<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 029</td>
<td>SS=D</td>
<td></td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>Both of the areas noted in the firewall were repaired with fire rated caulk. Any contractors providing services dealing with firewalls will be required to utilize fire proof caulk at the time of service. Random checks for firewall consistency will be conducted by the Director of Plant Services on a quarterly basis.</td>
<td>12/20/2012</td>
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<td>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</td>
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<tr>
<td>K 038</td>
<td>SS=D</td>
<td></td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
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</table>

This STANDARD is not met as evidenced by:
Based on observations, it was determined the facility failed to maintain the rated construction in hazardous areas.

The findings included:

1. Observation on 12/17/12 at 9:30 AM revealed penetrations in the fire wall of the 100 hall mechanical room.

2. Observation in the outside mechanical room on 12/17/12 at 10:48 AM revealed penetrations around the exhaust through the ceiling on the water heater and in the wall at the water line.

These findings were acknowledged by the maintenance director, the director of business development, and the facility administrator during the exit conference on 12/17/12.

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 038 Continued From page 1

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, it was determined the facility failed to maintain readily accessible exits at all times.

The findings included:

1. Observation on 12/17/12 at 10:04 AM revealed shrubs growing into the path of egress outside of the day room at the end of the 100 hall.

2. Observation on 12/17/12 at 10:30 AM revealed the concrete sidewalk had been worn away creating a tripping hazard in the path of egress outside the 200 hall.

These findings were acknowledged by the maintenance director, the director of business development, and the facility administrator during the exit conference on 12/17/12.

K 050 SS=D

NFPA 101 LIFE SAFETY CODE STANDARD

Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded
K 050: Continued From page 2
   announcement may be used instead of audible alarms.  19.7.1.2

   This STANDARD is not met as evidenced by:
   Based on records review, it was determined the facility failed to conduct the required fire drills.

   The finding included:

   Records review on 12/17/12 at 11:22 AM revealed there were no third shift (11:00 PM to 7:00 AM) fire drills during the second and third quarters of 2012.

   This finding was acknowledged by the maintenance director, the director of business development, and the facility administrator during the exit conference on 12/17/12.

K 062: NFPA 101 LIFE SAFETY CODE STANDARD

   SS=D

   Required automatic sprinkler systems are continuously maintained in reliable operating 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 in reliable operating condition.

   The findings included:

   1. Observation on 12/17/12 at 9:27 AM revealed a
<table>
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<tbody>
<tr>
<td>K062</td>
<td>Continued From page 3</td>
<td></td>
<td>corroded sprinkler in the dirty laundry room.</td>
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<td>2. Observation on 12/17/12 at 9:32 AM revealed that sprinkler deflectors in the following locations were not installed the minimum 1 inch from the ceiling: sprinkler in the home care office, in 100 corridor outside the storage room adjacent to staff break room.</td>
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<td>3. Observation on 12/17/12 at 10:05 AM revealed a corroded sprinkler in the back sink area of the kitchen.</td>
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<td>These findings were acknowledged by the maintenance director, the director of business development, and the facility administrator during the exit conference on 12/17/12.</td>
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<tr>
<td>K066</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>SS=D</td>
<td>Smoking regulations are adopted and include no less than the following provisions:</td>
<td>K066</td>
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<td>(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 or with the international symbol for no smoking.</td>
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<td>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</td>
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<td>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</td>
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<td>(4) Metal containers with self-closing covers</td>
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<td>Ashtrays of non-combustible materials and self closing were ordered for all smoking areas and placed on 12/27/2012. Function and placement of these items will be monitored by the Director of Environmental Services.</td>
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</table>
K 066. Continued From page 4

devices into which ashtrays can be emptied are readily available to 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 metal containers with self-closing cover devices into which ashtrays can be emptied in all areas where smoking is permitted.

The finding included:

Observation on 12/17/12 at 10:31 AM revealed there was no metal containers with self-closing cover devices into which ashtrays can be emptied in the smoking area outside the 200 hall.

This finding was acknowledged by the maintenance director, the director of business development, and the facility administrator during the exit conference on 12/17/12.

K 067 NFPA 101 LIFE SAFETY CODE STANDARD

Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2

This STANDARD is not met as evidenced by:

Door in the laundry area was repaired and now closes properly within its frame.
Function of the fire doors will be randomly tested on a quarterly basis by the Director of Plant Operations. 12/20/2012
**K 067** Continued From page 5

Based on observation, it was determined the facility failed to maintain negative air pressure in required areas.

