

PRINTED: 12/15/2015
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445118	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 12/08/2015
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD MEMPHIS, TN 38111	

(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 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain all doors protecting corridor openings.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observations of the dining rooms doors on 12/7/15 at 12:10 PM, revealed the doors would not close. 2. Observations of the kitchen door into the corridor on 12/7/15 at 12:12 PM, revealed the door would not close. <p>These findings were verified by the maintenance</p>	K 018	<p><u>K018</u></p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Dining room doors will be replaced by 1-10-16. Kitchen door in to the corridor will be replaced by 1-10-16..</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>The Administrator in-serviced the Maintenance Director and maintenance workers on ensuring that doors protecting corridor openings should have no impediment to the closing of the doors on 12-30-15. A Maintenance Inspection Audit will be completed</p>	1-10-2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: George Munschow TITLE: CEO-Administrator (X8) DATE: 12-30-15

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 15 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 018	Continued From page 1	K 018	weekly x 3 months then monthly ongoing to ensure closing of doors protecting corridor openings.	
K 026 SS=E	<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: National Fire Protection Association (NFPA) 101, 8.3.6.1 (2000 Edition)</p> <p>Based on observation, the facility failed to maintain all fire and smoke barriers.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observations above the fire doors by the barber shop on 12/7/15 at 12:30 PM, revealed open penetrations and older sealed penetrations in the fire barrier were not sealed. 2. Observations above the fire doors into the dining room on 12/7/15 at 12:35 PM, revealed penetrations. 	K 026	<p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Maintenance Director will present the findings of his Maintenance Inspection Audit monthly ongoing to the Quality Assurance Performance Improvement Committee (Assistant Director of Nursing or Staff Development Coordinator) to the Quality Assurance Performance Committee (Members of the Quality Assurance Performance Committee include: 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 further recommendations and/or follow up as needed.</p>	

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K 025	Continued From page 2 3. Observations of resident room 251 on 12/8/15 at 8:35 AM, revealed a penetration behind bed. 4. Observations of resident room 253 on 12/8/15 at 8:50 AM, revealed a penetration behind bed A. 5. Observations of the C-2 shower room on 12/8/15 at 8:55 AM, revealed a penetration above the door and above the wheel chair shower stall. 6. Observations of resident room 264 on 12/8/15 at 8:55 AM, revealed a penetration behind bed B. 7. Observations of resident room 266 on 12/8/15 at 9:00 AM, revealed a penetration around the receptacle box behind bed A. 8. Observations of resident room 272 on 12/8/15 at 9:05 AM, revealed the phone jack receptacle was not secured in wall. 9. Observations of residents' room 380 on 12/8/15 at 9:40 AM, revealed a section of ceiling had been removed. These findings were verified by the maintenance director during the tour of the facility and acknowledged by the administrator during the exit conference on 12/8/15.	K 025	<u>K025</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Penetrations above the fire doors near the barber shop were repaired on 12-14-15 Penetrations above the fire doors were repaired on 12-14-15. Penetrations in rooms 251 was repaired on 12-24-15, 253 on 12-30-15, 264 on 12-24-15, and 266 on 12-24-15. Penetrations in C-2 shower room were repaired on 12-24-15. Phone jack in room 272 was repaired on 12-24-15. Ceiling in room 380 repaired 12-29-15 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.	1-10-2016
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 029		

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K 029	<p>Continued From page 3</p> <p>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>This STANDARD is not met as evidenced by:</p> <p>A. Based on observation, the facility installed devices on doors which prevented the closing of the doors.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observation of the basement bio-hazard room on 12/7/15 at 10:00 AM, revealed a kick down door stop installed on the door. 2. Observation of the laundry storage room on 12/7/15 at 11:04 AM, revealed a kick down door stop installed on the door. <p>These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 12/8/15.</p> <p>B. Based on observation, the facility failed to provide door closures on all hazardous areas.</p> <p>The findings included:</p> <p>Observation of the laundry room on 12/7/15 at 11:04 AM, revealed the storage room did not have a self closing door device installed.</p>	K 029	<p>The administrator in-serviced the Maintenance Director and maintenance workers on 12-30-15 ensuring all fire and smoke barriers have no penetrations. Maintenance Director or maintenance workers will utilize a Maintenance Audit in which they will inspect for penetrations weekly x 3 months then monthly ongoing.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Maintenance Director will present the results of the Maintenance Audit to the monthly Quality Assurance Performance Improvement Committee (Assistant Director of Nursing or Staff Development Coordinator) to the Quality Assurance Performance Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities</p>	

