

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

PRINTED: 05/29/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  05/21/2013
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NAME OF PROVIDER OR SUPPLIER  ALLEN MORGAN HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 177 NORTH HIGHLAND 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 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 1 3/4 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, it was determined the facility failed to maintain all fire and smoke doors to latch.</p> <p>The findings included:</p> <p>Observations during the tour of the facility on 5/21/13 revealed the following:</p> <p>a. At 8:45 AM - the 1st floor 1 hour fire door at the entrance of the skilled unit would not latch.</p> <p>b. At 9:30 AM - the 2nd floor activities storage room, across from offices, did not have a door closure to keep the door latched.</p>	K 018	<p>Vendor for automatic doors Was contacted and rated doors were checked, adjusted and retested to ensure that doors latch appropriately. A door closure was installed on the 2<sup>nd</sup> floor storage room across from The activities offices to maintain closure. Door closures will be installed for 2<sup>nd</sup> floor storage room, the 2<sup>nd</sup> floor dining room and the 3<sup>rd</sup> floor utility room to ensure that the doors will latch.</p> <p>Audits will be done on fire and smoke doors weekly x2 weeks then monthly thereafter to ensure compliance by the Administrator and/or designee.</p> <p>Findings will be reported to the QA Committee monthly x2 then PRN thereafter.</p>	June 15, 2013
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>G. M. Harlan</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6/6/13</i>
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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 018	Continued From page 1 c. At 9:45 AM - the 2nd floor dining room doors would not latch. d. At 10:50 AM - the 3rd floor clean utility room door did not have a door closure to keep the door latched.	K 018		
K 064 SS=D	NFWA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: National Fire Protection Association (NFPA) 10 Portable Fire Extinguishers 1998 edition 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.  4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility  This STANDARD is not met as evidenced by:  Based on observation, it was determined the facility failed to maintain clearance to all fire extinguishers.  The findings included:	K 064	Dining room chair has been removed from the front of the fire extinguisher cabinet in the 2 <sup>nd</sup> floor dining room. Dining table has been removed from the front of the fire extinguisher cabinet in the 3 <sup>rd</sup> floor dining room.  Staff will be in-serviced by the administrator and/or designee on maintaining fire extinguishers free from obstruction.  Audits will be done daily x2 weeks, then weekly by the Administrator and/or designee to ensure compliance.  Findings will be reported to the QA Committee monthly x2, then PRN thereafter.	June 15, 2013

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K 064 Continued From page 2

Observations on 5/21/13 revealed the following:  
a. At 9:50 AM - the 2nd floor dining room had a dining room chair in front of the fire extinguisher cabinet, which could impede the door from being opened.  
b. At 10:35 AM - the 3rd floor dining room had a dining table in front of the fire extinguisher cabinet, which could impede the door from being opened.

K 067 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=E

Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2

This STANDARD is not met as evidenced by:  
Based on observation, it was determined the facility failed to provide constant air circulation in 9 of 85 (rooms 142, 217, 219, 221, 222, 224, 227, 229 and 330) resident rooms.

The findings included:

Observations of resident rooms on 5/21/13 from 9:00 AM until 1:00 PM, revealed the only source of air exchanges were the heating and air conditioning wall units. The fan function of the heat and air units was turned off in resident rooms 142, 217, 219, 221, 222, 224, 227, 229 and 330.

K 104 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D

K 064

K 067 The units controlling the bathroom exhaust fans in resident Rooms #142, #217, #219, #221, #222, #224, #227, #229 and #330 will be repaired to maintain a constant air circulation in the resident rooms. These fans cannot be turned off.

All residents have the potential to be affected by the deficient practice.

Maintenance will audit 10% of resident rooms daily x2 weeks, then monthly to ensure that resident rooms maintain constant air circulation.

Maintenance Supervisor will randomly monitor resident rooms monthly x3 months, then PRN thereafter to ensure compliance.

Findings will be reported to the QA Committee for review x2 months, then PRN thereafter.

June 15, 2013

K 104 Electrical box on the 1<sup>st</sup> floor corridor, outside the rehabilitation department was closed on 05/21/2013.

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K 104	Continued From page 3 Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.  This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain smoke resistance walls.  The findings included:  Observation of the 1st floor corridor, outside the rehabilitation department, on 5/21/13 at 8:50 AM, revealed an open electrical box.	K 104	Staff will be in-serviced to maintain protection of penetration smoke barriers by ducts at all times by the Administrator and/or designee.  Audits will be done daily x2 weeks, then weekly by the Administrator and/or designee to ensure compliance.  Findings will be reported to the QA Committee monthly x2, then PRN thereafter.	June 15, 2013	
K 130 SS=D	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to prevent the use of extension cords in 3 of 85 (rooms 221, 225 and 328) resident rooms.  The findings included:  Observation during the tour of the facility on 5/21/13 from 9:00 AM until 11:00 AM, revealed extension cords in use in resident rooms 221, 255 and 328.	K 130	Extension cords were removed from resident rooms #221, #225, and #328.  All residents have the potential to be affected by the deficient practice.  Staff will be in-serviced on maintaining residents rooms free from extension cords. Family members will be instructed via mail that extension cords are not allowed in resident rooms. Audits will be done daily x2 weeks, weekly x2 weeks, then PRN thereafter per QA Nurse and/or designee to ensure compliance.	June 15, 2013	
K 141 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas	K 141	Findings will be reported to the QA Committee monthly x2, then PRN thereafter.		

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K 141	<p>Continued From page 4 where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2.</p> <p>This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain oxygen tank storage.</p> <p>The findings included:</p> <p>Observations during the facility tour in 5/21/13 revealed the following:</p> <p>a. At 1:00 PM - the 1st floor oxygen storage room had no signage on the door indicating oxygen tanks were present. There was no designation on the oxygen tank storage racks to indicated whether the oxygen tanks were full or empty.</p> <p>b. At 1:10 PM - the 1st floor bath had an unsecured oxygen tank in the corner of the room.</p>	K 141	<p>Oxygen in Use Sign was posted on the 1<sup>st</sup> floor oxygen storage room on 05/21/2013.</p> <p>The oxygen storage racks were labeled to indicate whether the tanks are full or empty.</p> <p>The unsecured oxygen tank in the 1<sup>st</sup> floor bath in the corner of the room was removed and appropriately secured.</p> <p>The facility will maintain appropriate oxygen storage. Staff will be in-serviced on proper oxygen storage by the QA Nurse and/or designee.</p> <p>Audits will be done daily x2 weeks, then weekly by the QA nurse and/or Designee to ensure compliance.</p> <p>Findings will be reported to the QA Committee monthly x2, then PRN thereafter.</p>	June 15, 2013