

CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 110415

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445481	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ASBURY PLACE AT KINGSFORT  B. WING	(X3) DATE SURVEY COMPLETED  11/17/2014
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NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT KINGSFORT	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSFORT, TN 37660
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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
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K 021 SS=E	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor fire doors closed to a positive latch. The findings include: Observation and Interview with the Maintenance Director, on November 17, 2014 at 7:20 p.m. confirmed the 3-hour corridor fire door was not provided with any operable latching mechanism and would not close to a positive latch. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on November 17, 2014.</p>	K 021	<p><b>K 021</b></p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>A contractor reviewed the door latch on 11/20/14. Parts have been ordered and repairs will be completed by 12/22/14.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All residents have the potential to be affected. The door latch will be in place and fully functional by 12/22/14.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:</p> <p>The maintenance department staff will ensure all fire doors in place and functional by 12/22/14.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place:</p>	12/22/14
K 025 SS=E	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at</p>	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Charles P. Hill* TITLE: *Administrator* (X6) DATE: *12/4/14*

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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NAME OF PROVIDER OR SUPPLIER  ASBURY PLACE AT KINGSPORT	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NETHERLAND LANE KINGSPORT, TN 37660
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K 025	<p>Continued From page 1</p> <p>least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke walls were capable to resist the passage of smoke.. (NFPA 101, 8.2.4.4) The findings include:</p> <p>Observation and interview with the Maintenance Director, on November 17, 2014 at 10:15 p.m. confirmed unsealed penetrations in the corridor wall above the lay-in ceiling at the fire doors by room 21.</p> <p>This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on November 17, 2014.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p>	K 025	<p>The Maintenance Director will inspect all fire doors monthly and report findings to the Administrator. Inspection reports will be reported to the QAPI Committee.</p> <p>K 025 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The penetrations above the ceiling and fire doors near room 21 were fire caulked on 11/18/14.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <p>All residents have the potential to be affected. The walls above all fire doors were inspected by 12/1/14 and all penetrations found were caulked.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:</p> <p>The Maintenance Director will educate all vendors/contractors that any penetrations created must be fire caulked before the conclusion of their work. This is an ongoing process.</p>	12/22/14
K 029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p>	K 029		

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NAME OF PROVIDER OR SUPPLIER  <b>ASBURY PLACE AT KINGSPORT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>100 NETHERLAND LANE KINGSPORT, TN 37680</b>
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K 029	<p>Continued From page 2</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous area 's one (1) hour fire rated construction is maintained and provided with self-closing doors. The findings include: Observation and interview with the Maintenance Director, on November 17, 2014 at between 7:30 pm and 9:50 pm confirmed the following: 1. The outside boiler room's head of wall joint was not sealed. (NFPA 101, 8.2.3.2.4.2)</p> <p>2. Observation and interview with the Maintenance Director, on November 17, 2014 at 10:15 p.m. confirmed the medical record storage room door was not provided with a door closer (NFPA 101, 19.3.2.1 (7)). These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on November 17, 2014.</p>	K 029	<p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place:</p> <p>The Maintenance staff will inspect all work by Vendors/Contractors at the conclusion of their work to ensure no penetrations have been left open without appropriate fire caulking.</p>	12/22/14
K 062 SS=F	<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>	K 062	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The boiler room wall will be completely fire caulked around the ceiling by 12/22/14. A door closer was installed on the door of the Medical Records office by 11/20/14.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be take:</p> <p>All residents have the potential to be affected. The Maintenance Director will have inspected and repaired any deficiencies throughout the entire facility for compliance relative to door closures and fire caulking by 12/22/14.</p>	

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K 062	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and record review, it was determined the facility failed to ensure the sprinkler system was maintained (NFPA 13 and NFPA 25).</p> <p>The findings include:</p> <p>Observation and record review with the maintenance director, on November 17, 2014 at 9:50 p.m. confirmed the following:</p> <ol style="list-style-type: none"> <li>1. Observation and interview with the maintenance director in the fire pump room on October 17, 2014 at 7:50 p.m. confirmed the spare head cabinet in the sprinkler fire pump/riser room only had 5 spare heads of only one type. (NFPA 13, 6.2.9.1, 6.2.9.5)</li> <li>2. Observation and record review with the maintenance director on October 17, 2014 at 7:50 p.m. confirmed three different types of sprinkler heads were installed in the facility.</li> <li>3. Observation and interview with the maintenance director, in the corridor, on November 17, 2014 at 8:30 p.m. confirmed wiring and a junction box above the lay in ceiling by the fire doors near room 17 was attached to sprinkler piping.</li> <li>4. Observation and record review of the past three quarterly sprinkler system reports on October 17, 2014 at 7:30 p.m. revealed the following discrepancies with no corrective actions having been taken.             <ul style="list-style-type: none"> <li>- Fire pump ventilation louvers were covered with plywood (NFPA 25, 8.2.2.(1))</li> <li>- Fire pump diesel engine battery charger is not</li> </ul> </li> </ol>	K 062	<p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:</p> <p>The Maintenance Director will review any additions or modifications to the facility for compliance with this standard prior to completion.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place:</p> <p>Quarterly x 2 quarters, the Maintenance Director will tour the Administrator to perform a joint inspection of the facility to ensure the compliance with this standard.</p> <p>K 062</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>An inventory of sprinkler heads has been completed and the appropriate stock of sprinkler heads will be secured by 12/22/14.</p> <p>Items attached to the sprinkler line were removed by 11/20/14.</p> <p>Issues identified by the quarterly sprinkler system inspection reports will have been addressed and corrected by 12/22/14.</p>	12/22/14
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K 062	Continued From page 4 working properly. (NFPA 25, 8.2.2(4)) - Flash arrestor is not at least 10-feet above the fuel tank. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on November 17, 2014.	K 062	<p><b>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</b></p> <p>All residents have the potential to be affected. Sprinkler system inspection reports will be reviewed and corrections will be made as indicated within 4 weeks of notice of a problem, unless otherwise indicated by documentation.</p> <p><b>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur:</b></p> <p>The Maintenance Director will complete the inspection process with the contracted sprinkler inspectors and plan for corrections as issues are identified.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place:</b></p> <p>The Maintenance Director will report issues of the sprinkler inspections to the Administrator. The Administrator will ensure corrections are made timely. Significant issues will be reported to the QAPI Committee.</p>	