STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445391

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

(X5) DATE SURVEY COMPLETED: 12/10/2012

NAME OF PROVIDER OR SUPPLIER

MANCHESTER HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
395 INTERSTATE DRIVE
MANCHESTER, TN 37355

<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 038</td>
<td>SS = D</td>
<td><strong>NFPA 101 LIFE SAFETY CODE STANDARD</strong>&lt;br&gt;Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</td>
<td>K 038</td>
<td>SS = D</td>
<td>This Plan of Correction has been developed in compliance with State and Federal Regulations. This plan affirms Manchester Health Care Center's intent and allegation of compliance with those regulations. This POC does not constitute an admission or concession of either accuracy or factual allegation made in, or existence or scope of significance, of any cited deficiency.&lt;br&gt;1. The Plant Operations Manager installed &quot;NOT AN EXIT&quot; signs on the doors in the Activity Room leading to the outside courtyard on 12/14/12.&lt;br&gt;2. All other doors leading to the outside of the building were evaluated by the Plant Operations Manager on 12/14/12 to determine if additional signs were necessary. No other doors were identified.&lt;br&gt;3. The Plant Operations Manager was instructed by the administrator on 12/14/12 and instructed to include the observation of the &quot;NOT AN EXIT&quot; signs on the monthly preventive maintenance checks.&lt;br&gt;4. Ongoing verification that the signs are clearly visible on the doors leading from the Activity Room to the courtyard will be included on the monthly preventive maintenance check. The results of the monthly preventive maintenance check will be reported by the Plant Operations Manager to the Quality Assurance Performance Improvement Committee comprising of Administrator, Director of Nursing, Medical Director, Nurse Educator, Activities Director, and Minimum Data Set Coordinator, Director of Social Services, Plant Operations Manager, Registered Dietitian, Director of Dietary, Director of Therapy and Medical Records Coordinator.&lt;br&gt;Completion date: 12/14/12</td>
<td>12/14/12</td>
</tr>
<tr>
<td>K 066</td>
<td>SS = D</td>
<td><strong>NFPA 101 LIFE SAFETY CODE STANDARD</strong>&lt;br&gt;Smoking regulations are adopted and include no less than the following provisions:&lt;br&gt;(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING</td>
<td>K 066</td>
<td>SS = D</td>
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</table>

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

ADMINISTRATOR

12-27-12

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.
K 066 Continued From page 1
or with the international symbol for no smoking.

(2) Smoking by patients classified as not
responsible is prohibited, except when under
direct supervision.

(3) Ashtrays of noncombustible material and safe
design are provided in all areas where smoking is
permitted.

(4) Metal containers with self-closing cover
devices into which ashtrays can be emptied are
readily available in all areas where smoking is
permitted. 19.7.4

This STANDARD is not met as evidenced by:
Based on observation, it was determined the
facility failed to provide adequate equipment in
the smoking area.

The finding included:

Observation on 12/10/12 at 10:26 AM revealed
there was no metal container with self-closing
cover device into which ashtrays can be emptied
in the staff smoking area.

This finding was acknowledged by the
maintenance director and the facility administrator
during the exit conference on 12/10/12.

K 067 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

Heating, ventilating, and air conditioning comply
with the provisions of section 9.2 and are installed.

K 068 A non-slip, hard surface will be installed
between the dietary back driveway and the main
dining room cement pad. It will be 12 feet by 4
feet in size and the work is scheduled to be
completed no later than 1/10/13.

2. All other exits from the building were
checked by the Plant Operations Manager on
12/14/12 to determine if any other non-slip
surfaces were needed. No other areas were
identified.

3. The Plant Operations Manager will include
this item on his monthly preventive maintenance
check.

4. The results of the monthly preventive
maintenance check will be reported by the Plant
Operations Manager to Quality Assurance
Performance Improvement Committee
comprising of Administrator, Director of
Nursing, Medical Director, Nurse Educator,
Activities Director, and Minimum Data Set
coordinator, Director of Social Services, Plant
Operations Manager, Registered Dietitian,
Director of Dietary, Director of Therapy and
Medical Records Coordinator.

Completion date: 1/10/13

K 068 1-10-13

1. The Plant Operations Manager purchased
a metal container with a self-closing lid and it
was placed in service in the designated smoking
area on 12/14/12. It is clearly marked that the
metal container is for ashes only and not trash
and it is emptied daily.

2. The facility has only one designated smoking
area, therefore no other areas are affected.

3. Nursing staff, Dietary staff, Housekeeping
staff, administrative staff, Activities staff, plant
operations staff, therapy staff and Social
Services staff have been informed by the Plant
Operations Manager and Director of Nursing on
12/14/12 through 1/2/13 regarding the proper
use of the covered container and the importance
of using it for ashes only.

