DEPARTMENT OF HEALTH AND HL .N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 1/16/11

PRINTED: 12/02/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	445456		11/29/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWEETWATER NURSING CENTER	978 HWY 11 SOUTH SWEETWATER, TN 37874

(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 000	INITIAL COMMENTS The facility is single story, LSC construction type II(000), fully sprinklered. Licensed bed capacity is 100 beds and census on the day of this survey was 88.	K 000	The facility believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions.....	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure the corridor doors were provided with a means to keep the door closed in a latched position, with hold open devices such that the door could be closed with one motion, push or pull (NFPA 101 LSC 2000 Ed., 19.3.6.3.3). The findings include:	K 018	**K018** **Corrective Action:** Double doors located at the entrance to the kitchen were repaired by Presley Construction Company on 12-2-10 and close to a positive latch. Double doors located at the entrance to the therapy room are not being propped open and have been repaired so that they self close to a positive latch and also have the possibility of remaining open without being propped. Props were removed on 12-2-10 by Maintenance Director. Therapy doors will remain closed when no one is in the therapy department. **Identification:** Inspection of all cross corridor doors on 12-10-10, 12-12-10, and 12-14-10 by Maintenance Director found them working properly. **Measures/Systematic Changes:** Maintenance Director shall in-service staff on 12-14-10, 12-15-10, 12-16-10, and 12-17-10, to ensure there is continual monitoring of cross corridor door operation.	

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

Jeffrey W. Scott — Administrator — 12/14/2010

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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K 000	INITIAL COMMENTS The facility is single story, LSC construction type II(000), fully sprinklered. Licensed bed capacity is 100 beds and census on the day of this survey was 88.	K 000	**K018 (continued)** **Monitor/Q.A.:** Maintenance Director will check all fire doors at least three times a month to ensure that they are in proper working order. Results will be reported to the facility's Performance Improvement Committee (Administrator, D.O.N., A.D.O.N., Social Services Director, Admissions, Dietary Manager, M.D.S. Coordinator, R.N. Assessment Nurse, Medical Records Clerk, Activity Director, Medical Director, and Pharmacy Consultant) by the Maintenance Director monthly for review and determination of ongoing compliance. **Completion Date:** December 17, 2010	12/17/10
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure the corridor doors were provided with a means to keep the door closed in a latched position, with hold open devices such that the door could be closed with one motion, push or pull (NFPA 101 LSC 2000 Ed., 19.3.6.3.3). The findings include:	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeffrey W. Scott	Administrator	12/14/2010

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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K 018	Continued From page 1 Observation on November 29, 2010, between 7:20 a.m. and 7:40 a.m., with the maintenance staff in attendance, revealed the double corridor doors to the physical therapy room were held open by two free-weights and the fire rated door into the kitchen was provided with a self-closing device but failed to close to a positive latch.	K 018	~~The facility believes its current~~ practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions..... **K027** **Corrective Action:** Corridor fire doors located near the East Shower Room and near the Beauty Shop were repaired by Presley Construction on 12-2-10 in order to self close during a fire alarm to a positive latch. **Identification:** Inspection of all cross corridor doors on 12-10-10, 12-12-10, and 12-14-10, by Maintenance Director found them working properly. **Measures/Systematic Changes:** Maintenance Director shall in-service staff on 12-14-10, 12-15-10, 12-16-10, and 12-17-10, to ensure there is continual monitoring of cross corridor door operation. **Monitor/Q.A.:** Maintenance Director will check all fire doors at least three times a month to ensure that they are in proper working order. Results will be reported to the facility's Performance Improvement Committee (Administrator, D.O.N., A.D.O.N., Social Services Director, Admissions/Marketing Director, Dietary Manager, M.D.S. Coordinator, R.N. Assessment Nurse, Medical Records Clerk, Activity Director, Medical Director, and Pharmacy Consultant) by the Maintenance Director monthly for review and determination of ongoing compliance. **Completion Date:** December 17, 2010	12/17/10
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure the cross corridor doors for compartmentation closed properly. The findings include: Observation on November 29, 2010, between 7:30 a.m. and 8:15 a.m., with the maintenance staff in attendance, revealed one side of the cross corridor doors near the front entrance, equipped with latching hardware, did not close to a latch and, for the cross corridor doors near the dietitian ' s office, one side did not close to a latch and one side would not release with pressure applied to	K 027		

