

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

PRINTED: 05/19/2014  
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  05/12/2014
--	--	--	--

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 029 SS=D NFPA 101 LIFE SAFETY CODE STANDARD  
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:  
Based on observation, it was determined the facility failed to install self closing devices on all smoke barrier doors per National Fire Protection Association.

The findings included:

Observation of the housekeeping storage room on 5/12/14 at 9:30 AM, revealed the door was standing open and did not have a self closing device.

This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 5/12/14.

K 052 SS=D 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

K 029  
NFPA 101 LIFE SAFETY CODE STANDARD  
SS=D  
Requirement:  
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When he approved automatic fire extinguishing system option is used, the areas are separated from other spaced by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

Corrective Action:

1. The housekeeping storage room door on 6/11/14 had a self-closing device placed on it.
2. On 6/13/14 the Maintenance Director completed a walk-through of the building inspecting the doors to ensure that self-closing devices were in place and working.

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

*Stacy Wilson*

Administrator

10-12-14

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.

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

PRINTED: 05/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>445411</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/12/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>APPLINGWOOD HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1536 APPLING CARE LANE CORDOVA, TN 38018</b>
---	--

(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 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to install self closing devices on all smoke barrier doors per National Fire Protection Association.  The findings included:  Observation of the housekeeping storage room on 5/12/14 at 9:30 AM, revealed the door was standing open and did not have a self closing device.  This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 5/12/14.	K 029	3. The Administrator on 6/13/14 in serviced the Maintenance Director regarding self-closing devices for doors and ensuring they are proper working order.  4. The Maintenance Director and/or designee will randomly monitor for 3 months to ensure that door in the building are closing correctly. 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.  Completion Date: 6/18/14	6/18/14
K 052 SS=D	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	K 052		

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

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.

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

PRINTED: 05/19/2014  
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  05/12/2014
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 052	Continued From page 1 and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4  This STANDARD is not met as evidenced by: Based on observation and manual testing, it was determined the facility failed to maintain all fire alarm components according to National Fire Protection Association 72, 1-5.4.6  The findings included:  Observation and manual testing of the dialer component test on 5/12/14 at 2:15 PM, revealed when one of 2 telephone lines were disconnected the trouble signal was not received at the remote annunciator at the nurses station.  This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 5/12/14.	K 052	K 052  NFPA 101 LIFE SAFETY CODE STANDARD  SS=D  Requirements:  A fire alarm system required for life safety is installed, test, 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  Corrective Action:  1. On 6/13/14 Miller Protective Services assessed the system and repaired the system so that a trouble signal will be received at the annunciator panels.  2. On 6/13/14 the Maintenance Director conducted a test on the system to ensure that both telephone line were working and another test to ensure that a trouble signal was received at the remote annunciator at the nurse's station.		

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

PRINTED: 05/19/2014  
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  05/12/2014
--	--	--	--

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 052 Continued From page 1  
and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4

This STANDARD is not met as evidenced by:  
Based on observation and manual testing, it was determined the facility failed to maintain all fire alarm components according to National Fire Protection Association 72, 1-5.4.6

The findings included:

Observation and manual testing of the dialer component test on 5/12/14 at 2:15 PM, revealed when one of 2 telephone lines were disconnected the trouble signal was not received at the remote annunciator at the nurses station.

This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 5/12/14.

K 052 3. The Administrator in serviced the Maintenance Director on 6/18/14 to ensure that we check routinely the emergency phone lines for our fire system.

4. The Maintenance Director and/or designee will randomly monitor for 3 months to ensure that the emergency phone lines are working and signally correctly. 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.

Completion Date: 6/18/14

6/18/14