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K 029	Continued From page 4 This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 12/8/15. C. Based on observation, the facility failed to maintain all 20 minute hazardous area doors to resist the passage of smoke. The findings included: 1. Observation of the 2nd floor soiled linen room on 12/7/15 at 2:25 PM, revealed the top of the door was damaged. 2. Observation of the storage room by the maintenance shop on 12/7/15 at 10:30 AM, revealed a greater than 3/8 inch gap at the top of the door that would allow smoke to pass through. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 12/8/15. D. Based on observation, the facility failed to maintain the doors in hazardous areas. The findings included: 1. Observation of the maintenance shop on 12/7/15 at 10:10 AM, revealed a penetration above the door around a copper pipe.	K 029	Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) ongoing for further recommendations and/or follow up as needed. <u>K029</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The kick down door stops on the biohazard room and laundry room doors were removed on 12-10-15. A self closing door device was installed in the laundry's storage room on 12-30-15. The top of the 2 nd floor linen room door was repaired on 12-24-15. The door of the storage room by the maintenance room was repaired on 12-21-15. The penetration above the door in the maintenance shop was repaired on 12-18-15. The door will be replaced to the storage room in the kitchen by 1-10-16. The door to the back storage room in the kitchen will be replaced by 1-10-16.	1-10-2016

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K 029	Continued From page 5 2. Observation of the kitchen on 12/7/15 at 11:45 AM, revealed the door to the storage room had been removed. 3. Observation of the kitchen on 12/7/15 at 11:52 AM, revealed the door to the back storage room had been removed. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 12/8/15. NFFPA 101 LIFE SAFETY CODE STANDARD	K 029	How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.	
K 047 SS=D	Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based observation, the facility failed to maintain all exit signs. The findings included: Observation of the laundry washer room on 12/7/15 at 11:00 AM, revealed the exit sign above the door was not illuminated. This finding was verified by the maintenance director during the tour of the facility and acknowledged by the administrator during the exit conference on 12/8/15. NFFPA 101 LIFE SAFETY CODE STANDARD	K 047	The Administrator in-serviced the Maintenance Director and maintenance workers on 12-30-15 on ensuring doors are self closing and do not have kick downs, ensuring there are self closing door devices in all hazardous areas, maintaining 20 minute hazardous area doors to resist passage of smoke, and maintain the doors and ensure not removed. The Maintenance Director/workers will complete a Maintenance Audit which will include inspecting doors for self closing devices, ensure kick downs not installed, no penetrations, doors not removed and in good repair weekly x 3 months then monthly ongoing.	
K 050 SS=D	Fire drills are held at unexpected times under	K 050		

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K 050	<p>Continued From page 6 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</p> <p>This STANDARD is not met as evidenced by: A. Based on record review, the facility could not provide fire drills for all shifts during 2015.</p> <p>The findings included: During record review the facility was unable to provide documentation of the 1st and 3rd shift fire drill for the first quarter of 2015, a 2nd shift drill for the 2nd quarter and a 1st shift drill for the 3rd quarter of 2015.</p> <p>This finding was verified by the maintenance director during the record review and acknowledged by the administrator during the exit conference on 12/8/15.</p> <p>B. Based on observation, the facility failed to conduct fire drills per the fire plan.</p> <p>The findings included: Observation of the fire drill conducted by the</p>	K 050	<p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Maintenance Director will present the results of the Maintenance Audit to the monthly Quality Assurance Performance Improvement Committee</p> <p>(Assistant Director of Nursing or Staff Development Coordinator) to the Quality Assurance Performance Committee (Members of the Quality Assurance Performance Committee include: 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.) ongoing for further recommendations and/or follow up as needed.</p>	

