

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

PRINTED: 07/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445411	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2014
NAME OF PROVIDER OR SUPPLIER APPLINGWOOD HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1536 APPLING CARE LANE CORDOVA, TN 38018	
(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 This Comparative Federal Life Safety Code (LSC) Survey was conducted on June 18, 2014. It was conducted as per the requirements of the Federal Register at 42CFR 483.70 (a) using the existing Health Care Section of the 2000 edition of the LSC and its referenced publications. It is of Type II (111) single story. It was fully sprinklered and certified 78 beds. Census was 68.	K 000	<div style="border: 2px solid black; padding: 5px; text-align: center;"> <p>POC ACCEPTED</p> <p>JUL 28 2014</p> <p><i>B.C.</i></p> </div>	
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 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 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interviews, the facility failed to maintain corridor doors that would resist the passage of smoke and were free of	K 018 K 018		NFPA 101 LIFE SAFETY CODE STANDARD SS=D Requirements: 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 are no impediment of 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 Corrective Action: 1. On 6/18/14 the door stops that were found in use for the Recreation Room and Beauty Salon were removed by the Maintenance Director.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stacy Wilson TITLE: Administrator (X6) DATE: 7-17-14

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 impediments to closing. Finding include: On June 18, 2014, the door stops were found being used in Recreation Room and Beauty Salon. This was verified with the Administrator and the Director of Maintenance, at the exit conference. Ref: 2000 NFPA 101 Section 19.3.6.3.3 Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Failure to maintain hold open devices on doors increases the risk of death or injury due to smoke and/or fire. The deficiency affects 2 of 4 smoke compartments.	K 018	2. On 6/18/14 the Maintenance Director and the Administrator did a walk-through of the building to ensure that no other doors were being held open by any devices such as a door stop. 3. On 7/15/14 the Administrator in serviced staff regarding the use of door stops and how a door should never be propped open with an unapproved device such as a door stop. 4. The Maintenance Director and/or designee will randomly monitor for 3 months to ensure that no doors are being propped opened with a door stop. Findings will report their findings to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinators, Staffing Coordinator, Dietary Supervisor, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the QA team will re-in-service the Maintenance Director and will continue monitoring until substantial compliance is achieved.	
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based upon observation and staff interview during the survey it was determined that the	K 070	Completion Date: 7/17/14	7/17/14

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K 070	<p>Continued From page 2</p> <p>facility failed to meet portable space heating devices where the heating elements of such devices do not exceed 212°F (100°C).</p> <p>Findings included:</p> <p>On June 18, 2014, a space heater was found in the Social Services office.</p> <p>This was verified with the Administrator and the Director of Maintenance, at the exit conference.</p> <p>Ref: 2000 NFPA 101 Section 19.7.8</p> <p>Failure to maintain portable space heating devices increases the risk of death or injury due to smoke and/or fire.</p> <p>The deficiency affects 1 of 4 smoke compartments.</p>	K 070	<p>Corrective Action:</p> <ol style="list-style-type: none"> On 6/18/14 the space heater found in the Social Service office was removed by the Maintenance Director. On 6/18/14 the Maintenance Director and the Administrator did a walk-through of the building to ensure that no other space heaters were being used. On 7/15/14 the Administrator in serviced Department Head staff regarding the use of space heaters in the facility and how they are not appropriate for use in a health care setting. The Maintenance Director and/or designee will randomly monitor for 3 months to ensure that space heaters are not found in use in the facility. Findings will report their findings to the QA Committee consisting of the Medical Director, Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinators, Staffing Coordinator, Dietary Supervisor, Social Worker, Maintenance Supervisor, and Activity Coordinator. If compliance is not met the QA team will re-inservice the Maintenance Director and will continue monitoring until substantial compliance is achieved. <p>Completion Date: 7/17/14</p>	7/17/14	

Applingwood Healthcare Center

1536 Appling Care Lane • Cordova, TN 38016
Phone: (901) 385-1803 • Fax: (901) 385-1817
Email: admapp@thmgt.com

July 17, 2014

Ms. Sandra M. Pace
Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, Suite 4T20
Atlanta, Georgia 30303-8909

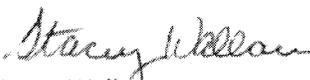
Re: Applingwood Healthcare Center
Federal Life Survey Dated June 18, 2014

Dear Ms. Sandra M. Pace:

Enclosed you will find the Plan of Correction for the deficiencies cited during a Federal Life survey conducted by a member of your staff on June 18, 2014. Please accept this Plan of Correction as the facility's Allegation of Compliance.

Applingwood Healthcare Center files this Plan of Correction solely to satisfy State and Federal mandates. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey finding through the Informal Dispute Resolution, Formal Appeal and any other applicable legal or administrative proceedings. The Plan of Correction should not be taken as establishing any standard of care and facility submits that the action by it in response to the survey findings establishes an acceptable standard of care. This document is not intended to waive any defense, legal or equitable, in any proceedings administrative, civil, or criminal.

Sincerely,


Stacey Wallace
Administrator