

NOV 02 2010

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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: 445485	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2010
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NAME OF PROVIDER OR SUPPLIER ALLENBROOKE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3633 ALLENBROOKE COVE MEMPHIS, TN 38118
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(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 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and manual testing, it was determined that the facility failed to maintain 2 of 10 exit doors.</p> <p>The findings included:</p> <p>Observations and manual testing of the two dining room exit doors on 10/18/10 at 2:20 PM, revealed the dining room exit doors were hard to open.</p>	K 038	<p>The Exit doors were corrected immediately by Maintenance</p> <p>All residents have the potential to be affected.</p> <p>Maintenance staff will be re-inserviced on checking doors for possible obstruction.</p> <p>ED will conduct Door Checks weekly for 1 month then monthly for 2 months. Findings will be reported to the QA Committee for review monthly for 2 months and corrective action measures will be implemented as deemed necessary.</p>	11/07/10
K 147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation, it was determined that the facility failed to maintain clearance to electrical equipment.</p> <p>The findings included:</p> <p>Observations in the kitchen on 10/18/10 at 9:30 AM, revealed a hot plate stand was obstructing two electrical panel boxes.</p>	K 147	<p>The plate warmer was immediately removed by Maintenance.</p> <p>All residents have the potential to be affected.</p> <p>All dietary staff will be re-inserviced regarding maintaining clearance of electrical panel.</p> <p>Maintenance will conduct electrical panel checks weekly for 1 month then monthly for 2 months. Findings will be reported to the QA Committee for review monthly for 2 months and corrective action measures will be implemented as deemed necessary.</p>	11/07/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Executive Director* (X6) DATE: 10/31/10

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.