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
	445411		07/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLINGWOOD HEALTH CARE CENTER	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 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide illumination with 2 bulb fixtures at the 6 exit discharge locations. The findings included: Observation of the exterior exits on 7/14/15 from 8:30 AM until 2:30 PM revealed the emergency lighting at the following exits paths were 1 bulb fixtures: a. The main entrance. b. The 100 hall exit. c. The 200 hall exit by room 211. d. The patio dining exit. e. The vending machine exit. f. The sun room exit. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 7/14/15.	K 045	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8) 19.2.8 Corrective Action: 1. On 8/15/15 the lighting outside of the main entrance, the 100 hall exit, the 200 hall exit by room 211, the patio dining exit, the vending machine exit, and the sun room exit were switched out to accommodate a two bulb lighting fixture. 2. On 8/16/15 an audit was completed by the Administrator and Maintenance Director to ensure that the lighting fixtures were in proper working order. 3. On 8/14/15 the Administrator in-serviced the Maintenance Director to ensure that outside lighting areas of the main entrance, the 100 hall exit, the 200 hall exit, the patio dining exit, the vending machine exit and the sun room exit have all have proper working 2 bulb lights. 4. The Maintenance Director will randomly monitor for compliance for three months. Findings will be reported to the QA & A Committee, consisting of the Medical Director, Administrator, DON, ADON, Staffing Coordinator, MDS Coordinator, Dietary, Social, & Activity Directors. If compliance is not met, the maintenance director will be re-in-serviced and monitoring will continue until compliance is met. Completion date:	8/16/2015
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by:	K 130	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Corrective Action: 1. (A) On 8/14/15 the maintenance director sealed the abandoned exhaust duct in the ceiling above the water heaters. (B) On 8/14/15 the maintenance director sealed the 3 penetrations found in riser room.	

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

Stacey Wallace — Administrator — 8-14-15

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.

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
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K 130	Continued From page 1 National Fire Protection Association 101, 8.2.3.2.4 Penetrations and Miscellaneous Openings in Fire Barriers. 2000 edition Based on observation, the facility failed to seal all penetrations in rated assemblies. The findings included: 1. Observation of the central mechanical room on 7/14/15 at 9:00 AM, revealed an open abandoned exhaust duct in the ceiling above the water heaters. 2. Observation of the riser room on 7/14/15 at 9:30 AM, revealed 3 penetrations around low voltage conduit and piping. This finding was verified by the facilities director and acknowledged by the administrator during the exit conference on 7/14/15. National Fire Protection Association 25, 10-2.2* Obstruction Prevention. 1998 edition This STANDARD is not met as evidenced by: Based on record review, the facility failed to provide a 5 year obstruction test on the fire sprinkler system. The findings included: During record review the facility was unable to provide documentation of a 5 year obstruction test on the fire sprinkler system.	K 130	(C) On 7/21/15 a 5 year obstruction test was completed. 2. (A) On 8/14/15 the maintenance director completed a walk through of the building to ensure that all wall penetrations are correctly sealed. (B) On 8/15/15 it was verified with our Sprinkler Company that we are up-to-date on all tests by the Maintenance director. 3. On 8/14/15 the Administrator in-serviced the maintenance director on the importance of sealing any wall penetrations and tracking when 5 year obstruction tests need to be completed. 4. The Maintenance director will monitor for compliance by random weekly rounds for three months. All findings will be reported to the QA & A Committee, consisting of the Medical Director, Administrator, DON, ADON, Staffing Coordinator, MDS Coordinator, Dietary, Social, & Activity Directors. If compliance is not met, the maintenance director will be re-in-serviced and random weekly rounding will continue until compliance is met. Completion date:	8/16/2015

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K 130	Continued From page 2 This finding was verified by the facilities director and acknowledged by the administrator during the exit conference on 7/14/15.	K 130		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: National Fire Protection Association 110, 5-3.1 1999 edition Lighting. The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide emergency back up lighting in the gener ator housing. The findings included: Observation of the emergency generator, (located outdoors) on 7/14/15 at 10:30 AM, revealed the generator did not have an emergency back up	K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1 Corrective Action: 1. On 8/13/15 the facility placed a flashlight outside at the generator to provide emergency back up lighting in the generator housing. 2. On 8/15/15 the maintenance director ensure that the flashlight was in proper working order. 3.On 8/14/15 the Administrator in-serviced the maintenance director on the importance of keeping a backup lighting source outside in the generator housing. 4. The Maintenance director will randomly monitor for compliance weekly for three months. Findings will be reported to the QA & A Committee, consisting of the Medical Director, Administrator, DON, ADON, Staffing Coordinator, MDS Coordinator, Dietary, Social, & Activity Directors. If compliance is not met, the maintenance director will be re-in-serviced and random weekly rounding will continue until compliance is met. Completion date:	8/16/2015

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K 144	Continued From page 3 light. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 7/14/15.	K 144		