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NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD MEMPHIS, TN 38111	
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K 050	Continued From page 7 maintenance director on 12/8/15 at 10:50, revealed the staff failed to follow the fire plan procedures.	K 050	<p><u>K047</u></p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Exit sign above laundry washer room repaired on 12-21-15.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>The Administrator in-serviced the Maintenance Director and maintenance workers on 12-30-15 to ensure exit and directional signs have continuous illumination which is also served by the emergency lighting system. The Maintenance Director/workers will utilize a Maintenance Audit which includes inspecting for the continuous illumination weekly x 3 months then monthly ongoing.</p>	1-10-2016
K 052 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: NFPA 72 1998 edition Table 7-3.2</p> <p>Based on record review, the facility could not provide a fire alarm inspection report.</p> <p>The findings included:</p> <p>During record review the facility was unable to provide documentation of fire alarm test documents including the bi-annual smoke detector sensitivity test.</p>	K 052		

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K 062	Continued From page 8 This finding was verified during the document review and acknowledged by the administrator during the exit conference on 12/8/15.	K 052	<p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Maintenance Director will present the results of the Maintenance Audit to the monthly Quality Assurance Performance Improvement Committee (Assistant Director of Nursing or Staff Development Coordinator) to the Quality Assurance Performance Committee (Members of the Quality Assurance Performance Committee include: 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.) ongoing for further recommendations and/or follow up as needed.</p>	
K 062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: National Fire Protection Association (NFPA) 25, 2-2.1.1 (1999 edition).</p> <p>A. Based on observation, the facility failed to maintain all sprinkler heads.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observations of the facility on 12/7/15 beginning at 10:00 AM and on 12/8/15 beginning at 8:30 AM, revealed a heavy build up of lint on the sprinkler heads in rooms 112, 123, 127, 128, 182, 183, 185, 186, 187, 188, 190, 192, 205, 207, 209, 211, 221, 230, 236, 283, 285, 286, 287, 288, 289, 293 and 294. 2. Observation of the nurses' storage room on 11/10/15 at 9:40 AM, revealed the sprinkler head above the refrigerator had paint on the pendant and the head was installed closer than 4 inches to the wall. <p>These findings were verified by the maintenance director during the tour of the facility and</p>	K 062		

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K 062	<p>Continued From page 9 acknowledged by the administrator during the exit conference on 12/8/15.</p> <p>NFPA 25, 2-2.1.2 (edition 1999) B. Based on observation, the facility failed to maintain clearance for water spray coverage for all sprinkler heads.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observation of the facility on 12/7/15 beginning at 10:00 AM and on 12/8/15 beginning at 8:30 AM, revealed sprinkler heads in the nutrition rooms on 1st, 2nd, and 3rd floors were obstructed with the ice machines. 2. Observation of the kitchen on 12/7/15 at 11:50 AM, revealed the sprinkler head in the walk in freezer and the walk in cooler were obstructed with supplies. <p>These findings were verified by the maintenance director during the tour of the facility and acknowledged by the administrator during the exit conference on 12/8/15.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p>	K 062	<p>K050</p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Maintenance Director conducted a fire drill on 12-29-15 on first shift, on 12-30-15 on second shift, and on 12-30-15 on third shift.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>All staff will be in-serviced on the fire drill procedure by 1-10-16 by the Maintenance Director or designee (Administrator or Director of Nursing). The administrator in-serviced the Maintenance Director and maintenance workers on 12-30-15 regarding conducting fire drills at least quarterly on all shifts and to keep a log of such along with sign</p>	1-10-2015
K 064 SS=D		K 064		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445118	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2015
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD MEMPHIS, TN 38111	

