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

PRINTED: 12/11/20
FORM APPROVED
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445294	A. BUILDING 02 - MAIN B. WING	12/08/2014

NAME OF PROVIDER OR SUPPLIER: LIFE CARE CENTER OF COLLEGEDALE

STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 658, 9210 APISON PIKE, COLLEGEDALE, TN 37315

(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
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to have a fire rated door on rooms that are protected as a hazardous area. The findings include: Observation and record review of building drawings on December 8, 2014 at 3:45 p.m. revealed the soiled linen room and clean utility room by room 220 are protected as hazardous with 1 hour fire rated construction. Inspection of the doors revealed they are not labeled 45 minute doors. Review of the building drawings confirms that those rooms are protected as hazardous with 1 hour fire rated construction and are to be provided with 45 minute fire rated doors. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on December 8, 2014.	K 029	K 029 Two new doors, with proper rating, have been ordered.(12/16/14) Delivery is expected by 1/15/14. Installation should be complete by 1/24/15. No other doors were identified to be at incorrect rating on inspection by maintenance director or assistant. Any future changes in doors will be made per NFPA code Doors will remain an open item in Performance Improvement Meeting (PI) until resolved.	12/16/14
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. 18.2.1	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carolyn Newman

TITLE: NHA

(X6) DATE: 12/29/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X1) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN B. WING	(X3) DATE SURVEY COMPLETED
	445294		12/08/2014

NAME OF PROVIDER OR SUPPLIER: LIFE CARE CENTER OF COLLEGEDALE

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K 038	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and testing, it was determined that the facility failed to arrange exits so that they are accessible at all times. The findings include: 1. Observation revealed on December 8, 2014 at 2:00 p.m. that all 10 of 10 delayed egress doors did not have the correct signage. The signage is placed on glass exit doors with the required lettering not on a contrasting background, due to the clear adhesive sticker with red lettering on the glass door. 2. Testing of the delayed egress doors on December 8, 2014 at 11:40 a.m. and 11:50 a.m. revealed they doors did not operate correctly. The delayed egress exit doors by room 102 and by the fire place in the dining room do not alarm when the required force is applied to them. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on December 8, 2014. NFPA 101 7.2.1.6.1	K 038	1. Signage has been replaced on 10 glass egress doors. New signage has a contrasting background. 1. No other doors were identified to be in need of signage change. 1. Any future changes to egress doors will have proper signage. 1. Glass egress door signage will be reviewed at monthly PI meeting. 2. Mag. Lock in dining room was adjusted and works properly now. Mag. Lock near room 102 was replaced with a new lock on 12/15/14 2. No other delayed egress doors have been identified as not working properly, after testing by maintenance.	K038 12/15/14 12/15/14
K 052 SS=F	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	2. All delayed egress doors will be tested monthly by maintenance director to assure proper operation. 2. Proper operation of the egress doors will be reported and reviewed at monthly Performance Improvement Meeting, by maintenance director.	

POC #2 Acceptable TT

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

PRINTED: 12/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445294		12/10/2014

