STANDARD  
 SS=D

Cooking facilities are protected in accordance with 9.2.3, 19.3.2.6, NFPA 96

This STANDARD is not met as evidenced by:  
 Based on observation, the facility failed to provide complete extinguishing coverage for the

K 064 NFPA 101 LIFE SAFETY-  
 PORTABLE FIRE  
 EXTINGUISHERS- NFPA 10

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Knox fire Extinguisher has been contacted with to perform 6 year maintenance for all fire extinguishers on the 2nd and 3rd floor of the health care facility. Inspections and labeling will be completed by 7/31/2015

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

Maintenance staff will perform a thorough inspection of all fire extinguishers by July 31, 2015.

3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.

7/31/15

Director of Facilities will educate the maintenance staff as to the proper way to inspect fire extinguishers by July 31, 2015.

Cont. on separate page.  
 Followed by K-069. CRNul

K-064  
cont.

7/31/15

- 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.

Maintenance staff to inspect and document all fire extinguishers each month. Knox Fire Extinguisher Company will inspect and document all fire extinguishers quarterly. Facilities Director and/or maintenance staff will ensure that the inspections by Knox Fire Extinguisher Company are done timely and thoroughly to include all floors in the health center

**K 069 NFPA 101 LIFE SAFETY CODE- COOKING FACILITIES- NFPA 96**

K-069

7/31/15

- 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Fryer was centered under the ANSUL nozzle on 6-18-15.

- 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

N/A

- 3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.

The Director of Dining has ensured that all required equipment in the kitchen was reviewed and is in proper alignment under ANSUL nozzles.

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NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT MARYVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2848 SEVIERVILLE RD MARYVILLE, TN 37804		
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K 069	Continued From page 4 appliances below the kitchen hood.  The findings include:  Observation on 6/16/15 at 3:00 PM revealed the deep fat fryer in dietary has been moved and now the nozzle for the ANSUL system is not providing adequate coverage for the deep fat fryer.  This finding was verified by the maintenance and acknowledged by the administrator during the exit conference on 6/16/15. NFPA 17A 3-5.1 NFPA 101 LIFE SAFETY CODE STANDARD	K 069	4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.  Audit of ANSUL nozzles and equipment will be done monthly for 3 months and, following that, quarterly for 2 quarters.	7/31/15	
K 072 SS=D	Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Based on observation, the facility failed to have the means of egress free of all obstructions and impediments.  The findings include:  Observation on 6/16/15 at 10:55 AM revealed the exit to the patio area is obstructed by a wheel chair and a stand.  This finding was verified by the maintenance and acknowledged by the administrator during the exit	K 072	NFPA 101 LIFE SAFETY CODE- EGRESS FREE OF OBSTRUCTIONS- 7.1.10  1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  The wheelchair and stand identified as obstructing the exit to the patio door was removed on 6/17/15.	7/31/15	

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K 072	Continued From page 5 conference on 6/16/15. NFA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: 1. Based on observation, the facility failed to maintain the 2 hour fire rating of the generator room.  The findings include:  Observation on 6/16/15 at 10:20 AM revealed the 2 hour fire rated generator room has unsealed penetrations in the wall and the door closer for the fire door has been disconnected. NFA 110 5-2.1, NFA 80 2-4.1.2*  This finding was verified by the maintenance and acknowledged by the administrator during the exit conference on 6/16/15.  2. Based on observation and testing, the facility failed to have magnetically locked doors release with the fire alarm.  The findings include:  Observation and testing on 6/16/15 at 2:47 PM revealed 2 of 10 observed delayed egress doors located at the 2nd floor south stairwell and 2nd floor short hall did not release when the fire alarm was activated. NFA 72 3-9.7.2	K 072	2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.  Maintenance staff inspected all exit doors and removed any other obstructions from exits on 6/17/2015.  3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.  The Facilities Director and/or Therapy Director will educate therapy staff on all means of egress being continuously maintained free of all obstructions or impediments to insure full and instant use in case of fire or other emergency by July 31, 2015.  <i>Cont separate page CMMK</i>	7/31/15	
K 130 SS=D		K 130		<i>K-130 next page -</i>	

K-072  
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- 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.