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K 064	Continued From page 10 This STANDARD is not met as evidenced by: National Fire Protection Association (NFPA) 10, 4.3 and 4-4.1 (1999 edition) Based on observation, the facility failed to provide required inspections on all fire extinguishers. The findings included: Observation of the transfer switch room on 12/7/15 at 10:15 AM, revealed the annual inspection had not been documented on the inspection card. This finding was verified by the maintenance director during the tour of the facility and acknowledged by the administrator during the exit conference on 12/8/15.	K 064	in sheets. These will be done ongoing. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur. The Maintenance Director will present the results of the Quarterly fire drills and attendees to the monthly Quality Assurance Performance Improvement Committee (Assistant Director of Nursing or Staff Development Coordinator) to the Quality Assurance Performance Committee (Members of the Quality Assurance Performance Committee include: 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.) ongoing for further recommendations and/or follow up	
K 104 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on record review, the facility failed to provide four year inspection and testing of fire dampers. The findings included: During record review the facility was unable to provide documentation of the 4 year fire damper inspections.	K 104	as needed.	

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K 104	Continued From page 11	K 104	<p><u>K052</u></p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>A fire alarm inspection will be completed by 1-10-16.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents have the potential to be affected.</p> <p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>The Administrator in-serviced the Maintenance Director and maintenance workers on scheduling a bi-annual smoke detector sensitivity test on 12-30-15. The Maintenance Director will keep the inspection report and log the date this is completed bi-annually.</p>	1-10-2016
K 130 SS=E	<p>NFPA 101 MISCELLANEOUS</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Guidelines for Design and Construction, Ventilation Requirements, Table 8.1</p> <p>A. Based on observation, the facility failed to provide exhaust in all soiled holding areas.</p> <p>The findings included:</p> <p>Observation of the bio-hazard waste room on 12/7/15 at 10:00 AM, revealed the room did not have an exhaust vent.</p> <p>This finding was verified by the maintenance director during the tour of the facility and acknowledged by the administrator during the exit conference on 12/8/15.</p> <p>National Fire Protection Association (NFPA) NFPA 101, 8.2.2.2</p> <p>B. Based on observation, the facility failed to</p>	K 130		

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K 130	<p>Continued From page 12 maintain all fire rated assemblies.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observation of the transfer switch on 12/7/15 at 10:15 AM, revealed penetrations in the rated ceiling above electrical panel RP-EMA, above the transfer switch, and the sewer line. 2. Observation of the laundry storage area in the basement on 12/7/15 at 10:30 AM, revealed penetrations in the rated ceiling. 3. Observation of the storage room by the maintenance shop on 12/7/15 at 10:35 AM, revealed penetrations in the rated ceiling around pipe hangars and above the door. 4. Observation of the staff education office on 12/7/15 at 11:45 AM, revealed penetrations in the rated ceiling. 5. Observation of the fire pump room on 12/7/15 at 11:55 AM, revealed penetrations in the ceiling. 6. Observation of the 3rd floor E wing mechanical room on 12/8/15 at 10:05 AM, revealed penetrations in the ceiling and penetrations that were not sealed per Under Writers Laboratories. <p>These finding were verified by the maintenance director during the tour of the facility and acknowledged by the administrator during the exit conference on 12/8/15.</p>	K 130	<p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Maintenance Director will present the results of the bi-annual smoke detector sensitivity test to the monthly Quality Assurance Performance Improvement Committee (Assistant Director of Nursing or Staff Development Coordinator) to the Quality Assurance Performance Committee (Members of the Quality Assurance Performance Committee include: 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.) twice a year ongoing for further recommendations and/or follow up as needed.</p>	