NAME OF PROVIDER OR SUPPLIER: LIFE CARE CENTER OF COLLEGEDALE

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F 000	INITIAL COMMENTS During the annual recertification survey conducted on December 8, 2014, through December 10, 2014, at Life Care Center of Collegedale, investigation of complaint #34889 and complaint #34890 were conducted in conjunction with the survey. The complaints were unsubstantiated and no deficiencies were cited under CFR Part 483.13, Requirements for Long Term Care.	F 000		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure residents were informed prior to a room change for two residents (#19 and #139) of twenty-six residents reviewed. The findings included: Resident #19 was admitted to the facility on March 14, 2014, with diagnoses including Chronic Pulmonary Heart Disease, and Anemia. Resident #139 was admitted to the facility on December 28, 2013, with diagnoses including Anxiety State, Diabetes Mellitus, and Atrial Fibrillation. Interview with resident #139 on December 8, 2014, at 2:11 p.m., in the resident room, revealed	F 247	F 247 Both residents have been interviewed by Social Services and are pleased with their rooms. No other residents, with room changes in the last 3 months, were found to be affected by the practice, after interview by Social Services. Director of Social Services will maintain a notebook with all room status changes. Notebook will show when resident and, if appropriate, family were notified of change., and by what staff member. New Director of Social Services has been inserviced, on 12/15, on room change procedure by Administrator. Notebook with room change information will be brought to monthly Performance Improvement Meeting, and Director of Social Worker will bring audit of all room change notifications to the Performance Improvement Meeting meeting monthly, for 3 months to assure compliance. Members of the Performance Improvement committee are: Administrator, Medical Director, Dietary Director, Activity Director, Medical Records Director, Director of Nursing, Social Services Director, Director of Maintenance; Director of Environmental Servcies, Director of Rehab. Services, Director of Admissions, Director of HR.	12/23/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carolyn Freeman
TITLE: NHA
(X6) DATE: 12/29/14

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.

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	445294		12/10/2014

NAME OF PROVIDER OR SUPPLIER: LIFE CARE CENTER OF COLLEGEDALE

STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 658, 9210 APISON PIKE, COLLEGEDALE, TN 37315

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F 247	Continued From page 1 the resident had a room change in the last nine months, and was not notified prior to a change of rooms. Interview with resident #19 on December 9, 2014, at 8:42 a.m., in the resident room, revealed the resident had a room change in the last nine months, and was not notified prior to a change of rooms. Review of the facility policy Resident Room Relocation revealed, "...resident's ability to cope and adjust to the relocation are adressed by taking the following steps...1. Providing the resident, legal guardian and interested family member with a verbal notice and documenting this in the medical record..." Interview with the Social Services Director and medical record review, on December 10, 2014, at 8:24 a.m., at the 300 hall nurse's station, confirmed there was no documentation the family or resident was notified of the room changes prior to the room change.	F 247		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 The wet containers were put back through the dishwasher and not used for food preparation. No other wet and stored dishes have been found in the kitchen. On 12/10.14, all dietary staff were inserviced on proper procedure for drying and storing dishes, by the Director of Dietary Services. The Director of Dietary Services will do a weekly audit for wet dishes, which will be conducted for 4 weeks and reported on at Monthly Performance Improvement meeting. After that, an audit will be conducted monthly for 6 months and reported on at the Monthly Performance Improvement meeting. The committee members are the Administrator, Dire. of Nursing., Director of Social Services, Director of Maintenance, Director of Environmental Services, Director of Rehab. Services, Director of HR and Director of Admissions, Director of Medical Records, Acticity Director, Medical Director.	12/23/14

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

PRINTED: 12/15/201
FORM APPROVE
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445294	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/10/2014
NAME OF PROVIDER OR SUPPLIER: LIFE CARE CENTER OF COLLEGEDALE		STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 558, 9210 APISON PIKE COLLEGEDALE, TN 37315	