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K 027	Continued From page 2 the push bar.	K 027	The facility believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions.....	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure the discharge nozzles on the extinguishing system is properly aligned to protect equipment, with the required 16 inches between the deep fryer and the open flame burner on the cooking range. (NFPA 96, 1998 Ed., 7-1.2, 9-1.2.3) The findings include: Observation on November 29, 2010, at 7:42 a.m., with the maintenance staff in attendance, revealed the deep fryer was not provided with a discharge nozzle aligned above the equipment.	K 069	**K069** **Corrective Action:** Nozzle from Fire Suppression system was extended to align with the center of deep fryer on 12-3-10 by Maintenance Director. An alignment mark was made on the floor by Maintenance Director on 12-3-10 to indicate the proper placement of the fryer so that it will not be shifted away from the nozzle. **Identification:** Inspection of all other Ansell system nozzles by the Maintenance Director on 12-8-10 found them to be in the appropriate position. **Measures/Systematic Changes:** Dietary staff was in-serviced by Dietary Manager on 12-3-10 to keep deep fryer in the appropriate position at all times to ensure location of nozzle is aligned correctly. **Monitor/Q.A.:** Visual checks from Dietary Manager will be made weekly. Results will be reported to the facility's Performance Improvement Committee (Administrator, D.O.N., A.D.O.N., Social Services Director, Admissions/Marketing Director, Dietary Manager, M.D.S. Coordinator, R.N. Assessment Nurse, Medical Records Clerk, Activity Director, Medical Director, and Pharmacy Consultant) by the Dietary Manager monthly for review and determination of ongoing compliance. **Completion Date:** December 3, 2010	12/3/10
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure portable space heaters are not permitted in the facility. The findings include:	K 070		

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K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure the discharge nozzles on the extinguishing system is properly aligned to protect equipment, with the required 16 inches between the deep fryer and the open flame burner on the cooking range. (NFPA 96, 1998 Ed., 7-1.2, 9-1.2.3) The findings include: Observation on November 29, 2010, at 7:42 a.m., with the maintenance staff in attendance, revealed the deep fryer was not provided with a discharge nozzle aligned above the equipment.	K 069	**K070** **Corrective Action:** The fireplace heater was removed from the building on 12-10-10 by Maintenance Director. **Identification:** Inspection of facility on 12-2-10 by Maintenance Director found no other portable space heaters. **Measures/Systematic Changes:** Maintenance Director will in-service staff on 12-14-10, 12-15-10, 12-16-10, and 12-17-10 to ensure there is continual monitoring for portable space heaters throughout the facility. **Monitor/Q.A.:** Maintenance Director will conduct routine inspections throughout the building to ensure that there are no portable space heaters. Results will be reported to the facility's Performance Improvement Committee (Administrator, D.O.N., A.D.O.N., Social Services Director, Admissions/Marketing Director, Dietary Manager, M.D.S. Coordinator, R.N. Assessment Nurse, Medical Records Clerk, Activity Director, Medical Director, and Pharmacy Consultant) by the Maintenance Director monthly for review and determination of ongoing compliance. **Completion Date:** December 17, 2010	12/17/10
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure portable space heaters are not permitted in the facility. The findings include:	K 070		

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K 070	Continued From page 3 Observation on November 29, 2010, at 7:38 a.m., with the maintenance staff in attendance, revealed a portable space heater located in the dining room.	K 070	~~The facility believes its current~~ practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions.....	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to assure the medical gas oxygen storage location, greater than 300 cubic feet, was provided with exhaust mechanical ventilation. (NFPA 99, 1999 Ed., 4-3.1.1.2(c)) The findings include: Observation on November 29, 2010, at 7:38 a.m. with the maintenance staff in attendance, revealed a closet adjacent to the corridor with 17 E size oxygen cylinders and the room was not provided with an exhaust for mechanical ventilation.	K 076	**K076** **Corrective Action:** Mechanical exhaust vent will be added to the O2 storage room on 12-14-10 by Taylor Mechanical. **Identification:** Inspection of all other oxygen storage locations by ADON on 12-13-10 found they did not exceed 300 cubic feet. **Measures/Systematic Changes:** DON and ADON will in-service staff on 12-17-10, 12-22-10, 1-7-11, and 1-13-11, to ensure that nursing staff will keep amount of stored O2 below 300 cubic feet (10 tanks or less) until installation of mechanical exhaust vent is completed. **Monitor/Q.A.:** Maintenance Director will check operation of mechanical exhaust vent monthly along with routine vent checks which are a part of the preventive maintenance list. Results will be reported to the facility's Performance Improvement Committee (Administrator, D.O.N., A.D.O.N., Social Services Director, Admissions/Marketing Director, Dietary Manager, M.D.S. Coordinator, R.N. Assessment Nurse, Medical Records Clerk, Activity Director, Medical Director, and Pharmacy Consultant) by the Maintenance Director monthly for review and determination of ongoing compliance. **Completion Date:** January 14, 2011	1/14/11