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K 130	Continued From page 13 National Fire Protection Association (NFPA) 70, article 400-8 NFPA 99, 3-3.2.1.2 (d) (2) (1999 Edition) and CMS Manual System Publication 100-07, State Operations Manual, Provider Certification; 8/17/2007 C. Based on observation, the facility failed to provide resident rooms with sufficient electrical receptacles to prohibit the use of power strips with medical equipment. The findings included: 1. Observation of resident room 105 on 12/7/15 at 11:30 AM, revealed the bed on the B side was connected to a power strip. 2. Observation of resident room 106, on 12/7/15 at 11:25 AM, revealed the bed on the B side was connected to a power strip. 3. Observation of resident room 110 on 12/7/15 at 11:15 AM, revealed bed A was connected to an approved electrical adapter and on B side the electric wheelchair was connected to a power strip. 4. Observation of resident room 112 on 12/7/15 at 11:10 AM, revealed bed A was connected to an unapproved power adapter. 5. Observation of resident room 182 on 12/7/15 at 11:05 AM, revealed a power adapter in use. 6. Observation of resident room 184 on 12/7/15 at 11:10 AM, revealed the oxygen concentrator was connected to an electrical adapter.	K 130	<u>K062</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The lint on the sprinkler heads in rooms 112, 123, 127, 128, 182, 183, 185, 186, 187, 188, 190, 192, 205, 207, 209, 211, 221, 230, 236, 283, 285, 286, 287, 288, 289, 293, and 294 were cleaned on 12-22-15 The paint on the sprinkler head in the nurses storage room was removed on 12-22-15 and will be moved at least 4 inches away from the wall by 1-10-16. The sprinkler heads in the first, second, and third floor nutrition rooms will no longer be obstructed by the ice machine by 1-10-16. The sprinkler head in the walk in freezer and walk in cooler are no longer obstructed with supplies effective 12-9-15. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected.	

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K 130	<p>Continued From page 14</p> <p>7. Observation of resident room 205 on 12/7/15 at 2:50 PM, revealed bed A was connected to an unapproved power adapter and B side had a white extension cord in use.</p> <p>8. Observation of resident room 211 on 12/7/15 at 2:40 PM, revealed bed A was connected to an unapproved power adapter.</p> <p>9. Observation of resident room 220 on 12/7/15 at 2:25 PM, revealed bed B and the oxygen concentrator was connected to an unapproved power adapter.</p> <p>10. Observation of resident room 224 on 12/7/15 at 2:15 PM, revealed bed B was connected to an unapproved power adapter.</p> <p>11. Observation of resident room 224 on 12/7/15 at 2:15 PM, revealed bed A was connected to an unapproved power adapter.</p> <p>12. Observation of resident room 227 on 12/7/15 at 2:10 PM, revealed bed A was connected to an unapproved power adapter.</p> <p>13. Observation of resident room 232 on 12/7/15 at 2:05 PM, revealed bed A and B were connected to a power strip, and A side had oxygen concentrator connected to an extension cord.</p> <p>14. Observation of resident room 283 on 12/7/15 at 3:15 PM, revealed the oxygen concentrator was connected to a power adapter.</p> <p>15. Observation of resident room 285 on 12/7/15 at 3:15 PM, revealed the bed, the suction canister, the oxygen concentrator, and the</p>	K 130	<p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>The Administrator in-serviced the Maintenance Director and maintenance workers on 12-30-15 on ensuring that sprinkler heads are lint and paint free, not obstructed, and have to be at least 4 inches away from the wall. The Maintenance Director or maintenance workers will utilize the Maintenance Audit weekly x 3 months then monthly ongoing inspecting sprinklers to ensure there are no obstructions, lint or paint build up, and are 4 inches or more from the wall.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Maintenance Director will present the results of the Maintenance Audit to the monthly Quality Assurance Performance Improvement Committee (Assistant Director of Nursing or Staff Development Coordinator) to the Quality Assurance Performance</p>	

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K 130	Continued From page 15 intravenous solution station was connected to an unapproved power adapter. 16. Observation of resident room 289 on 12/7/15 at 3:05 PM, revealed the bed was connected to a power strip. These finding were verified by the maintenance director during the tour of the facility and acknowledged by the administrator during the exit conference on 12/8/15. NFPA 1, 7-4.5.1 (1999 edition) D. Based on observation and interview, the facility failed to maintain all components off the fire pump system. The findings included: Observation and interview on 12/7/15 at 11:55 AM, in the fire pump room, revealed an auxillary pump to the fire pump was making an abnormal sound. The maintenance director was asked why the pump was making a sound. the maintenance director stated, it was low of oil. This finding was verified by the maintenance director during the tour of the facility and acknowledged by the administrator during the exit conference on 12/8/15.	K 130	Committee include: 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.) ongoing for further recommendations and/or follow up as needed. <u>K064</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The fire extinguisher in the transfer switch room was inspected 12-8-15.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected.	1-10-2016