(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 371	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store five of five storage containers and failed to store dishes in a sanitary manner in one of one plate warmer racks. The findings included: Observation on December 8, 2014, at 10:00 a.m., with the Dietary Manager (DM) in the facility kitchen, revealed five white storage containers (approximately 2 quart size) stacked, the inside of each container was wet, and the containers were stored and ready for use. Interview with the DM on December 8, 2014, at10:00 a.m., in the facility kitchen, confirmed the five containers were stacked wet and ready for use to serve resident food. Observation on December 8, 2014, at 10:15 a.m., with the DM in the facility kitchen, revealed a two sided plate warmer rack, with food debris on both plate platforms. Continued observation revealed approximately twenty plates stored in the left side, and ready for use to serve the residents' lunch. Interview with the DM on December 8, 2014, at 10:20 a.m., in the facility kitchen, confirmed both plate platforms of the plate warmer rack were soiled with food debris, and the twenty plates stored on the left side were ready for use to serve residents food. Observation on December 8, 2014, at 11:55 a.m., in the facility kitchen, revealed the plate warmer platforms still had food debris, and the staff used the plates in the plate warmer to serve the	F 371	The plate warmer has been cleaned. No other equipment was identified as being soiled. All current dietary staff, checked to payroll roster, were inserviced on proper cleaning and maintanence of plate warmer daily, by the Dietary Manager, on 12/10/14. All newly hired dietary employees will receive this inservice as part of thier orientation. The plate warmer will be audited, by the Director of Dietary, for cleanliness, weekly for 4 weeks, then monthly for 6 months. This will be reported on at the Monthly Performance Improvement Meeting by the Dietary Director. The Performance Improvement committee members are the Administrator, Director of Nursing, Medical Director, Director of Social Services, Director of Activities, Director of Admissions, Director of HR, Director of Environmental Services,Director of Maintenance, Director of Dietarty Services, Activity Director,.	12/22/14

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

PRINTED: 12/
FORM APP
OMB NO. 093

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445294	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SUR COMPLETE 12/10/20
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF COLLEGEDALE		STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315	

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F 371	Continued From page 3 residents lunch. Observation on December 10, 2014, at 12:45 p.m., with the DM in the facility kitchen, revealed both plate platforms in the plate warmer had food debris. Continued observation revealed approximately twenty plates in the left side ready for use to serve the residents' lunch. Interview with the DM on December 10, 2014, at 12:57 p.m., in the facility kitchen, revealed the plate warmer rack was scheduled to be cleaned daily. Continued interview confirmed both plate platforms in the plate warmer had food debris, the plates in the left side were ready for use to serve residents food, and the plate warmer had not been cleaned for two days.	F 371		

Division of Health Care Facilities

PRINTED: 12
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SU COMPLET
	TN3307		12/10/2

NAME OF PROVIDER OR SUPPLIER: LIFE CARE CENTER OF COLLEGEDALE

STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315

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N 002	1200-8-6 No Deficiencies During annual Licensure survey and complaint investigation of complaints #34889 and #34890, conducted on December 10, 2014, at Life Care Center of Collegedale, no deficiencies were cited in relation to the complaint under 1200-8-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carolyn Thurman

TITLE: NHA

(X6) DATE: 12/29/14

STATE FORM

X78U11

If continuation sheet 1 of

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445294	A. BUILDING 07 - MAIN B. WING	12/08/2014

NAME OF PROVIDER OR SUPPLIER: LIFE CARE CENTER OF COLLEGEDALE

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to have a fire rated door on rooms that are protected as a hazardous area. The findings include: Observation and record review of building drawings on December 8, 2014 at 3:45 p.m. revealed the soiled linen room and clean utility room by room 220 are protected as hazardous with 1 hour fire rated construction. Inspection of the doors revealed they are not labeled 45 minute doors. Review of the building drawings confirms that those rooms are protected as hazardous with 1 hour fire rated construction and are to be provided with 45 minute fire rated doors. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on December 8, 2014.	K 029	K 029 Two new doors, with proper rating, have been ordered.(12/16/14) Delivery is expected by 1/15/14. Installation should be complete by 1/24/15. No other doors were identified to be at incorrect rating on inspection by maintenance director or assistant. Any future changes in doors will be made per NFPA code Doors will remain an open item in Performance Improvement Meeting (PI) until resolved.	12/16/14
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. 18.2.1	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carolyn Freeman

TITLE: NHA

(X8) DATE: 12/29/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN B. WING	(X3) DATE SURVEY COMPLETED
	445294		12/08/2014

