

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

RECEIVED
FEB 02 2016
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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 01/10/2016
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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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(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 025 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain fire/smoke barriers.</p> <p>The finding included:</p> <p>Observation on 1/10/16 at 10:48 AM, revealed unapproved fire stop (foam) in the fire barrier above the fire doors next to room 30. National Fire Protection Association (NFPA) 101, 8.2.3.2.4 (2000 Edition)</p> <p>This finding was verified and acknowledged by the maintenance director and administrator during the exit conference on 1/10/16.</p>	K 025	<ol style="list-style-type: none"> The foam that was located above the fire door near room 30 was replaced with a proper fire barrier on 1-15-2016 and fire caulk was applied to the identified penetration on the same day. The Maintenance Director was in serviced on penetrations and providing proper fire barrier for the building on 1-26-2016 by the Administrator. There was an audit on 1-19-2016 to identify any other areas that may have an improper foam barrier in place. There were no other areas identified during our audit. All residents could potentially be affected by this deficient practice. The Administrator or Maintenance Director will conduct two random audits monthly for three months to ensure no other areas are identified with improper foam barriers or penetrations. 	1-29-2016
K 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bruno White</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1-29-16</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 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 038	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the exits. The finding included: Observation on 1/10/16 at 11:43 AM, revealed the front 15 second delay egress door did not have any visible sign posted. National Fire Protection Association 101, 7.2.1.6.1 (2000 Edition) This finding was verified and acknowledged by the maintenance director and administrator during the exit conference on 1/10/16.		4. The Administrator or Maintenance Director will compile the audit results and present to the monthly Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for 3 months for further recommendations and/or follow up as needed.	
K 039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the corridor width. The finding included: Observations on 1/10/16 at 10:03 AM, revealed linen carts next to rooms 5, 13, 34, and 36. Further observations on 1/10/16 at 10:39 AM, revealed the linen carts were still located in the same areas as noted above. Centers of Medicare and Medicaid Services Survey and Certification 10-18-Life Safety Code			

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K 038	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the exits. The finding included: Observation on 1/10/16 at 11:43 AM, revealed the front 15 second delay egress door did not have any visible sign posted. National Fire Protection Association 101, 7.2.1.6.1 (2000 Edition) This finding was verified and acknowledged by the maintenance director and administrator during the exit conference on 1/10/16.	K 038	Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for 3 months for further recommendations and/or follow up as needed.	
K 039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the corridor width. The finding included: Observations on 1/10/16 at 10:03 AM, revealed linen carts next to rooms 5, 13, 34, and 36. Further observations on 1/10/16 at 10:39 AM, revealed the linen carts were still located in the same areas as noted above. Centers of Medicare and Medicaid Services Survey and Certification 10-18-Life Safety Code	K 039	1. The nursing staff was in serviced on not storing linen carts in corridors for more than 30 minutes by 1-29-2016. 2. An audit was conducted by the Administrator on 1-11-16 and 1-15-2016 to ensure that items were not being stored in the corridors. There were no items noted to be stored in the corridor. All residents could potentially be affected by this deficient practice. 3. The Administrator or Maintenance Director will conduct two random audits	1-29-2016

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K 038	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the exits. The finding included: Observation on 1/10/16 at 11:43 AM, revealed the front 15 second delay egress door did not have any visible sign posted. National Fire Protection Association 101, 7.2.1.6.1 (2000 Edition) This finding was verified and acknowledged by the maintenance director and administrator during the exit conference on 1/10/16.	K 038	1. There was a sign posted on the front door on 1-27-2016 to notify anyone that the door will release with in 15 seconds of pressing. The Maintenance Director was in serviced on 1-26-2016 on 15 second posting requirements.	1-29-2016
K 039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the corridor width. The finding included: Observations on 1/10/16 at 10:03 AM, revealed linen carts next to rooms 5, 13, 34, and 36. Further observations on 1/10/16 at 10:39 AM, revealed the linen carts were still located in the same areas as noted above. Centers of Medicare and Medicaid Services Survey and Certification 10-18-Life Safety Code		2. The Administrator and Maintenance Director conducted an audit on 1-14-16 and 1-15-16 to identify any other doors that needed notification and none were identified. All residents could potentially be affected by this deficient practice. 3. The Administrator or designee will conduct audits monthly for three months to ensure proper 15 second postings are in use. 4. The Administrator or Maintenance Director will compile the audit results and present to the monthly Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator;	