The Director of Facilities and/or maintenance and therapy staff will visibly monitor exits and egress during daily inspection rounds. Any obstructions will be immediately removed. Any significant trends will be reported to Quality Assurance committee, which meets at least quarterly and consists of the Medical Director, Pharmacist, Director of Nursing, Administrator, Staff Development Coordinator, Clinical Mentors, Dietician, and Social Workers.

K-130

K 130 NFPA 101 MISCELLANEOUS-GENERATOR ROOM

7/31/15

- 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

The penetrations found will be sealed with NFPA approved fire caulk by July 31, 2015.

The maintenance staff will re-install the door closure on the generator room fire door by July 31, 2015.

SimplexGrinnell has been contracted to troubleshoot /repair and reprogram the magnetic door locks on the delayed egress doors on 2<sup>nd</sup> floor south stairwell and the 2<sup>nd</sup> floor short hall to ensure that they release when the alarm is activated.

This work is to be completed by 7/31/2015.

Continued  
C. P. Neil

K-130

2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

1.) The Facilities Director and/or maintenance staff will inspect all generator rooms and other utility rooms for proper fire ratings and ensure there are no penetrations.

All doors on the same rooms will be inspected to insure fire door hardware are in place and operational.

2.) The Facilities Director and/or maintenance staff will inspect all delayed doors throughout the facility to insure they operate correctly with fire alarm system by July 31, 2015.

3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.

The Facilities Director will educate the maintenance staff as to the proper functionality of all magnetic locking doors and how to observe for/repair penetrations when indicated by July 31, 2015.

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place.

Continued another page -  
CNeil

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cont.

7/31/15

The Director of Facilities and /or the maintenance staff will monitor and inspect doors and magnetic locks during monthly fire safety inspections. They will also check magnetic lock door operations during monthly fire drills to insure they release when alarm is activated. Any significant trends will be reported to Quality Assurance committee, which meets at least quarterly and consists of the Medical Director, Pharmacist, Director of Nursing, Administrator, Staff Development Coordinator, Clinical Mentors, Dietician, and Social Workers.

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K 147 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and testing, the facility failed to have electrical wiring in accordance with NFPA 70 National Electrical Code.</p> <p>The findings include:</p> <p>Observation and testing on 8/16/15 at 11:20 revealed in dietary over the double sink is not provided with a ground fault current interrupter (GFCI) and this electrical outlet shows an open ground. The 2nd floor pantry room is not provided with a ground fault current interrupter (GFCI) by the sink.                  NFPA 70 210-8</p>	K 147	<p><b>NFPA 101 LIFE SAFETY CODE- ELECTRICAL WIRING AND EQUIPMENT- NFPA 70</b></p> <ol style="list-style-type: none"> <li>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?                     <p>A GFCI receptacle will be in working order over the double sink in dietary by July 31, 2015. Install GFCI receptacle in the A GFCI receptacle will be in working order over the 2<sup>nd</sup> floor pantry room left side of the sink by 7/31/2015.</p> </li> <li>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.                     <p>Director of Facilities and/or maintenance staff will inspect the facility to determine if there are any additional infractions to this code by 7/31/15.</p> </li> <li>3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur.                     <p>The Director of Facilities will provide education to the maintenance staff on proper placement of GFCI receptacles in moisture areas by 7/31/15.</p> </li> </ol>	7/31/15
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Division of Health Care Facilities

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N 002	1200-8-6 No Deficiencies  During the Life Safety portion of the annual Licensure survey conducted on 6/16/15, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002  K-147 Conf.	4. How the corrective action(s) will be monitored to ensure  the deficient practice will not recur; i.e. what quality assurance program will be put into place.  GFCI receptacles will be added to regularly scheduled inspection rotation to be performed quarterly with results and location to be documented upon each inspection. The Facilities Director and/or Maintenance staff will conduct these inspections and record compliance and/or necessary changes, repairs, or additions.	7/31/15

Division of Health Care Facilities  
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

4400

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If continuation sheet 1 of 1