

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

PRINTED: 11/14/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445321	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  11/05/2014
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NAME OF PROVIDER OR SUPPLIER  ARDMORE HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 25385 MAIN STREET ARDMORE, TN 38449
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K 029 SS=E	<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 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 style="text-align: center;"><b>RECEIVED</b> NOV 25 2014</p> <p>This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to protect all hazardous areas.</p> <p>The findings included:</p> <p>Observations on 11/5/14 from 8:50 AM to 1:40 PM revealed the following:</p> <ol style="list-style-type: none"> <li>Activities room needed a door closure due to combustible being stored in the room.</li> <li>The storage room in the basement had foam around the drain pipe.</li> <li>The file room in the basement has penetrations that need to be sealed with rated caulk.</li> <li>The dietary storage room in the basement had penetrations around floor/ceiling piping that needed to be sealed with rated caulk.</li> </ol> <p>These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 11/5/14.</p>	K 029	<ol style="list-style-type: none"> <li>1. A door closure was applied to the Activities office on 11/6/2014. The drain pipe with foam around the drain pipe was insulated and finished with fire caulk on 11/21/14. The penetrations in the file room were repaired and finished with fire rated caulk on 11/21/2014. The penetrations around the floor/ceiling piping were repaired and sealed with fire rated caulk on 11/21/14.</li> <li>2. No other offices were identified as needing a door closure due to the storage of combustible items. No other ceiling/floor perpetrations were identified to be sealed with rated caulk.</li> <li>3. The Administrator or designee will conduct weekly audits for penetrations and offices with stored combustible materials for three weeks and continue monthly for three months.</li> <li>4. The Administrator or designee will monitor audit results and present it to the Quality Assurance Committee monthly for 3 months. Subsequent plans of action will be developed as indicated by the committee. The Administrator is responsible for overall</li> </ol>	11/24/2014
K 046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 046	compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator (X6) DATE 11/20/14

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 046	Continued From page 1 Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to install emergency lighting from the exit discharge to a public way.  The findings included:  Observations of 4 of 4 exit discharges on 11/5/14 at 9:07 AM, revealed the pathways did not have emergency lighting.  These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 11/5/14.  NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on policy review and observation, it was determined the facility staff failed to perform their assigned duties according to the policies and	K 046	1. Emergency lighting was installed to illuminate the exit discharge areas that were identified to not be on emergency supply on 11/21/2014 2. All exit discharge areas were reviewed while under emergency power to see if there were any other areas that were without emergency power and affected areas were corrected. 3. The Administrator or designee will monitor the emergency operation of the exit discharge areas monthly to ensure the proper illumination is available in the case of an emergency. 4. The Administrator or designee will monitor audit results and present it to the Quality Assurance Committee monthly for 3 months. Subsequent plans of action will be developed as indicated by the committee. The Administrator is responsible for overall compliance.	11/24/2014
K 050 SS=D		K050	1. Education for staff will be provided for on closing doors to retain a fire during a fire drill. 2. All residents could be potentially affected by the deficient practice. There was a fire drill that was conducted on 11/14/2014 and 11/20/2014 in which all doors were closed properly to retain a fire.	

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K 050	Continued From page 2 procedures manual.  The findings included:  Review of the policy and procedure manual for a fire drill documented the staff are to close the door to rooms during the fire drill.  Observations during the fire drill in room 7 on 11/5/14 at 1:40 PM, revealed a staff member entered the room, came out of the room and left the door open. Other staff members responded to the room with fire extinguishers and no one closed the door to retain fire in the room.	K 050	3. Administrator or designee will conduct 2 fire drills a month for three months and monthly there after. Also in-service will be provided to staff to ensure the deficient practice does not reoccur. 4. The Administrator or designee will monitor audit results and present it to the Quality Assurance Committee monthly for 3 months. Subsequent plans of action will be developed as indicated by the committee. The Administrator is responsible for overall compliance.	11/24/2014
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  This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to ensure that smoke detectors had the required clearance from the air supply diffusers.  The findings included:	K052	1. The smoke detector by room 17 and the heat diffuser in the therapy room were relocated to be more than 3 feet apart from each other on 11/6/2014. 2. The Administrator surveyed the building to identify any other areas that may be affected by the deficient practice and no other areas were identified. The smoke detector and the heat diffuser were moved away from the air supply diffusers. 3. The Administrator or designee will audit monthly for three months to ensure that smoke detectors and heat detectors are not too close to each other.	