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K 039	Continued From page 2 This finding was verified and acknowledged by the maintenance director and administrator during the exit conference on 1/10/16.	K 039	weekly for four weeks to ensure compliance and then monthly for three months to ensure carts are not being improperly stored in the corridors.		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the sprinkler system. The finding included: Observations on 1/10/16 at 11:06 AM, revealed sprinklers with corrosion in the kitchen dishwashing area, the spa next to the O2 storage, and the spa next to room 32. National Fire Protection Association 25, 2.2.1.1 (1998 Edition)		4. The Administrator or Director of Nurses will compile the audit results and present to the monthly Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for 3 months for further recommendations and/or follow up as needed.		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING				

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K 066	<p>Continued From page 3</p> <p>or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(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</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the metal containers in the smoking area.</p> <p>The finding included:</p> <p>Observation on 1/10/16 at 11:00 AM, revealed one of the two metal containers self closures was not closing properly. National Fire Protection Association 101, 19.7.4 (2000 Edition)</p> <p>This finding was verified and acknowledged by the maintenance director and administrator during the exit conference on 1/10/16.</p>		<p>Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for 3 months for further recommendations and/or follow up as needed.</p>	1-29-2016	
K 141 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance</p>				

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K 066	<p>Continued From page 3</p> <p>or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(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</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the metal containers in the smoking area.</p> <p>The finding included:</p> <p>Observation on 1/10/16 at 11:00 AM, revealed one of the two metal containers self closures was not closing properly. National Fire Protection Association 101, 19.7.4 (2000 Edition)</p> <p>This finding was verified and acknowledged by the maintenance director and administrator during the exit conference on 1/10/16.</p>	K 066	<ol style="list-style-type: none"> The red can that was identified was replaced on 1-13-2016 by the Maintenance Director. No other red cans were identified during an audit conducted by the Administrator to not close properly on 1-13-2016. All residents could potentially be affected by this deficient practice. The Administrator or designee will conduct two random audits monthly for three months to ensure red cans are closing properly. The Administrator or Maintenance Director will compile the audit results and present to the monthly Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; 	1-29-2016
K 141 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance</p>			

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K 141	<p>Continued From page 4 with 19.3.2.4, NFPA 99, 8.6.4.2.</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to have no smoking signs posted where oxygen was being stored.</p> <p>The finding included:</p> <p>Observation on 1/10/16 at 11:35 AM, revealed oxygen stored in the therapy room with no visible precautionary sign posted outside the room. National Fire Protection Association 99, 8.6.4.2 (1999 Edition)</p>	K141	<p>Rehabilitation Director; and Medical Records Director.) for 3 months for further recommendations and/or follow up as needed.</p>	1-29-2016
K 147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</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 observations and document review, the facility failed to maintain the electrical equipment.</p> <p>The finding included:</p> <p>1. Observations on 1/10/16 at 10:39 AM, revealed electrical junction box face covers not attached in the following locations: a. 1 above the ceiling next to room 25.</p>		<ol style="list-style-type: none"> 1. Oxygen storage in use sign was placed on the therapy door on 1-10-2016. 2. The Administrator and Maintenance Director conducted an audit on 1-14-16 and 1-15-16 to identify any other areas that stored oxygen without the proper signage. The staff was in serviced by 1-29-2016 on Oxygen in use sign requirements. All residents could potentially be affected by this deficient practice. 3. The Administrator or Director of Nurses will conduct two random audits monthly for three months to ensure that proper signage is present when oxygen is in use. 4. The Administrator or Director of Nurses will compile the audit results and present to the monthly Quality Assurance Performance Improvement Committee (Members include: 	

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K 141	Continued From page 4 with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation, the facility failed to have no smoking signs posted where oxygen was being stored. The finding included: Observation on 1/10/16 at 11:35 AM, revealed oxygen stored in the therapy room with no visible precautionary sign posted outside the room. National Fire Protection Association 99, 8.6.4.2 (1999 Edition) This finding was verified and acknowledged by the maintenance director and administrator during the exit conference on 1/10/16.	K 141	Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for 3 months for further recommendations and/or follow up as needed.	
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 This STANDARD is not met as evidenced by: Based on observations and document review, the facility failed to maintain the electrical equipment. The finding included: 1. Observations on 1/10/16 at 10:39 AM, revealed electrical junction box face covers not attached in the following locations: a. 1 above the ceiling next to room 25.	K 147	1. The identified junction box covers were replaced by 1-26-16. The multi plug adaptor was removed on 1-10-2016. The beds that were found to be plugged into power strips in rooms 13 and 21 were relocated to outlets on 1-10-2016. The oxygen concentrator that was plugged into a power strip was removed and placed into an outlet on 1-10-2016. The extension cord in room 25 was removed on 1-10-2016. An annual retention force test was conducted on 1-19-2016 on the resident room	1-29-2016

