STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	445406		R **02/24/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE OF RUTHERFORD	**901 COUNTY FARM RD** **MURFREESBORO, TN 37127**

(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 000}	INITIAL COMMENTS Stories: 1 Construction Type: NFPA, II (000); IBC, II unprotected Limited Plans Available Constructed: 1950's Sprinklered: Yes Census: 93 Certified beds: 131 A Life Safety revisit survey was conducted on 02/24/2020 for the previous deficiencies cited on 12/02/2019. The deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

45th day 1-18-20 / 70th 2-12-20

PRINTED: 12/05/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC#1	445406	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE OF RUTHERFORD	901 COUNTY FARM RD MURFREESBORO, TN 37127

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K 000	INITIAL COMMENTS Stories: 1 Construction Type: NFPA, II (000); IBC, II unprotected Limited Plans Available Constructed: 1950's Sprinklered: Yes Census: 93 Certified beds: 131 A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 12/02/2019. During this Life Safety Survey, Community Care of Rutherford was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K 353	K 353 Sprinkler System - Maintenance and Testing SS=D CFR(s): NFPA 101 **1) What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** a) On 12/3/2019, TN/KY Sprinkler was contacted by the Maintenance Director to repair and/or replace corroded sprinklers in room J104, employee restroom by room 111, and room 107 b) On 12/19/2019, TN/KY Sprinkle completed a facility wide sprinkler inspection replacing a total of 15 sprinklers. **2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents within the facility have the potential to be affected.	12/19/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teresa Rodgers	Administrator	12/20/19

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RECEIVED 12-20-19

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	445406	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	12/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY CARE OF RUTHERFORD	**901 COUNTY FARM RD** **MURFREESBORO, TN 37127**

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K 353	Continued From page 1 b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the sprinkler system. The findings included: Observations on 12/02/2019 between 10:25 AM - 10:53 AM, revealed corroded sprinklers in the following locations: A. Room J104 B. Employee restroom by room 111 C. Room 107 NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.5 (2012 Edition), NFPA 25, 5.2.1.1.1 (2011 Edition) NFPA 25, 5.2.1.1.2 (2011 Edition) The maintenance director was present when these deficiencies were identified, and were later acknowledged by the administrator during the exit conference on 12/02/2019.	K 353	**3) What measures will be put into place or what systematic change you will make to ensure that the deficient practice does not recur.** a) On 12/2/2019, Maintenance staff were individually re-educated by the Administrator regarding the requirement of the facility to maintain the facility's sprinkler system in accordance with NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.5 (2012 Edition), NFPA 25, 5.2.1.1.1 (2011 Edition) and NFPA 25, 5.2.1.1.2 (2011 Edition). b) Visual inspection of sprinkles throughout the facility will be included in the monthly preventative maintenance program to ensure continued compliance. **4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** Visual inspection of the sprinklers audits will be conducted weekly by the Administrator, Maintenance Director and/or Designee with findings reported monthly to the QA/I Committee x 3 months or until substantial compliance is achieved.	

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E 000	Initial Comments A Emergency Preparedness Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 12/02/2019. During this Emergency Preparedness Survey, Community Care of Rutherford was found in substantial compliance with the requirements for participation in Emergency Preparedness Regulations for Long-Term Care Facilities, Federal CFR §483.73.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jerry Beckins	Administrator	12/20/19

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