

PRINTED: 08/25/2016
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4705	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - BUILDING A B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2016
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NAME OF PROVIDER OR SUPPLIER BEVERLY PARK PLACE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 6321 BEVERLY PARK CIRCLE KNOXVILLE, TN 37918
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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) COMPLETE DATE
N 831	<p>1200-8-6-.08 (1) Building Standards</p> <p>(1) A nursing home shall construct, arrange, and maintain the condition of the physical plant and the overall nursing home environment in such a manner that the safety and well-being of the residents are assured.</p> <p>This Rule is not met as evidenced by: Based on observations and testing, the facility failed to maintain the overall physical environment. Findings include:</p> <p>Based on observation and testing with the maintenance director, on 8/22/16 between 10:44 and 2:00 PM revealed the following:</p> <p>1) Emergency lighting not working in resident rooms M09, 127 and 238. (NFPA 101, 19.2.1)</p> <p>2) 4 unsealed openings above ceiling at the 2nd floor new construction area. Fire rated oriental strand board is used to cover the opening where a window was removed. At the top of the wall there are 4 unsealed openings allowing air flow into the building. (NFPA 101, 19.1.1.3)</p> <p>These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 8/22/16.</p>	N 831	<p>N-831</p> <p>1. The emergency lighting in rooms M09, 127 and 238 was repaired on 8-23-16 by facilities management staff. The four unsealed openings noted in the construction area were sealed on 8-23-16 by the supervisor of the Merritt Construction crew.</p> <p>2. The Director of Facilities Management conducted a 100% audit of emergency lighting on 8-23-16. The Director of Facilities Management conducted a 100% audit of the construction areas on 8-23-16. No other emergency lights or construction areas were identified as being affected.</p> <p>3. The Facilities Management Director in-serviced the facilities management department on emergency lighting and penetrations in construction areas on 8-26-16. The Facilities Management Director in-serviced the supervisor of the Merritt Construction crew on penetrations in construction areas on 08-01-16.</p> <p>4. 100% of the construction areas will be audited for penetrations 3 x weekly x 1 month, weekly x 1 month and then monthly x 1 month by facilities management staff. 100% of emergency lighting will be audited weekly x 4 then monthly x 2 by facilities management staff.</p> <p>Results of the findings will be reported to the Quality Assurance Performance Improvement Committee x 3 months or until 100% compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Therapy</p>	9-15-16

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Walter Williamson

TITLE

Administrator

(X5) DATE

9-1-16

STATE FORM

6800

810821

If continuation sheet 1 of 1

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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4706	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/24/2016
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NAME OF PROVIDER OR SUPPLIER
BEVERLY PARK PLACE HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE
**5321 BEVERLY PARK CIRCLE
KNOXVILLE, TN 37918**

(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) COMPLETE DATE
N 002	<p>1200-8-6 No Deficiencies</p> <p>A licensure survey was conducted from 8/22/16, through 8/24/16 at Beverly Park Place Health and Rehab. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.</p>	N 002	<p>N 8 21 <i>Continued</i> Manager, Staff Development Coordinator, Social Services Department, MDS Coordinators, Maintenance Director, Laundry Director, Admissions Director, Business Office Manager, Housekeeping Director, Medical Records, Dietary Manager, Activity Director, and Medical Director</p>	9-15-16

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X5) DATE

DATE FORM

Doreen Williams

Administrator

9/1/16

810011

If continuation sheet 1 of 1