

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

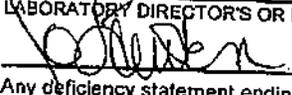
RECEIVED PRINTED: 05/12/2011  
FORM APPROVED  
OMB NO. 0938-0391

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  05/09/2011
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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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(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 027 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain 2 of 7 (smoke barrier doors beside resident room 101 and 227) corridor doors.</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>1. Observation of the corridor doors on the first floor on 5/9/11 at 9:39 AM, revealed the smoke barrier doors beside resident room 101 would not close.</li> <li>2. Observation of the corridor doors on the second floor on 5/9/11 at 11:52 AM, revealed the smoke barrier doors beside resident room 227 would not close.</li> </ol> <p>The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 5/9/11.</p>	K 027	<p>K027</p> <p>The facility will ensure door openings in smoke barriers have at least a 20 minute fire protection rating or are at least 1 3/4 inch thick solid bonded wood core.</p> <ol style="list-style-type: none"> <li>1. <ul style="list-style-type: none"> <li>• New hardware has been ordered by the Maintenance Director on 5/23/11 for corridor doors beside resident room 101 and beside resident room 227.</li> </ul> </li> <li>2. All residents in facility have the potential to be affected by this alleged deficient practice.</li> <li>3. Maintenance Director to complete door checks on corridor doors to ensure appropriate smoke barrier is maintained as appropriate at least weekly for the next 4 weeks and monthly thereafter to ensure compliance.</li> <li>4. Maintenance Director to report findings of door audits monthly for the next 3 months to the QA committee for further recommendations and follow up.</li> </ol>	06/08/2011
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 062	<p>K062</p> <p>The facility will continue to ensure the automatic sprinkler systems are maintained in reliable operating condition.</p>	06/08/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO/Administrator	(X6) DATE 5-24-11
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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 062	Continued From page 1 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 observation, it was determined the facility failed to provide a fire sprinkler wrench inside the sprinkler head supply box.  The findings included:  Observations off the sprinkler room on 5/9/11 at 10:10 AM, revealed the sprinkler supply box did not have the required wrench.  The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 5/9/11. NFPA 101 LIFE SAFETY CODE STANDARD	K 062	I. <ul style="list-style-type: none"> <li>• Maintenance Director has ordered the required wrench for the sprinkler supply box on 5/12/11.</li> <li>2. All residents have the potential to be affected by this alleged deficient practice.</li> <li>3. Maintenance Director to ensure appropriate equipment is maintained in the sprinkler supply box. The Maintenance Director will educate the maintenance staff by 6/8/11 of the requirement that these tools are safeguarded in the sprinkler supply box at all times when not in use.</li> <li>4. Maintenance Director to report to QA committee monthly for the next 3 months to report that appropriate equipment is available in the sprinkler supply box as required.</li> </ul>	
K 066 SS=D	Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.	K 066	K066 The facility will ensure that smoking regulations are adopted to include ashtrays of noncombustible material and safe design are provided in all areas where smoking is allowed. Facility also will ensure metal containers with self-closing cover devices into which ashtrays can be emptied into in smoking area.	06/08/2011

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K 066	Continued From page 2 (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.  (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4  This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to provide metal containers with self-closing lids.  The findings included:  Observation of the smoking area on 5/9/11 at 11:30 AM, revealed the smoking area did not have a metal container with a self closing lid.  The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 5/9/11. NFPA 101 LIFE SAFETY CODE STANDARD	K 066	1. • Maintenance Director has ordered on 5/23/11 a self-closing cover metal trashcan device for smoking area.  2. All residents have the potential to be affected by this alleged deficient practice. 3. Maintenance Director or designee to educate maintenance staff by 6/8/11 on the appropriate use of this metal container with self-closing cover device into which ashtrays can be emptied in resident smoking area. Maintenance Director to monitor the resident smoking area weekly for the next 4 weeks to ensure appropriate utilization of such device is being maintained. 4. Maintenance Director to report findings of above audit to the QA committee monthly for the next 3 months for further recommendation and follow up.	06/08/2011
K 144 SS=D	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K144 The facility will continue to ensure the facility generators are inspected weekly and exercised under load for 30 minutes per month as required.  1. • Maintenance Director educated on requirement to document	06/08/2011

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K 144	Continued From page 3	K 144	readings from the generator meters during the run and load testing.		
K 211 SS=D	<p>This STANDARD is not met as evidenced by: Based on document review, it was determined the facility failed to document generator readings.</p> <p>The findings included:</p> <p>The facility was unable to provide documentation of the readings from the generator meters during the run and load testing.</p> <p>The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 5/9/11.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> <li>o The corridor is at least 6 feet wide</li> <li>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</li> <li>o The dispensers have a minimum spacing of 4 ft from each other</li> <li>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.</li> <li>o Dispensers are not installed over or adjacent to an ignition source.</li> <li>o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623</li> </ul>	K 211	<ol style="list-style-type: none"> <li>2. All residents have the potential to be affected by this alleged deficient practice.</li> <li>3. All maintenance staff to be educated by the Maintenance Director by 6/8/11 on the requirement to document readings from the generator meters during the run and load testing. Maintenance Director and Administrator to audit the generator readings monthly for the next 3 months.</li> <li>4. Maintenance Director to report findings of audit to the QA committee monthly for the next 3 months for further recommendation and follow up.</li> </ol> <p><b>K211</b> The facility will ensure that alcohol base rub dispensers are installed appropriately as dictated in the Life Safety Code Standard.</p> <ol style="list-style-type: none"> <li>1. <ul style="list-style-type: none"> <li>• Maintenance Director moved the two dispensers identified to ensure appropriate compliance is achieved on 5/10/11.</li> </ul> </li> <li>2. All residents in facility at risk of alleged deficient practice. Maintenance Director completed an audit of all dispensers in facility on 5/10/11</li> </ol>	06/08/2011	

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K 211	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation, it was determined the facility had installed 2 of 5 (alcohol base rub dispensers in gym 2 and in the fine dining room) alcohol based hand rub dispensers adjacent or over an ignition source.</p> <p>The findings included:</p> <p>Observations of gym 2 on 5/9/11 at 9:23 AM, revealed an alcohol based hand rub dispenser had been installed adjacent to an electrical switch.</p> <p>Observations in the fine dining room on 5/9/11 at 9:27 AM, revealed an alcohol dispenser installed over an electrical receptacle.</p> <p>The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 5/9/11.</p>	K 211	<p>to ensure all units are compliant and installed appropriately as required.</p> <p>3. Maintenance Director to educate maintenance staff by 6/8/11 on appropriate installation of wall units such as this per Life Safety Code. Maintenance Director to audit through environmental rounds that all units are appropriately installed for the next 3 months to ensure compliance of such.</p> <p>4. Maintenance Director to report findings of environmental rounds audit with regards to this to the QA Committee monthly for the next 3 months for further recommendations and follow up.</p>		