

45th 9102/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445427	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BETHESDA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501
---	---

(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 018
SS=E

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 1 1/4 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 observations, it was determined the facility failed to maintain the corridor doors.

The findings include:

Observation of the service hall storage room and the file room by room 201 on 7/17/11 at 9:33 AM, revealed the doors were being held open with pegs.

This finding was acknowledged by the Director of Nurses and verified by the Director of Maintenance at the exit conference on 7/17/11.

K 018

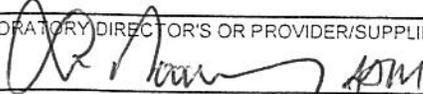
NFPA 101 Life Safety Code Standard
SS=E

Requirement:
There will be no impediment to the closing of doors.

Corrective Action:

1. On 7/17/11 the pegs holding open the doors to the service hall storage and file room by room 201 were removed by the Maintenance Director.
2. On 7/17/11 the facility doors were inspected by the Maintenance Director to ensure proper functioning.
3. On 8/1/11 the Maintenance Director was inserviced by the Administrator regarding the proper closing of doors and the risks of having impediments to the closing of doors.
4. The Maintenance Director and the Maintenance Assistant will monitor for compliance through daily observations X60 days, if compliance is maintained decrease audits to weekly X3 months. Findings will be reviewed in Quality Assurance Committee.

8/1/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 8/3/11
---	------------------------	---------------------

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.

AUG 23 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445427	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BETHESDA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501
---	---

(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 051
SS=E

NFPA 101 LIFE SAFETY CODE STANDARD

A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6

K 051

NFPA 101 Life Safety Code Standard
SS=E

Requirement:

The facility fire alarm system will be installed and maintained to provide effective warning of fire in any part of the building.

Corrective Action:

1. On 7/17/11 the facility contacted a fire alarm repair company to schedule the synchronization of the fire alarm strobe lights.
2. On 7/17/11 the facility fire alarm system was inspected by the Maintenance Director to ensure effective warning of fire in any part of the building.
3. On 8/1/11 the Maintenance Director was inserviced by the Administrator regarding the proper functioning of the fire alarm strobe lights.
4. The Maintenance Director and the Maintenance assistant will monitor for compliance through weekly observations X30 days, if compliance is maintained decrease audits to monthly X3 months. Findings will be reviewed in Quality Assurance Committee.

8/1/11

This STANDARD is not met as evidenced by:
Based on observations, it was determined the facility failed to maintain the fire alarm system.

The findings include:

Observation during the fire drill on 7/17/11 at 10:18 AM, revealed the fire alarm strobe lights in the corridors were not synchronized as required.

AUG 23 2011

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

PRINTED: 07/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445427	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BETHESDA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501
---	---

(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 051 Continued From page 2
This finding was acknowledged by the Director of Nurses and verified by the Director of Maintenance at the exit conference on 7/17/11.

K 051

K 052 NFPA 101 LIFE SAFETY CODE STANDARD SS=E
A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4

K 052

NFPA 101 Life Safety Code Standard SS=E
Requirement:
The facility fire alarm system will be installed, tested and maintained in accordance with NFPA 70 and NFPA 72.

Corrective Action:
1. On 7/17/11 the equipment blocking the pull stations at the South nurse's station and by the exit door on the 100 hall were removed by the Maintenance Director.
2. On 7/17/11 the facility pull stations were inspected by the Maintenance Director to ensure proper clearance.
3. On 8/1/11 the Maintenance Director was inserviced by the Administrator regarding the proper clearance needed in front of the pull stations.
4. The Maintenance Director and the Maintenance Assistant will monitor for compliance through daily observations X30 days, if compliance is maintained decrease audits to monthly X3 months. Findings will be reviewed in Quality Assurance Committee.

8/1/11

This STANDARD is not met as evidenced by:
Based on observations, it was determined the facility failed to maintain the fire alarm system.

The findings include:

Observation of the South nurses's station and by the exit door in the 100 hall on 7/17/11 at 9:40 AM, revealed the pull stations were blocked with equipment.

These findings were acknowledged by the Director of Nurses and verified by the Director of Maintenance at the exit conference on 7/17/11.

