

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

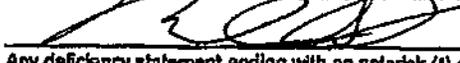
PRINTED: 10/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445488	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/13/2014
NAME OF PROVIDER OR SUPPLIER ALLENBROOKE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3933 ALLENBROOKE COVE MEMPHIS, TN 38118	
(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 082 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain all fire sprinkler components.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observation of the front entrance on 10/13/14 at 9:00 AM, revealed the three sprinkler heads corroded and needed to be replaced. 2. Observation of the covered walkway by the activities office revealed two escutcheons were missing on the sprinkler heads. <p>These findings were verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 10/13/14.</p>	K 082	<ol style="list-style-type: none"> 1. On 11/7/2014, the three sprinkler heads near the front entrance were replaced and two escutcheon rings were replaced by a licensed contract vendor. 2. All residents have the potential to be affected 3. Executive Director/Designee to inservice Maintenance staff on 11/5/2014 regarding the automatic sprinkler system being maintained in reliable operating condition, specifically corroded sprinkler heads and escutcheon rings. On 11/3/2014, Maintenance Director/Designee audited all sprinkler heads for corrosion and missing escutcheon rings. 4. Maintenance Director/Designee to monitor for compliance weekly on-going. Any negative findings will be addressed immediately and all findings will be taken to Quality Assurance committee for review monthly. 	11/5/14
K 064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by:</p>	K 064		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Administrator

10-31-14

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445486	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/13/2014
NAME OF PROVIDER OR SUPPLIER ALLENBROOKE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3933 ALLENBROOKE COVE MEMPHIS, TN 38118		
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K 064	Continued From page 1 Based on observation, it was determined the facility failed to inspect 1 of 15 fire extinguishers. The findings included: Observation of the kitchen mechanical room on 10/13/14 at 11:25 AM, revealed monthly inspections on the fire extinguisher had not been documented on the inspection card since June of 2014. This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 10/13/14.	K 064	1. On 10/13/2014, all Fire Extinguishers were inspected by the Maintenance Director/Designee. 2. All residents had the potential to be affected. 3. Executive Director to in-service Maintenance staff on 11/5/2014 regarding ensuring all Fire Extinguishers are inspected monthly. 4. Executive Director/designee to monitor compliance monthly, ongoing. Any negative findings will be addressed immediately and all findings will be taken to Quality Assurance committee for review monthly.		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Standard for the installation of air-conditioning and ventilation National Fire Protection Association (NFPA) 90 1999 edition 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. This STANDARD is not met as evidenced by:	K 067		11/5/14	

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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 10/13/2014
NAME OF PROVIDER OR SUPPLIER ALLENBROOKE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3933 ALLENBROOKE COVE MEMPHIS, TN 38118		
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K 067	Continued From page 2 Based on document review, it was determined the facility failed to provide inspection and maintenance for fire dampers every four years as required. The findings included: During document review the facility was unable to provide documentation of 4 year damper inspection and testing. This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 10/13/14.	K 067	1. On 11/5/2014, Maintenance Director/Designee immediately checked all dampers to verify the fully close, checked the latch, if applicable, and ensured moving parts were fully lubricated as necessary. 2. All residents have the potential to be affected. 3. On 11/4/2014, Executive Director/Designee in-serviced Maintenance staff regarding the requirement of NFPA 101, specifically that all dampers shall be check at least every 4 years to verify they fully close, the latch shall be checked, if provided, and moving parts shall be lubricated as necessary. 4. Executive Director/Designee to monitor yearly to ensure compliance. Any negative findings will be corrected immediately and all findings will be taken to Quality Assurance committee monthly.	11/5/14	
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Guidelines for Design and Construction of Health Care Facilities, 2010 edition Nursing Facilities Table 4.1 Ventilation Requirements for Areas Affecting Resident Care in Nursing Facilities. This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to provide outside exhaust for 43 of 43 (rooms 113, 114, 115, 116, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338 and 339) resident bathrooms and the facility failed to ensure 2 of 111 (central				

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K 130	<p>Continued From page 3</p> <p>bio-hazard room and west nutrition room) smoke detectors were installed at least 3 feet from an air duct supply National Fire Protection Association (NFPA) 72, 5.7.4.1.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observations of the bathrooms for rooms 113, 114, 115 and 116 rooms on 10/13/14 at 10:30 AM, did not have working ventilation to remove odors. 2. Observations of the bathrooms for rooms 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138 and 139 on 10/13/14 at 10:10 AM, did not have working ventilation to remove odors. 3. Observations of the bathrooms for rooms 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238 and 239 on 10/13/14 at 10:10 AM, did not have working ventilation to remove odors. 4. Observations of the bathrooms for rooms 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338 and 339 on 10/13/14 at 9:20 AM, did not have working ventilation to remove odors. 5. Observations of the central bio-hazard room on 10/13/14 at 10:00 AM, revealed the smoke detector was closer than 3 feet to the return air duct. 6. Observations of the west nutrition room at 10:30 AM, revealed the smoke detector closer than 3 feet to the air supply duct. <p>These findings were verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on</p>	K 130		

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K 130	Continued From page 4 10/13/14.	K 130	<ol style="list-style-type: none"> 1. On 11/3/2014, Maintenance Director/Designee immediately ensured exhaust fans for all 43 resident rooms (113, 114, 115, 116, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338 and 339) resident bathrooms and a licensed contractor moved 2 smoke detectors to be at least 3 feet from an air duct supply in Central Bio Hazard room and West Nutrition room. 2. All residents have the potential to be affected. 3. On 10/31/2014, Executive Director/Designee in-serviced Maintenance Staff regarding exhaust fans and smoke detectors being within 3 ft of an air duct supply. Maintenance Director/Designee to audit all exhaust fans and smoke detectors on 10/31/2014. 4. Maintenance Director/Designee to monitor daily to ensure exhaust fans are operating. Any negative findings will be corrected immediately and all findings will be taken to Quality Assurance committee monthly. 	11/5/14