

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

PRINTED: 05/16/2011
FORM APPROVED
OMB NO. 0938-0391

45th 6/25/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445392	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/09/2011
NAME OF PROVIDER OR SUPPLIER ADAMSPLACE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1927 MEMORIAL BOULEVARD MURFREESBORO, TN 37129	
(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 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observations during the survey, it was determined the facility failed to maintain the exit doors as required. The findings include: Observation during the survey on 5/9/11 at 1:00 PM, revealed the fire door by elevator # 1 required more than fifteen (15) pound force to open and close. The deficiency was corrected prior to the exit interview on 5/9/11. This finding was acknowledged by the Administrator and verified by the Maintenance Director. The deficiency was corrected prior to the exit interview on 5/9/11.	K 038	It is the policy and procedure of AdamsPlace that it complies with the applicable building and fire safety regulations. Plant Operations corrected the fire door by elevator #1 prior to the exit interview. Director of Plant Operations will do a QA weekly for 4 weeks to monitor for compliance.	5/9/11
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on testing during the survey, it was determined the facility failed to maintain the electrical equipment as required.	K 147	It is the policy and procedure of AdamsPlace that it complies with the applicable building and fire safety regulations. Plant Operations replaced the GFCI outlet in the recreation room and is now in compliance. Director of Plant Operations will continue to monitor GFCI outlets for compliance.	5/19/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator (X8) DATE 5-24-11

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.

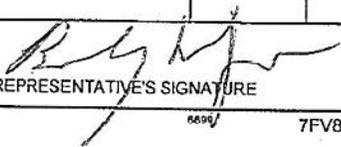
PRINTED: 05/13/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7501	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2011
NAME OF PROVIDER OR SUPPLIER ADAMSPLACE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1927 MEMORIAL BOULEVARD MURFREESBORO, TN 37129		
(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) COMPLETE DATE	
N 000	Initial Comments During the annual Licensure survey conducted on May 9-11, 2011, at Adams Place, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

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



TITLE *Administrator*

(X6) DATE

5-24-11

STATE FORM

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If continuation sheet 1 of 1