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

PRINTED: 03/04/2013
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
	445411	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/26/2013

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 018 SS=E	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 2 of 2 (100 and 200 hall shower room) shower room doors to resist the passage of smoke. The findings included: 1. Observations of the 100 hall shower room on 2/26/13 at 9:40 AM, revealed the door would not latch. 2. Observations of the 200 hall shower room on 2/26/13 at 10:25 AM, revealed the door would not	K 018	**K 018** **NFPA 101 LIFE SAFETY CODE STANDARD** **SS=E** **Requirement:** Doors protecting corridor openings in other than required enclosure of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 ¾ 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. **Plan of Correction:** 1. On 2/27/2013 the 100 and 200 hall shower room doors were adjusted to ensure that they were able to latch when closed. 2. On 2/27/2013 the Maintenance Director inspected the facility's remaining doors to ensure that the doors properly latched when closed. 3. On 3/15/2013 the Administrator in-serviced the Maintenance Director regarding the importance of doors completely latching when closed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: George Munchow
TITLE: Administrator
(X6) DATE: 3/14/13

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.

RECEIVED
APR 11 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445411	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/26/2013

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 018	Continued From page 1 close and latch. These findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 2/26/13.	K 018	4. The Maintenance Director and/or designee will monitor weekly for one quarter to ensure that doors latch completely. Findings will be reported to the QA committee for one quarter. Completion Date: 3/15/2013	3/15/13
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: National Fire Protection Association 72 1999 4-4.4.2.3 In corridors where there are more than two visible notification appliances in any field of view, they shall be spaced a minimum of 55 ft (16.76 m) from each other or they shall flash in synchronization. Based on observation, it was determined the facility failed to maintain the visual notification devices (strobe lights) in 2 of 5 (100 and 300 halls) fire alarm areas. The findings included: Observations during the fire drill on 2/26/13 from	K 052	**K 052** **NFPA 101 LIFE SAFETY CODE STANDARD** **SS=E** **Requirement:** A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 **Plan of Correction:** 1. On 2/28/2013 State System, Inc. came to inspect our strobe lights for the 100 and 300 halls and determined that a circuit module had to be ordered and will be replaced by 3/28/2013. 2. On 2/28/2013 the Maintenance Director and State System's personnel inspected the remaining strobe lights to ensure compliance. 3. On 3/15/2013 the Administrator in-serviced the Maintenance Director to ensure that the strobe lights remain in sync.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445411	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/26/2013

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 052	Continued From page 2 2:35 PM until 2:50 PM, revealed the strobe lights on the 100 hall and the 300 hall had 3 strobe lights in each area that were not flashing in synchronization. This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 2/26/13.	K 052	4. The Maintenance Director and/or designee will monitor monthly for one quarter. Findings will be reported to the QA committee for one quarter. Completion Date: 3/28/2013	3/28/13
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 means of egress clearance in 1 of 7 (300 hall exit door) exit doors. The findings included: Observation of the 300 exit corridor on 2/26/13 at 9:05 AM, revealed a wheelchair and a set of wheelchair scales obstructing the path to full instant use of the exit. This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 2/26/13.	K 072	**K 072** **NFPA 101 LIFE SAFETY CODE STANDARD** **SS=D** **Requirements:** 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 **Plan of Correction:** 1. On 2/26/2013 the Assistant Administrator removed the wheelchair and wheelchair scale from the 300 exit corridor. 2. On 2/26/2013 the Maintenance Director inspected the remaining exit door corridors to ensure that no items were obstructing egress.	
K 104 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are	K 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445411	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/26/2013

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 052	Continued From page 2 2:35 PM until 2:50 PM, revealed the strobe lights on the 100 hall and the 300 hall had 3 strobe lights in each area that were not flashing in synchronization. This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 2/26/13.	K 052		
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 means of egress clearance in 1 of 7 (300 hall exit door) exit doors. The findings included: Observation of the 300 exit corridor on 2/26/13 at 9:05 AM, revealed a wheelchair and a set of wheelchair scales obstructing the path to full instant use of the exit. This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 2/26/13.	K 072	3. On 3/15/2013 the Administrator in-serviced the Maintenance Director and facility staff regarding the importance of keeping exit door corridors clear of obstructions. 4. The Maintenance Director and/or designee will monitor exit corridors routinely to ensure free egress. Findings will be reported to the QA committee for one quarter. Completion Date: 3/15/2013	3/15/13
K 104 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are	K 104		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445411	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/26/2013

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 104	Continued From page 3 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 2 of 4 (100 and 200 hall fire doors) twenty minute fire doors. The findings included: 1. Observation above the 100 hall fire doors on 2/26/13 at 1:50 PM, revealed a penetration inside the 1 inch metal conduit with blue low voltage cable. 2. Observation above the 200 hall fire doors on 2/26/13 at 2:00 PM, revealed a penetration through the wall with low voltage blue cable. These findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 2/26/13.	K 104	**K 104** **NFPA 101 LIFE SAFETY CODE STANDARD** **SS=E** **Requirements:** Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. **Plan of Correction:** 1. On 2/26/2013 the Maintenance Director repaired the penetration found above the 100 and 200 hall fire doors. 2. On 2/26/2013 the Maintenance Director inspected above the remaining fire doors to ensure that there were on open penetrations. 3. On 3/15/2013 the Administrator in-serviced the Maintenance Director to inspect behind contracted personnel to ensure that there were no open penetrations left behind. 4. The Maintenance Director and/or designee will monitor routinely for compliance. Findings will be reported to the QA committee for one quarter. Completion Date: 3/15/2013	3/15/13

RECEIVED
APR 11 2013