K 062 NFPA 101 LIFE SAFETY CODE STANDARD SS=D
Required automatic sprinkler systems are continuously maintained in reliable operating

K 062

NFPA 101 Life Safety Code Standard SS=D

AUG 23 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445427	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BETHESDA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501
---	---

(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 062	Continued From page 3 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the sprinkler system. The findings include: Observation of the kitchen freezer on 7/17/11 at 9:25 AM, revealed the sprinkler head was frozen over with ice. This finding was acknowledged by the Director of Nurses and verified by the Director of Maintenance at the exit conference on 7/17/11.	K 062	<u>Requirement:</u> There facility sprinkler system will be maintained in a reliable operating condition. <u>Corrective Action:</u> 1. On 7/17/11 the Maintenance Director removed the ice from the sprinkler head in the kitchen freezer. 2. On 7/17/11 the Maintenance Director inspected the facility sprinkler heads to ensure that no other sprinkler heads were frozen over with ice. 3. On 8/1/11 the Maintenance Director was inserviced by the Administrator regarding the proper maintenance of the facilities sprinkler system.. 4. The Maintenance Director and the Maintenance Assistant will monitor for compliance through weekly observations X30 days, if compliance is maintained decrease audits to monthly X3 months. Findings will be reviewed in Quality Assurance Committee.	8/1/11
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the fire extinguishers. The findings include: (1) Observation of the physical therapy room and the outside riser room on 7/17/11 at 9:46 AM, revealed the fire extinguishers were blocked with	K 064	NFPA 101 Life Safety Code Standard SS=E <u>Requirement:</u> Portable fire extinguishers will be provided in accordance with 9.7.4.1.19.3.5.6, NFPA 10. <u>Corrective Action:</u> 1. a. On 7/17/11 the equipment blocking the fire extinguishers in the outside riser room and physical therapy room were removed by the Maintenance Director. b. On 7/17/11 the fire extinguisher was remounted at a height no higher than 60 inches by the Maintenance Director. 2. On 7/17/11 the facility fire extinguishers were audited by the Maintenance Director to ensure they were not blocked and mounted at a proper height.	

AUG 23 2011

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

PRINTED: 07/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445427	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BETHESDA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501
---	---

(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 076 Continued From page 5
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 observations, it was determined the facility failed to maintain the combustible liquids.

The findings include:

Observation of the North utility room and the 100 hall clean utility room on 7/17/11 at 10:08 AM, revealed oxygen cylinders were not secured.

K 076

Requirement:
Medical gas storage and administration areas will be protected in accordance with NFPA99, Standards for Health Care Facilities.

Corrective Action:
1. On 7/17/11 the Maintenance Director secured the oxygen cylinders properly in the North hall clean utility room and the 100 hall clean utility room.
2. On 7/17/11 the Maintenance Director inspected the facility to ensure that oxygen cylinders were properly secured.
3. On 8/1/11 the Maintenance Director was inserviced by the Administrator regarding proper storage of oxygen cylinders.
4. The Maintenance Director and the Maintenance Assistant will monitor for compliance through weekly observations X30 days, if compliance is maintained decrease audits to monthly X3 months. Findings will be reviewed in Quality Assurance Committee.

8/1/11

K 141
SS=E NFPA 101 LIFE SAFETY CODE STANDARD

Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2.

This STANDARD is not met as evidenced by:
Based on observations, it was determined the facility failed to maintain the no smoking signs.

K 141

NFPA 101 Life Safety Code Standard
SS=E

Requirement:
The facility will maintain non-smoking and no smoking signs in areas where oxygen is used or stored.

AUG 23 2011

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

PRINTED: 07/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445427	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BETHESDA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501
---	---

(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 141 Continued From page 6

The findings include:

Observation of resident rooms 110, 203, 305, 309, 403, 405, 507, 510, 604, 605, and in the physical therapy room and the 100 hall biohazard room, revealed oxygen being used in the rooms and no precautionary signs posted on the doors.

This finding was acknowledged by the Director of Nurses and verified by the Director of Maintenance at the exit conference on 7/17/11.

K 147 NFFA 101 LIFE SAFETY CODE STANDARD SS=E

Electrical wiring and equipment is in accordance with NFFA 70, National Electrical Code. 9.1.2

This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the electrical codes.