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K 052	Continued From page 3  Observations on 11/5/14 from 9:55 AM to 10:11 AM revealed the following: a. The smoke detector by room 17 was too close to the air supply diffuser. b. The heat detector in the therapy room was too close to the air supply diffuser. NFPA 101 LIFE SAFETY CODE STANDARD SS=D 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: Based on observation, it was determined the	K 052	4. The Administrator or designee will monitor audit results and present it to the Quality Assurance Committee monthly for 3 months. Subsequent plans of action will be developed as indicated by the committee. The Administrator is responsible for overall compliance.	11/24/2014
K 066		K066	1. The red metal container with the self closing lid was emptied on 11/5/2014 2. The Administrator checked ever red metal container with the self closing lid to ensure that no other red container was being utilized as a trash can. Staff was in serviced by on not utilizing the red containers as a trash cans. 3. The Administrator or designee will audit weekly for 3 weeks and monthly for three months to ensure the red containers are not being utilized as trash cans. 4. The Administrator or designee will monitor audit results and present it to the Quality Assurance Committee monthly for 3 months. Subsequent plans of action will be developed as indicated by the committee. The Administrator is responsible for overall compliance.	

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K 066	Continued From page 4 facility failed to maintain a metal container with a self-closing lid in the smoking area.  The findings included:  Observation of the smoking area on 11/5/14 at 9:30 AM, revealed the red self closing lid container was being used for a trash can.  This finding was verified by the maintenance director and verified by the administrator during the exit conference on 11/5/14.	K 066		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  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, it was determined the facility failed to maintain the exit discharge to the public way.  The findings included:  Observations on 11/5/14 at 9:06 AM, revealed the exit door at the end of the north hall would not open to full width of path of egress in case of fire or other emergency.  This finding was verified by the maintenance supervisor and acknowledged by the	K 072	1. The exit door was adjusted on 11/6/2014 to open completely. 2. The remaining exit doors were checked by the Maintenance Director to ensure that the doors opened appropriately on 11/6/2014. 3. The Administrator or designee will audit weekly for 3 weeks and monthly for three months to ensure that all exit doors are opening appropriately. 4. The Administrator or designee will monitor audit results and present it to the Quality Assurance Committee monthly for 3 months. Subsequent plans of action will be developed as indicated by the committee. The Administrator is responsible for overall compliance.	11/24/2014

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K 072	Continued From page 5 administrator during the exit conference on 11/5/14.	K 072		
K 130 SS=D	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: 3-5* Fire Extinguisher Size and Placement for Class C Hazards. Fire extinguishers with Class C ratings shall be required where energized electrical equipment can be encountered that would require a nonconducting extinguishing medium. This requirement includes situations where fire either directly involves or surrounds electrical equipment. Since the fire itself is a Class A or Class B hazard, the fire extinguishers shall be sized and located on the basis of the anticipated Class A or Class B hazard.  This STANDARD is not met as evidenced by:  Based on observation, it was determined the facility failed to provide a class A or B fire extinguisher in the dietary area as required.  The findings included:  Observations in the dietary area on 11/5/14 at 9:45 AM, revealed there was no class A or B fire extinguisher as required.	K 130	1. An ABC fire extinguisher was placed in the dietary area on 11/14/14. 2. No other area's were identified by the Administrator that were absent of an ABC fire extinguisher. 3. The Administrator or designee will audit weekly for 3 weeks and monthly for three months to ensure that the ABC fire extinguisher is in present in the dietary area. 4. The Administrator or designee will monitor audit results and present it to the Quality Assurance Committee monthly for 3 months. Subsequent plans of action will be developed as indicated by the committee. The Administrator is responsible for overall compliance.	11/24/2014
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147	Continued From page 6  This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to prohibit the use of plug adaptors and extension cords in the facility and failed to maintain all electrical equipment.  The findings included:  Observations on 11/5/14 from 8:00 AM until 10:14 revealed the following: a. Rooms 9, 12, 17, 19, 20, 31, main dining room, director of nursing's office, time clock, therapy office had unapproved electrical equipment (plug adaptor) in use. b. The electrical outlet was broken. c. Room 17 had an extension cord in use. d. The air condition in room 16 had a power cord that had been spliced and needed to be replaced. e. The hydroculator was not connected to a ground fault circuit interrupter receptacle.  These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 11/5/14.	K 147	1. Plug adaptors in rooms 9,12,17,19,20,31, the main dining room, DON's office, the time clock, and the therapy office were all removed. The electrical outlet was repaired on 11/6/2014. The extension cord was removed out of room 17. The power cord in room 16 was replaced. The hydroculator was moved to a ground fault circuit interrupter receptacle. 2. The facility was audited on 11/6/2014 by the Administrator to identify any other areas that may be affected by the defective practice and all items found were corrected. Staff was in serviced on not using plug adaptors, extension cords notify maintenance when there are broken outlets, and damaged cords. The Therapy staff was in serviced by 11/21/2014 on the proper outlet to plug the hydroculator into. 3. The Administrator or designee will audit weekly for 3 weeks and monthly for three months to ensure that plug adaptors, and extension cords are not in use in the facility. They will also audit plug placement of the hydroulator, electrical outlet cover integrity, and power cord integrity. 4. The Administrator or designee will monitor audit results and present it to	

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