NAME OF PROVIDER OR SUPPLIER: LIFE CARE CENTER OF COLLEGEDALE

STREET ADDRESS, CITY, STATE, ZIP CODE: PO BOX 658, 9210 APISON PIKE, COLLEGEDALE, TN 37315

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K 038	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and testing, it was determined that the facility failed to arrange exits so that they are accessible at all times. The findings include: 1. Observation revealed on December 8, 2014 at 2:00 p.m. that all 10 of 10 delayed egress doors did not have the correct signage. The signage is placed on glass exit doors with the required lettering not on a contrasting background, due to the clear adhesive sticker with red lettering on the glass door. 2. Testing of the delayed egress doors on December 8, 2014 at 11:40 a.m. and 11:50 a.m. revealed they doors did not operate correctly. The delayed egress exit doors by room 102 and by the fire place in the dining room do not alarm when the required force is applied to them. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on December 8, 2014. NFPA 101 7.2.1.6.1	K 038	1. Signage has been replaced on 10 glass egress doors. New signage has a contrasting background. 1. No other doors were identified to be in need of signage change. 1. Any future changes to egress doors will have proper signage. 1. Glass egress door signage will be reviewed at monthly PI meeting. 2. Mag. Lock in dining room was adjusted and works properly now. Mag. Lock near room 102 was replaced with a new lock on 12/15/14 2. No other delayed egress doors have been identified as not working properly, after testing by maintenance.	K038 12/15/14 12/15/14
K 052 SS=F	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	2. All delayed egress doors will be tested monthly by maintenance director to assure proper operation. 2. Proper operation of the egress doors will be reported and reviewed at monthly Performance Improvement Meeting, by maintenance director.	

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	445294		12/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF COLLEGEDALE	PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315

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K 052	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and testing, it was determined that the facility failed to maintain the automatic magnetic door release devices for the corridor fire doors. The findings include: Observation and testing on December 8, 2014 at 3:20 p.m. revealed after the fire alarm system was activated and the audible alarms were silenced, the silenced still active fire alarm system re-energized the magnetic hold open devices on 5 of 5 sets of fire doors. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on December 8, 2014. NFPA 72 3-9.7.1, 3-9.7.2	K 052	K 052 Malfunctioning doors were re-programmed by International Fire Protection on 12/17 All facility doors with magnetic hold open devices were tested by maintenance director. No others were found to be malfunctioning. All doors with magnetic hold open devices will be observed during routine fire drills for proper closing, by maintenance director and assistant. This item will become a part of the monthly Performance Improvement Meeting review.	12/17/14
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and record review, it was determined that not all control valves for the sprinkler system are electronically supervised. The findings include: Observation and record review of the sprinkler system on December 8, 2014 at 10:55 a.m.	K 061	K 061 An electronic tamper switch has been installed . No other area has been identified in need of an electronic tamper switch. Monthly testing will be conducted by the maintenance director or assistant. Monthly TELs reporting, as well as review and reporting, at monthly Performance Improvement Meeting.	12/15/14

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	445294		12/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF COLLEGEDALE	PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315

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K 061	Continued From page 3 revealed the Outside Stem & Yoke (OS&Y) valve in the pit is not electronically supervised to provide a signal that sounds and is displayed at a continuously attended location when the sprinkler operation is impaired. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on December 8, 2014.	K 061		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and record review, it was determined that the facility failed to maintain the automatic sprinkler system and its components. The findings include: 1. Observation on December 8, 2014 at 10:55 a.m. revealed the sprinkler pit has an accumulation of 1'6" to 2' of standing water. 2. Record review on December 8, 2014 at 10:15 a.m. revealed 5 year sprinkler tests and inspections are past due for the obstruction test, gauges, and the internal inspection of check valves. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on December 8, 2014.	K 062	K 062 1. Sump pump has been ordered and electrician will install in pit to remove accumulated moisture. Installed by 12/30 1. No other sprinkler pit is affected by this problem. 1. Sump pump will be installed. 1. Bi-weekly checks will be made by the maintenance director or assistant. These will be reviewed and reported on in monthly Performance Improvement Meeting. 2. A 5 year obstruction test, gauges, and internal inspection of check valves was done on 12/11/14. Gage replacements of 2 wets systems and 1 dry system was completed. All systems were re-set. 2. No other sprinkler system exists in facility. 2. Records will note that 5 year inspection will be needed in 2020. 2. Report will be taken to Performance Improvement Monthly meeting and dates recorded.	12/17/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN B. WING	(X3) DATE SURVEY COMPLETED
	445294		12/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF COLLEGEDALE	PO BOX 658, 9210 APISON PIKE COLLEGEDALE, TN 37315

