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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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445490	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA HOME	2805 CHARLES BRYAN RD BARTLETT, TN 38134

(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	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ 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 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain smoke resistant doors. The findings included: 1. Observation of the storage room in the service hall on 5/29/12 at 11:45 AM, revealed a gap approximately 3/16 of an inch between the double doors. 2. Observation of the east wing storage room by the exit on 5/29/12 at 11:50 AM, revealed the storage room door did not have a door closing	K 018	Facility will continue to maintain smoke resistant doors as stipulated in NFPA 101 Life Safety Code standard. Plan of Correction: 1. Gap in service hall storage doors repaired by installing stripping by 6-22-12. 2. Door closure for east wing storage room by exit installed on 6-15-12. Preventative Action: 1. All smoke resistant doors will be checked by Maintenance Director on a monthly basis to ensure there are no gaps utilizing monthly safety surveillance check list. 2. All storage room doors will be checked for proper closure by Maintenance Director. QA and Monitoring: Maintenance Director will report any concerns with fire resistant doors and door closures along with repair completion dates to the QA Committee. Administrator will monitor for compliance. Date of Completion: 7-01-12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda L Hardin	NHA	6-14-12

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 device. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 5/29/12.	K 018		
K 039 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain clear passage through the exit corridor. The findings included: Observations of the west corridor on 5/29/12 at 11:27 AM, revealed a paper recycling box stored in the hallway by the assistant director of nursing's office which was in the means of egress. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 5/29/12.	K 039	Facility will continue to maintain clear passage through exit corridors as stipulated in NFPA Life Safety Code standard. Plan of Correction: 1. Recycling box for paper relocated to office area on 5-29-12. Preventative Action and QA Monitoring: Maintenance Director will ensure there are no obstructions to exit corridors by daily monitoring and utilizing the monthly safety surveillance check list. Any concerns will be addressed to the QA Committee. Administrator will monitor for compliance. Date of Completion: 5-29-12	
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	K 054	Smoke detectors in the facility will be relocated away from air-handling systems as outlined in NFPA 101 Life Safety Code standard.	

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K 054	Continued From page 2 This STANDARD is not met as evidenced by: National Fire Protection Association (NFPA) 72, 1999 edition 2-3.5 Heating, Ventilating, and Air-Conditioning (HVAC).2-3.5.1*In spaces served by air-handling systems, detectors shall not be located where airflow prevents operation of the detectors. Based on observation, it was determined the facility failed to install the smoke detector away from airflow register in the kitchen's chemical utility room. The findings included: Observation of the kitchen on 5/29/12 at 12:00 PM, revealed the smoke detector was too close to the exhaust vent inside the chemical utility room. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 5/29/12.	K 054	Plan of Correction: Smoke detector in kitchen chemical utility room was relocated more than 3 feet away from air-handling system. Preventative Action and QA Monitoring: Maintenance Director will inspect all smoke detectors in facility to ensure location of 3 feet or more from air-handling system utilizing monthly safety surveillance check list. Any concerns and repairs will be reported to QA Committee. Administrator will monitor for compliance. Date of Completion: 7-01-12	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 maintain the sprinkler head in the walk in freezer.	K 062	Facility will maintain sprinkler heads in walk-in freezer to assure maintaining in reliable operating condition. Plan of Correction: Sprinkler head in walk-in freezer was cleaned on 5-29-12 Preventative Action and QA Monitoring: Sprinkler head will be visibly checked by Food Service Supervisor or Assistant Food Service Manager on a daily basis for any ice build-up. Maintenance Director will clean	

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K 062	Continued From page 3 The findings included: Observations in the walk in freezer on 5/29/12 at 12:10 PM, revealed an ice build up on the sprinkler head. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 5/29/12.	K 062	sprinkler head monthly or more often as needed. Any further problems will be reported to QA Committee by Maintenance Director. Administrator will monitor for compliance Date of Completion:	6-12-12
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain egress to 1 of 7 (kitchen exit) exit doors. The findings included: Observations in the kitchen on 5/29/12 at 12:05 PM, revealed a rolling metal shelf was obstructing the exit door. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 5/29/12.	K 072	Means of egress in facility will be maintained. Free of all obstructions to full instant use. Plan of Correction: Rolling metal shelf in kitchen has been relocated from area by fire door. Preventative Action and QA Monitoring: Food Service Supervisor or Assistant Food Service Manager will monitor on a daily basis to ensure there are no obstructions to exit doors. Any concerns will be corrected immediately and reported to the QA Committee. Administrator will monitor for compliance. Date of Completion:	6-15-12
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance	K 147	Facility shall maintain clearance to electrical equipment.	

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K 147	Continued From page 4 with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain clearance to electrical equipment. The findings included: Observation of the 100 hall break room on 5/29/12 at 11:30 AM, revealed a 6 foot table (with 3 employees present) obstructing the 3 foot clearance in front of 3 electrical panels. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 5/29/12.	K 147	Plan of Correction: Table in 100 hall break room was relocated on 6-12-12. There is now 3 feet clearance in front of electrical panels. Preventative Action and QA Monitoring: Maintenance Director or designee will ensure there are no obstructions to electrical panels in the facility through the monthly safety surveillance check list. Administrator will monitor for compliance. Date of Completion: 7-01-12	