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K 144	Continued From page 16 This STANDARD is not met as evidenced by: Based on document review, the facility failed to conduct 30 minute load test monthly. The findings included: Document review revealed the monthly load test for the generator was not operated for 30 minutes. This finding was verified by the maintenance director during the record review, and acknowledged by the administrator during the exit conference on 12/8/15. 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: NFPA 70, article 410-56 A. Based on observation, the facility failed to maintain all electrical receptacles. The findings included: 1. Observation of resident room 182 on 12/7/15	K 144	<p>What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>The Administrator in-serviced the Maintenance Director and maintenance workers on 12-30-15 on ensuring all fire extinguishers are inspected annually. The Maintenance Director or maintenance workers will utilize the Maintenance Audit and ensure all fire extinguishers are inspected on an annual basis weekly x 3 months then monthly ongoing.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Maintenance Director will present the results of the Maintenance Audit to the monthly Quality Assurance Performance Improvement Committee (Assistant Director of Nursing or Staff Development Coordinator) to the Quality Assurance Performance Committee (Members of the Quality Assurance Performance Committee include: Committee Chairperson – Administrator; Director of Nursing; Assistant Director of Nursing; Medical Director; Dietary Director;</p>	

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K 147	Continued From page 17 at 1:05 PM, revealed the receptacle cover was missing. 2. Observation of resident room 222 on 12/7/15 at 2:20 PM, revealed the receptacle cover was missing. 3. Observation of resident room 224 on 12/7/15 at 2:15 PM, revealed the receptacle cover behind bed A was damaged and the receptacle box behind bed B was hanging and not secured in the wall. 4. Observation of resident room 287 on 12/7/15 at 3:05 PM, revealed the receptacle under the television was damaged. 5. Observation of the 200 hall shower on 12/7/15 at 2:30 PM, revealed the nurse call station was damaged. These findings were verified by the maintenance director during the tour of the building and acknowledged by the administrator during the exit conference on 12/8/15. National Fire Protection Association (NFPA) 70, Article 370-25. (1999 edition) In completed installations, each box shall have a cover, faceplate, or fixture canopy. B. Based on observation, the facility failed to maintain all electrical installations. the findings included:	K 147	Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director; and Medical Records Director.) ongoing for further recommendations and/or follow up as needed. <u>K104</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. A fire damper inspection will occur by 1-10-16. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.	1-10-2016

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K 147	<p>Continued From page 18</p> <p>Observation of the basement mechanical room on 12/7/15 at 10:00 AM, revealed an open electrical junction box.</p> <p>This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 12/8/15.</p> <p>NFPA 70, 110-12. (a)</p> <p>C. Based on observation, the facility failed to cover all unused openings in electrical panel cabinets.</p> <p>The findings included:</p> <p>Observation of the transfer switch room on 12/7/15 at 10:00 AM, revealed unused open spaces in electrical panel "L".</p> <p>This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 12/8/15.</p> <p>D. Based on observation, the facility failed to maintain all emergency lighting in resident rooms.</p> <p>The findings Included:</p> <p>Observations on 12/7/15 beginning at 10:00 AM and on 12/8/15 beginning at 8:30 AM, revealed the emergency lighting was not working in</p>	K 147	<p>The Administrator in-serviced the Maintenance Director and maintenance workers on 12-30-15 on ensuring that 4 year inspection and testing of fire dampers occurs. The Maintenance Director will keep a log on when these damper inspections occur ongoing.</p> <p>How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.</p> <p>The Maintenance Director will present the results of the four year inspection and testing of fire dampers when they occur in the monthly Quality Assurance Performance Improvement Committee (Assistant Director of Nursing or Staff Development Coordinator) to the Quality Assurance Performance Committee (Members of the Quality Assurance Performance Committee include: 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.) ongoing for further recommendations and/or follow up</p>	