(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
K 062	Continued From page 4 NFPA 13 5-14.1.4.2*, NFPA 25 Table 2-1 & 6-2.8	K 062		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain the HVAC system components in accordance with NFPA 90A. The findings include: Record review and interview with the maintenance director on December 8, 2014 at 10:30 a.m. revealed no 4-year fire damper maintenance has been conducted or documentation indicating that fire dampers has been serviced. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on December 8, 2014. NFPA 90A 3-4.7	K 067	K 067 All fire dampers were inspected/serviced by International Fire. One damper will be replaced by 1/24/15 All dampers were inspected. Only one will need to be replaced. Date for 4 year inspection will be noted and entered into PI data. Date for next 4 year service will be noted in Performance review Meeting.	12/17/14
K 077 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4.	K 077		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN B. WING	(X3) DATE SURVEY COMPLETED
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K 077	Continued From page 5 This STANDARD is not met as evidenced by: Record review and interview, it was determined that the facility failed to inspect and test the piped in medical gas system. Record review and interview with the maintenance director on December 8, 2014 at 11:30 a.m. revealed the piped in medical gas and vacuum system is not being inspected and tested annually. The last test was conducted in February of 2013. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on December 8, 2014. NFPA 99 1-4, NFPA 101 4.6.1.3	K 077	K 077 System was tested on 12/11/14. One gauge has been ordered and will be replaced by 12/30/14. Facility has only one system for medical gas and vacuum. Date of annual inspection will be recorded in Performance Improvement Meeting to assure annual testing, by maintenance director. Testing of these systems will become part of Monthly Performance Improvement Meeting.	12/17/14
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to maintain fire rated assemblies. The findings include: Observation on December 8, 2014 between 2:15 p.m. and 3:15 p.m. revealed unsealed penetrations in fire walls and unapproved fire stopping assemblies in the following locations: 1. Unsealed penetrations above ceiling at soiled linen room by room 220. 2. Unsealed penetration above ceiling at the fire doors by the ice cream parlor. 3. Unapproved fire stopping assembly by having difference brands of fire caulk mixed together in the same penetration. These findings were verified by the maintenance	K 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN B. WING	(X3) DATE SURVEY COMPLETED
	445294		12/08/2014

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K 130	Continued From page 6 director and acknowledged by the administrator during the exit conference on December 8, 2014. NFPA 101 8.2.3.2.4.2* Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) * Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met: a. The material shall be capable of maintaining the fire resistance of the fire barrier. b. The material shall be protected by an approved device that is designed for the specific purpose. (4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the fire barrier. b. It shall be made by an approved device that	K 130	K 130 1. & 2. Unsealed penetrations above soiled linen room by room 220, and above ceiling at fire doors by ice cream parlor, have been sealed. 3. mixed caulking has been removed and replaced with 3M fire rated caulking. (4 hour rated) Attic has been inspected for other penetrations in need of fire rated caulking and none were found, by maintenance director. Maintenance director and the assistant are aware that all penetrations must be properly caulked and that it is not permissible to mix brands of caulk. This issue will be taken to the Performance Improvement Meeting for review and follow up if needed.	12/17/14

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K 130	Continued From page 7 is designed for the specific purpose.	K 130		