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

**STATION OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:**  
445474

**(X2) MULTIPLE CONSTRUCTION**  
A. BUILDING 01 - MAIN BUILDING 01
B. WING

**STREET ADDRESS, CITY, STATE, ZIP CODE:**  
1633 HILLVIEW DRIVE  
ELIZABETHTON, TN 37643  
08/08/2013

**ID PREFIX TAG**  
**SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>K045</td>
<td>A double bulb lighting fixture was installed by the Maintenance Supervisor at the following locations:</td>
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<td>SS=E</td>
<td>1. The front sidewalk, 2. Sunroom exit, 3. Rear physical therapy exit sidewalk to the parking lot</td>
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<td>The three exterior lighting devices will be connected to emergency generator power by the Maintenance Supervisor by August 23, 2013.</td>
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<td>2. All exterior lighting devices were checked by the Maintenance Supervisor on August 5, 2013. No other lighting devices were found to be affected.</td>
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<td>3. The Maintenance Supervisor and the Maintenance Assistant were in-serviced on August 5, 2013, by the Administrator on exterior lighting device requirements.</td>
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<td>4. All exterior lighting devices for the facility will be audited to ensure proper functioning daily X 1 week, weekly X 3 weeks, and then monthly thereafter. Results obtained will be reported to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of the Administrator, the Director of Nursing, Minimum Data Set Coordinator, Rehabilitation Manager, Medical Director, Social Services Director, Environmental Services Director, Dietary Manager, and the Activities Director.</td>
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</table>

**PHARMACY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:**  

Galvin Bailer  

Administrator  
8/16/2013

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patient. (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 disclosed 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued participation.