The findings include:

(1) Observation of the kitchen area, the laundry room, and the outside electrical room on 7/17/11 at 9:20 AM, revealed the electrical panels were blocked with equipment.

(2) Observation of the service hall on 7/17/11 at 9:30 AM, revealed a light cover was missing.

(3) Observation of the medical records office on 7/17/11 at 10:03 AM, revealed an open space in the electrical panel.

(4) Observation of the outside riser room on

K 141

Corrective Action:

- On 7/17/11 the Maintenance Director placed no smoking signs on resident rooms 110, 203, 305, 309, 403, 405, 507, 510, 604, 605, and in the physical therapy room and the 100 hall biohazard room.
- On 7/17/11 the Maintenance Director inspected the facility to ensure that areas using or storing oxygen had no smoking signs posted on the doors.
- On 8/1/11 the Maintenance Director was inserviced by the Administrator regarding the facilities non-smoking status. All entry doors have no smoking signs prominently displayed upon entry to the facility. The facility is a non-smoking facility everywhere inside of the facility.
- The Maintenance Director and the Maintenance Assistant will monitor weekly to ensure that required postings on facility entrance doors are prominently displayed so as to alert visitors, residents, and staff that the facility continues to be a non-smoking facility everywhere inside of the facility. Findings will be reviewed in Quality Assurance Committee.

K 147

8/1/11

AUG 23 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445427	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BETHESDA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501
---	---

(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 141 Continued From page 6

K 141

The findings include:

Observation of resident rooms 110, 203, 305, 309, 403, 405, 507, 510, 604, 605, and in the physical therapy room and the 100 hall biohazard room, revealed oxygen being used in the rooms and no precautionary signs posted on the doors.

This finding was acknowledged by the Director of Nurses and verified by the Director of Maintenance at the exit conference on 7/17/11.

K 147 NFPA 101 LIFE SAFETY CODE STANDARD

K 147

SS=E

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

NFPA 101 Life Safety Code Standard
SS=E

Requirement:

The facilities electrical wiring will be maintained in accordance with NFPA 70, National Electrical Code 9.1.2

This STANDARD is not met as evidenced by:
Based on observations, it was determined the facility failed to maintain the electrical codes.

Corrective Action:

1. a. On 7/17/11 the Maintenance Director removed equipment which blocked electrical panels in the kitchen area, the laundry room, and the outside electrical room.
- b. On 7/17/11 the Maintenance Director replaced the missing light cover on the service hall.
- c. On 7/17/11 the Maintenance Director replaced cover on electrical panel in medical records office.
- d. On 7/17/11 the Maintenance Director replaced junction box cover in the outside riser room.
2. On 7/17/11 the Maintenance Director inspected the facility to ensure that electrical panels were not blocked, light covers were not missing, electrical panels did not have open spaces, and junction boxes were not missing covers.

The findings include:

(1) Observation of the kitchen area, the laundry room, and the outside electrical room on 7/17/11 at 9:20 AM, revealed the electrical panels were blocked with equipment.

(2) Observation of the service hall on 7/17/11 at 9:30 AM, revealed a light cover was missing.

(3) Observation of the medical records office on 7/17/11 at 10:03 AM, revealed an open space in the electrical panel.

(4) Observation of the outside riser room on

AUG 23 2011

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

PRINTED: 07/21/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445427	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2011
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BETHESDA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501
---	---

(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 147 Continued From page 7
7/17/11 at 10:30 AM, revealed a junction box cover was missing.

These findings were acknowledged by the Director of Nurses and the Director of Maintenance at the exit conference on 7/17/11.

K 147

3. On 8/1/11 the Maintenance Director was inserviced by the Administrator regarding the maintenance, inspection, and proper access needed for electrical panels. On 8/1/11 the Maintenance Director was inserviced by the Administrator on ensuring that light covers were not missing and junction boxes were covered.
4. The Maintenance Director and the Maintenance assistant will monitor for compliance through weekly observations X30 days, if compliance is maintained decrease audits to monthly X3 months. Findings will be reviewed in Quality Assurance Committee.

8/1/11

AUG 23 2011