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K 147	<p>Continued From page 5</p> <p>b. 2 above the ceiling between 42 and 44. c. 1 in the basement dietary needs storage. National Fire Protection Association (NFPA) 70, 370-28(c) (1999 Edition)</p> <p>2. Observation on 1/10/16 at 10:39 AM, revealed multiplug adaptor in use in room 13 (removed by staff during walk thru) NFPA 99 3-3.2.1.2 (1999 Edition)</p> <p>3. Observations on 1/10/16 at 11:19 AM, revealed hospital beds plugged into powerstrips in resident room's 13 and 21. (removed by staff during walk through) Centers of Medicare and Medicaid Services (CMS) Reference: Survey and Certification (S&C) 14-46-Life Safety Code.</p> <p>4. Observation on 1/10/16 at 11:21 AM, revealed an O2 concentrator plugged into a powerstrip in room 15.(removed by staff during walk through) CMS Ref: S&C: 14-46-LSC.</p> <p>5. Observation on 1/10/16 at 11:31 AM, revealed extension cords in use in resident room 25 (removed by staff during walk through) and in the Human Resource (HR) office. CMS Ref: S&C: 14-46-LSC.</p> <p>6. Document review on 1/10/16 at 12:14 PM, revealed the facility failed to provide documentation for an annual retention force test on the electrical outlets in patient care rooms. NFPA 99, 3.3.4.2.3 (2000 Edition)</p> <p>These findings were verified and acknowledged by the maintenance director and administrator during the exit conference on 1/10/16.</p>	K 147	<p>plugs. A log was created on 1-19-2016 which will be kept to ensure compliance.</p> <p>2. An audit was conducted on 1-19-2016 and a log was created to monitor going forward. The Maintenance Director was in serviced on keeping a plug retention log on 1-26-2016. The staff was in serviced on the use of multi plug adaptors, resident equipment must be plugged into a wall outlet, and extension cords are not allowed in the building. All residents could potentially be affected by these deficient practices.</p> <p>3. The Administrator or Maintenance Director will conduct two random audits monthly for three months to ensure that multi plug adaptors, and extension cords are not in use in the building. Beds, Oxygen concentrators and other like equipment are plugged into outlets and not power strips, and that we have a plug retention log in place.</p> <p>4. The Administrator or Director of Nurses will compile the audit results and present to the monthly Quality Assurance Performance</p>	

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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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(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 147	<p>Continued From page 5</p> <p>b. 2 above the ceiling between 42 and 44.</p> <p>c. 1 in the basement dietary needs storage. National Fire Protection Association (NFPA) 70, 370-28(c) (1999 Edition)</p> <p>2. Observation on 1/10/16 at 10:39 AM, revealed multiplug adaptor in use in room 13 (removed by staff during walk thru) NFPA 99 3-3.2.1.2 (1999 Edition)</p> <p>3. Observations on 1/10/16 at 11:19 AM, revealed hospital beds plugged into powerstrips in resident room's 13 and 21. (removed by staff during walk through) Centers of Medicare and Medicaid Services (CMS) Reference: Survey and Certification (S&C) 14-46-Life Safety Code.</p> <p>4. Observation on 1/10/16 at 11:21 AM, revealed an O2 concentrator plugged into a powerstrip in room 15.(removed by staff during walk through) CMS Ref: S&C: 14-46-LSC.</p> <p>5. Observation on 1/10/16 at 11:31 AM, revealed extension cords in use in resident room 25 (removed by staff during walk through) and in the Human Resource (HR) office. CMS Ref: S&C: 14-46-LSC.</p> <p>6. Document review on 1/10/16 at 12:14 PM, revealed the facility failed to provide documentation for an annual retention force test on the electrical outlets in patient care rooms. NFPA 99, 3.3.4.2.3 (2000 Edition)</p> <p>These findings were verified and acknowledged by the maintenance director and administrator during the exit conference on 1/10/16.</p>	K 147	<p>Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) for 3 months for further recommendations and/or follow up as needed.</p>	
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