4. The Plant Operations Manager or
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>K067</td>
<td>Continued From page 2</td>
<td>in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</td>
<td>Environmental Services Supervisor will check the metal container daily for five (5) days per week for four (4) weeks: then three (3) days per week for four (4) weeks; then one (1) day per week for four (4) weeks and/or 100% compliance. The results will be reported by the Plant Operations Manager monthly to Quality Assurance Performance Improvement Committee comprising of Administrator, Director of Nursing, Medical Director, Nurse Educator, Activities Director, and Minimum Data Set coordinator, Director of Social Services, Plant Operations Manager, Registered Dietitian, Director of Dietary Director of Therapy and Medical Records Coordinator. Completion date: 1/2/13</td>
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<tr>
<td>K130</td>
<td>SS=E</td>
<td>OTHER LSC DEFICIENCY NOT ON 2786</td>
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This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain negative air pressure in required areas.

The finding included:

Observation on 12/10/12 at 9:41 AM revealed the dirty utility room in the kitchen was unable to maintain a negative air pressure due to missing a door.

This finding was acknowledged by the maintenance director and the facility administrator during the exit conference on 12/10/12.

Observation on 12/10/12 at 9:36 AM revealed the following fire walls located in the attic had penetrations:

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

The finding included:
**MANCHESTER HEALTH CARE CENTER**

<table>
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<tr>
<td>K 130</td>
<td>Continued From page 3</td>
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<tr>
<td></td>
<td>1. 100 Hall attic fire wall had drywall tape and mud falling off where the wall meets the roof.</td>
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<tr>
<td></td>
<td>2. 500 Hall attic fire wall had penetration around data cables running through the wall and drywall tape and mud coming off at the seams and at roof.</td>
</tr>
<tr>
<td></td>
<td>3. 400 Hall attic fire wall had drywall tape and mud falling off where the wall meets the roof.</td>
</tr>
<tr>
<td></td>
<td>4. 300 Hall attic fire wall had drywall tape and mud falling off where the wall meets the roof.</td>
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<tr>
<td></td>
<td>5. 200 Hall attic fire wall had drywall tape and mud falling off where the wall meets the roof, penetration around data cables running through the wall, and 4 exposed screws.</td>
</tr>
</tbody>
</table>

This finding was acknowledged by the maintenance director and the facility administrator during the exit conference on 12/10/12.

**K 140 SS-D**

NFPA 101 LIFE SAFETY CODE STANDARD

Master alarm panels are in two separate locations and have audible and visible signals. There are high/low alarms for +/- 20% operating pressure.

NFPA 99, 4.3.1.2.2

This STANDARD is not met as evidenced by:

Based on observation, it was determined the facility failed to provide audible and visual alarms for the medical gas distribution system.

The finding included:

Observation on 12/10/12 at 10:12 AM revealed there was no power to the gas distribution system.

**K 130 K130**

The drywall tape separation in the 200 Hall attic was repaired by the Plant Operations Manager on 12/19/12. The drywall tape separation in the 100 Hall attic, the 300 Hall attic, the 400 Hall attic and the 500 Hall attic are being repaired by the Plant Operations Manager. The fire wall penetrations around the data cables in the 200 Hall attic and the 500 Hall attic were repaired by the Plant Operations Manager on 12/19/12.

2. The Plant Operations Manager inspected all other areas of the attic to identify penetrations or drywall tape separation on 12/17/12 and 12/19/12. No other areas were identified.

3. The Plant Operations Manager will include this item on his monthly preventive maintenance check.

4. The results of the monthly preventive maintenance check will be reported by the Plant Operations Manager to Quality Assurance Performance Improvement Committee comprising of Administrator, Director of Nursing, Medical Director, Nurse Educator, Activities Director, and Minimum Data Set coordinator, Director of Social Services, Plant Operations Manager, Registered Dietitian, Director of Dietary, Director of Therapy and Medical Records Coordinator.

Completion date: 1/10/13

1-10-13

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**JAN 02 2013**
K 140 Continued From page 4 monitor panel.

This finding was acknowledged by the maintenance director and the facility administrator during the exit conference on 12/10/12.

K 140K140

1. The power to the gas distribution monitoring panel was checked by the Plant Operations Manager on 12/14/12. A sensor was ordered and installed on 12/17/12 by the Plant Operations Manager.

2. This is the only gas distribution monitoring panel in the building, therefore, no other issues were identified.

3. The Plant Operations Manager will include this item on his monthly preventive maintenance check.

4. The Plant Operations Manager will check the gas distribution monitoring panel for five (5) days per week for four (4) weeks; then three (3) days per week for four (4) weeks; then one (1) day per week for four (4) weeks and/or 100% compliance. The results of the monthly preventive maintenance check will be reported by the Plant Operations Manager to Quality Assurance Performance Improvement Committee comprising of Administrator, Director of Nursing, Medical Director, Nurse Educator, Activities Director, and Minimum Data Set Coordinator, Director of Social Services, Plant Operations Manager, Registered Dietitian, Director of Dietary, Director of Therapy and Medical Records Coordinator.

Completion date: 1/10/13