The finding included:

Observation on 12/17/12 at 9:28 AM revealed the door between clean and dirty laundry did not close within the frame.

This finding was acknowledged by the maintenance director, the director of business development, and the facility administrator during the exit conference on 12/17/12.

**K 069**

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 observations, it was determined the facility failed to protect the cooking facilities.

The findings included:

1. Observation on 12/17/12 at 10:00 AM revealed the hood over the grill had dirty filters, exhaust duct with grease build-up, and the fire suppression system piping covered with a build-up of grease.

2. Observation in the kitchen on 12/17/12 at 10:02 AM revealed the oven/grill on the right side had grease build-up under the catch pan.

These findings were acknowledged by the maintenance director, the director of business.
## Department of Health and Human Services
### Centers for Medicare & Medicaid Services

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01</th>
<th>(X3) DATE SURVEY COMPLETED 12/17/2012</th>
</tr>
</thead>
</table>

### Name of Provider or Supplier

**Wyndridge Health and Rehab CTR**

### Statement of Deficiencies and Plan of Correction

#### Summary Statement of Deficiencies

(Each deficiency must be preceded by full regulatory or LSC identifying information)

#### Provider's Plan of Correction

(Each corrective action should be cross-referenced to the appropriate deficiency)

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<tr>
<td>K069</td>
<td>Continued From page 6 development, and the facility administrator during the exit conference on 12/17/12.</td>
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<td>K069</td>
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<td>K073</td>
<td>NFPA 101 Life Safety Code Standard SS=D No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to prohibit the use of decorations of highly flammable character. The findings included: 1. Observation on 12/17/12 at 10:31 AM revealed all the corridor doors in the 400 hall were covered with wrapping paper. 2. Observation in room 410B on 12/17/12 at 10:34 AM revealed the wall was covered with wrapping paper. These findings were acknowledged by the maintenance director, the director of business development, and the facility administrator during the exit conference on 12/17/12.</td>
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<td>K130</td>
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<tr>
<td>K130</td>
<td>NFPA 101 Miscellaneous SS=D Other LSC Deficiency Not on 2786 Emergency and disaster drills will be conducted on a semi-annual basis. An in-service concerning earthquake procedures was conducted on 12/20/2012. Compliance for disaster drills will be maintained by the Director of Plant Operations.</td>
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*Form CMS-2567(02-99) Previous Versions Obsolete Event ID: R1H321 Facility ID: TN1903 If continuation sheet Page 7 of 10*
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<td>K 130</td>
<td>Continued From page 7 11-5.3.9 Drills. Each organizational entity shall implement one or more specific responses of the emergency preparedness plan at least semi-annually. At least one semi-annual drill shall rehearse mass casualty response for health care facilities with emergency services, disaster receiving stations, or both. Based on records review, it was determined the facility failed to conduct the required emergency preparedness drills. The finding included: Review of records on 12/17/12 at 11:26 revealed the facility failed to conduct semi-annual emergency preparedness drills. This finding was acknowledged by the maintenance director, the director of business development and the facility administrator during the exit conference on 12/17/12. 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 observations, it was determined the facility failed to maintain the electrical wiring in accordance with NFPA 70. The findings included: 1. Observation on 12/17/12 at 9:32 AM revealed a...</td>
<td>K 147</td>
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K 147 Continued From page 8

damaged light switch cover in the 100 hall storage room.

2. Observation on 12/17/12 at 11:00 AM revealed a electrical junction box missing a cover located above the fire doors by the Director of Medical Records office.

These findings were acknowledged by the maintenance director, the director of business development, and the facility administrator during the exit conference on 12/17/12.

K 211 NFPA 101 LIFE SAFETY CODE STANDARD

Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:
- The corridor is at least 6 feet wide
- The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)
- The dispensers have a minimum spacing of 4 ft from each other
- Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet
- Dispensers are not installed over or adjacent to an ignition source.
- If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623

This STANDARD is not met as evidenced by:
Based on observation, it was determined the facility failed to install Alcohol Based Hand Rub (ABHR) dispensers in the correct location.

The ABHR dispenser was relocated away from the electrical outlet. Placement of the ABHR dispensers will be monitored by the Director of Plant Operations and Director of Environmental Services.
K 211. Continued From page 9

The finding included:

Observation on 12/17/12 at 9:26 AM revealed an ABHR dispenser in the clean laundry room installed above an electrical outlet.

This finding was acknowledged by the maintenance director, the director of business development, and the facility administrator during the exit conference on 12/17/12.