

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445481	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ASBURY PLACE AT KING; B. WING _____	(X3) DATE SURVEY COMPLETED  09/24/2012
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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 011 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure the 4-hour fire rated common fire wall to a non-conforming building and its opening protective was maintained. The findings include: Observation and interview with the Maintenance Director, on September 24, 2012 at 6:45 p.m. confirmed unsealed penetrations above the lay-in ceiling through the 4-hour fire wall separating the independent living side from the nursing home. Observation and interview with the Maintenance Director, on September 24, 2012 at 6:45 p.m. confirmed the 3-hour fire door was missing it's astragal. These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 24, 2012.</p>	K 011	<p>K 011</p> <p>Unsealed penetrations between the independent living and healthcare buildings were sealed on 9/28/12. The astragal was replaced on fire doors in the same area on 9/28/12.</p> <p>On 9/28/12, a survey was done on all areas. No other penetrations were found or astragals missing.</p> <p>Administrator and/or Maintenance Director will ensure quarterly that there are no penetrations or astragals missing.</p> <p>Results of the Quarterly inspections will be discussed in Quality Assurance Committee Meeting (DON, Administrator, Facilities Director – maintenance and housekeeping, Pharmacy, Social Services, Medical Director, ADON, Dining Services) for the next two quarters.</p>	9/28/12
K 021 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</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</p>	K 021	<p>K 021</p> <p>The latch on fire doors at room 14 will be replaced by 11/1/12.</p> <p>On 9/27/12, a survey was done on all areas. No other fire doors failed to latch.</p>	11/1/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jessica Shelton* TITLE *Administrator* (X6) DATE *10-5-12*

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.

OCT 09 2012

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

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K 021	Continued From page 1 activation of:  a) the required manual fire alarm system;  b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and  c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure corridor fire doors closed to a positive latch. The findings include: Observation and interview with the Maintenance Director, on September 24, 2012 at 7:45 p.m. confirmed the fire door by room 14 failed to close to a positive latch: These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 24, 2012.	K 021	Administrator and/or Maintenance Director will ensure monthly that there are no issues with fire doors latching.  Results on the Monthly inspections will be discussed in Quality Assurance Committee Meeting (DON, Administrator, Facilities Director – maintenance and housekeeping, Pharmacy, Social Services, Medical Director, ADON, Dining Services) for the next three months.	
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045	K 045  An additional light fixture was installed at the three identified exits on 10/10/12 to assure exit paths were lighted so the area would not be in total darkness.	10/10/12

*Jessica Shelton*      *Administrators*      *10/5/12*

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K 045	Continued From page 2	K 045	On 10/4/12, an audit of all exits was performed. All other exits were found to be illuminated by two bulb fixtures.	
K 050 SS=F	<p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure 3 of 6 outside exits and paths were lighted so the failure of a single bulb would not leave the area in total darkness. The findings include: Observation and interview with the Maintenance Director, on September 24, 2012 at 8:20 pm. confirmed the outside lights at the exits by room 01, 25, and from the dining room exit were not illuminated such that the failure of any single lighting fixture (bulb) would not leave the area in darkness (NFPA 101, 7.8.1.4). This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 24, 2012.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure staff was familiar with the fire plan's procedures.</p>	K 050	<p>Administrator and/or Maintenance Director will ensure two bulb fixtures are installed at exits for any new construction. The plans for new construction will be reviewed by the Quality Assurance Committee (DON, Administrator, Facilities Director – maintenance and housekeeping, Pharmacy, Social Services, Medical Director, ADON, Dining Services).</p> <p>K 050</p> <p>All staff will be re-serviced on Fire Safety. Fire drills will be conducted monthly on each shift for the next three months.</p> <p>On 10/20/12, a fire drill on 2<sup>nd</sup> shift will be completed and staff monitored for compliance for fire drill procedure.</p> <p>Administrator and/or Maintenance Director will ensure that monthly fire drills are in compliance and if not, additional training will be provided.</p>	10/20/2012

*Jessica Shelton, Administrator 10/5/12*

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K 050	Continued From page 3 The findings include: Observation during a fire drill conducted on September 24, 2012 at 9:35 p.m. confirmed the staff failed to close 11 of 14 resident room doors in the front corridor. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 24, 2012.	K 050	Results of the Monthly fire drills will be discussed in Quality Assurance Committee Meeting (DON, Administrator, Facilities Director maintenance and housekeeping, Pharmacy, Social Services, Medical Director, ADON, Dining Services) for the next three months.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: NFPA 110, 5-3.1 - The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. Based on observation and interview, the facility failed to provide the two (2) of (2) Automatic Transfer switch locations with battery-powered emergency lighting (NFPA 110, 5-3.1.)  The findings include:  Observation and interview with the Maintenance	K 144	K 144  Automatic transfer switch locations were provided with battery powered emergency lighting effective 10/12/12. This lighting will be check monthly. A checklist has been created that includes all parameters (such as voltage, frequency, amps, water temp, oil pressure, etc.) to ensure the generator is operating under a load and that the emergency transfer occurred in less than ten seconds.  On 10/12/12, the battery powered emergency lighting will be in effect. Beginning 10/5/12 the new checklist will be implemented and the load tests performed as required.  Administrator and/or Maintenance Director will ensure that monthly generator tests are being performed.	10/12/12

*Jessica Shelton, Administrator 10/5/12*

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K 144	<p>Continued From page 4</p> <p>Director, on September 24, 2012 at 10:10 pm. confirmed the emergency generator Automatic Transfer switch locations were not provided with battery-powered emergency lighting.</p> <p>Based on record review and interview, the facility failed to assure the emergency generator was maintained and was run for 30 minutes under load each month.</p> <p>The findings include: Record review of the Emergency Generator logs with the Maintenance Director, on September 24, 2012 at 10:00 pm. confirm the Generator failed to have a 2-hour load bank test run annually and was not run under load monthly. Logs reviewed indicated the generator was run under load in January, March, April, and July of 2012. Record review of actual logs did not indicate any actual parameters (such as voltage, frequency, amps, water temp, oil pressure, etc.) that could verify the generator is operating under a load or that the emergency transfer occurred in less than 10 seconds.</p> <p>These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on September 24, 2012.</p>	K 144	<p>Results of the Monthly load tests will be discussed in Quality Assurance Committee Meeting (DON, Administrator, Facilities Director maintenance and housekeeping, Pharmacy, Social Services, Medical Director, ADON, Dining Services) for the next three months.</p>	

*Jessica Shelton, Administrator 10/5/12*

09/28/2012