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K 147	<p>Continued From page 19 resident rooms 108, 112, 114, 207, 215, 220, 221, 232, 245, 248, 264, 271, 289, and 381.</p> <p>These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 12/8/15.</p>	K 147	<p><u>K130</u></p> <p>How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>The biohazard waste room is being moved to a room with an exhaust on 12-31-15. The penetration in the rated ceiling above the electrical panel RP-EMA, above the transfer switch, and sewer line was repaired on 12-11-15. The penetration in the ceiling of the laundry storage area in the basement was repaired on 12-11-15. The penetration in the storage room by the maintenance shop in the rated ceiling around pipe hangars and above door was repaired on 12-15-15. Penetrations in the rated ceiling of the staff education office was repaired on 12-28-15. Penetrations in the ceiling of the fire pump room were repaired on 12-15-15. Penetrations in the ceiling of the 3rd floor E wing mechanical room were repaired on 12-29-15. Power strips were removed and replaced with sufficient electrical receptacles in rooms 105, 106, 110, 112, 182, and 184 on 12-10-15; rooms 205, 211, 220, 224 A & B, 227, 232 A & B, 283, 285, and 289 on 12-11-15. The auxiliary pump to the fire pump was repaired on 12-29-15.</p>	1-10-2016
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K 147	Continued From page 19 resident rooms 108, 112, 114, 207, 215, 220, 221, 232, 245, 248, 264, 271, 289, and 381. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 12/8/15.	K 147	How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Administrator will in-service the Maintenance Director and maintenance workers on 12-30-15 on maintaining all fire rated assemblies (inspecting for penetrations), ensuring power strips are not used and electrical receptacles are in place, and on maintaining all components of the fire pump system. The Maintenance Director will utilize a Maintenance Audit inspecting for power strips and adaptors, penetrations, and exhaust fans in biohazard rooms weekly x 3 months then monthly ongoing. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.	

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445118	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2015
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3030 WALNUT GROVE RD MEMPHIS, TN 38111	
(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 147	Continued From page 19 resident rooms 108, 112, 114, 207, 215, 220, 221, 232, 245, 248, 284, 271, 289, and 381. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 12/8/15.	K 147	The Maintenance Director will present the results of the Maintenance Audit to the monthly Quality Assurance Performance Improvement Committee (Assistant Director of Nursing or Staff Development Coordinator) to the Quality Assurance Performance Committee (Members of the Quality Assurance Performance Committee include: 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.) ongoing for further recommendations and/or follow up as needed. <u>K144</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	1-10-2016

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K 147	Continued From page 19 resident rooms 108, 112, 114, 207, 215, 220, 221, 232, 245, 248, 264, 271, 289, and 381. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 12/8/15.	K 147	A monthly load test was done on 12-28-15 in which the generator operated for 30 minutes. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur. The Administrator will in-service the Maintenance Director and maintenance workers on 12-30-15 on ensuring a monthly generator load test is conducted for at least 30 minutes. The Maintenance Director will keep a log ongoing on conducting monthly generator load tests that are at least 30 minutes in duration. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.	

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K 147	Continued From page 19 resident rooms 108, 112, 114, 207, 215, 220, 221, 232, 246, 248, 264, 271, 289, and 381. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 12/8/15.	K 147	The Maintenance Director will present the results of the monthly generator load test in the monthly Quality Assurance Performance Improvement Committee (Assistant Director of Nursing or Staff Development Coordinator) to the Quality Assurance Performance Committee (Members of the Quality Assurance Performance Committee include: 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.) ongoing for further recommendations and/or follow up as needed. <u>K147</u> How the corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	1-10-2016

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K 147	Continued From page 19 resident rooms 108, 112, 114, 207, 215, 220, 221, 232, 245, 248, 264, 271, 289, and 381. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 12/8/15.	K 147	A receptacle cover was replaced in rooms 182 and 222 on 12-25-15. The receptacle cover was replaced behind bed A and the receptacle box behind bed B was replaced and secured on 12-21-15. The receptacle in room 287 was replaced. The 200 hall shower room nurse call station was fixed on 12-21-15. The door to the electrical junction box was replaced on 12-16-15. The unused open spaces in electrical panel "L" was fixed on 12-16-15. The emergency lighting in rooms 108, 112, 114, 207, 215, 220, 221, 232, 245, 248, 264, 271, 289, and 381 were repaired on 12-12-15. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.	

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