<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
</tr>
</thead>
</table>
| K021 | SS=D | **NFPA 101 LIFE SAFETY CODE STANDARD**

Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:

a) the required manual fire alarm system;

b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and

c) the automatic sprinkler system, if installed.

19.2.2.2.6, 7.2.1.8.2

This STANDARD is not met as evidenced by:

Based on observation, it was determined the facility failed to maintain clearance at all fire and smoke doors.

The findings included:

Observations of the 400 hall dining area on 1/24/11 at 5:10 AM, revealed a cart with an ice chest parked unattended in the path of a 1 hour fire door.

NFPA 101 LIFE SAFETY CODE STANDARD

**K045**

Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency

<table>
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| K021 | SS=D | **NFPA 101 LIFE SAFETY CODE STANDARD**

Requirement:

Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure will be held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:

a) the required manual fire alarm system;

b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and

c) the automatic sprinkler system, if installed.

19.2.2.2.6, 7.2.1.8.2

Correction:

The ice chest parked unattended in the path of a 1 hour fire door at the 400 hall dining area was removed. Staff will be insserted regarding the requirements that these doors cannot be obstructed.

The QA Team, consisting of the Medical Director, Administrator, Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three...
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<th>COMPLETION DATE</th>
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</thead>
<tbody>
<tr>
<td>K 045</td>
<td>Continued From page 1 lighting (in accordance with section 7.8.)</td>
<td>19.2.6</td>
<td>This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to provide lighting at 1 of 10 exit discharge areas. The findings included: Observations of the 100 hall by room 115 on 1/24/11 at 5:20 AM, revealed the area was dark. The single bulb fixture mounted on the outside wall was not working. 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</td>
<td>K 045</td>
<td>months through random observation audits to ensure compliance. If compliance is not met, the team will re-inservice and continue monitoring until substantial compliance is achieved. Different members of the QA Team will participate depending on the nature of the audit.</td>
<td>02-04-11</td>
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<tr>
<td>K 064</td>
<td>SS=D</td>
<td></td>
<td>This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain access to fire extinguishers. The findings included: 1. Observations of the corridors on 1/24/11 from 5:00 AM until 5:40 AM revealed a fire extinguisher in the 400 hall obstructed with a linen cart and an overbed table. 2. Observations of the kitchen on 1/24/11 at 5:36</td>
<td>K 064</td>
<td></td>
<td></td>
<td>Requirement: Illumination of means of egress, including exit discharge, will be arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8). Correction: An additional single bulb fixture was mounted on the outside wall of 100 hall by room 115, for a total of two lighting fixtures for this area. The Maintenance Supervisor was in-serviced on 01-24-11 regarding this lighting requirement. The QA Team, consisting of the Medical Director, Administrator, Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random observation audits to ensure compliance. If compliance is not</td>
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<tr>
<td>K 064</td>
<td>Continued From page 2. AM revealed the following: a. A stand mixer obstructing the activation pull station. b. The K-class fire extinguisher did not have a placard posted to instruct the user.</td>
<td>K 064               met, the team will re-inservice and continue monitoring until substantial compliance is achieved. Different members of the QA Team will participate depending on the nature of the audit.</td>
<td>02-03-11</td>
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<tr>
<td>K 072 SS=E</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</td>
<td>K 072               SS-D Portable fire extinguishers will be provided in all health care occupancies in accordance with 9.7.4.1 19.3.5.6, NFPA 10</td>
<td>02-03-11</td>
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This STANDARD is not met as evidenced by: Based on observations, it was determined that the facility failed to maintain egress in the corridors.

The findings included:

1. Observations of the 100 corridor on 1/24/11 from 5:19 AM to 7:15 AM, revealed a linen cart by room 113 in the path of egress.

2. Observations of the therapy corridor on 1/24/11 from 5:13 AM to 7:10 AM, revealed a linen cart by the entry door in the path of egress.

3. Observations of the 300 corridor on 1/24/11 from 5:12 AM to 7:07 AM, revealed a linen cart and hoyer lift in the path of egress by room 305.

4. Observations of the 400 corridor on 1/24/11 from 5:05 AM to 7:05 AM, revealed a vitals monitor plugged into a receptacle in the path of egress.
**K 072** Continued From page 3 egress by room 418.

**K 104** NFPA 101 LIFE SAFETY CODE STANDARD

Penetrations of smoke barriers by ducts are protected in accordance with 8.3.8.

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

The findings included:

1. Observations above the fire doors entering the 300 hall on 1/24/11 at 8:10 AM, revealed a penetration around a 1 inch conduit and a penetration where a cable had been removed.

2. Observations of the electrical room beside the staff development office on 1/24/11 at 8:15 AM, revealed 2 penetrations above the door on the outside and 2 penetrations above the door on the inside. The back wall of the electrical room revealed a penetration inside a 3 inch sleeve and a penetration inside a 1 inch conduit with red cable.

**K 130** NFPA 101 MISCELLANEOUS

OTHER LSC DEFICIENCY NOT ON 2786

This STANDARD is not met as evidenced by: National Fire Protection Association (NFPA) 101 chapter 19
**K 130** Continued From page 4

8.2.3.2.3.3 Opening Protective.

8.2.3.2.3.1 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protective shall be as follows:

1. **2-hour fire barrier - 11/2-hour fire protection rating**
2. **1-hour fire barrier - 1-hour fire protection rating**
3. Where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42.

**Exception No. 1:** Where the fire barrier specified in 8.2.3.2.3.1(2) is provided as a result of a requirement that corridor walls or smoke barriers be of 1-hour fire resistance-rated construction, the opening protective shall be permitted to have not less than a 20-minute fire protection rating when tested in accordance with NFPA 252, Standard Methods of Fire Tests of Door Assemblies, without the hose stream test.

This STANDARD is not met as evidenced by:

Based on observation, it was determined the facility failed to maintain all 2 hour fire barriers.

The findings included:

Observations of the dining room on 1/24/11 at 11:45 AM, revealed a 2 hour fire barrier between the kitchen dishwasher room and the dining room wall with an opening in the wall to pass soiled trays through to the dishroom. The opening is not protected for restriction of smoke and fire.
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| K147 | SS=D | | **NFPA 101 LIFE SAFETY CODE STANDARD** Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 8.1.2 | K211 | SS=D | | **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, 483.523, 485.523 | 

This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain all electrical equipment. The findings included:  
Observations in the dining room on 1/24/11 at 5:25 AM, revealed an orange extension cord hanging from the ceiling.  
**K 147** Completion Date: 01-27-11  
**K 130 NFPA MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 SS=D** Requirement: Every opening in a fire barrier will be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protective will be as follows:  
1. 2-hour fire barrier – 1 ½ hour fire protection rating where used for vertical openings or exit enclosures, or 1-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42.  
Exception No. 1: Where the fire barrier specified in 8.2.3.2.3.1(2) is provided as a result of a requirement that corridor walls or smoke barriers be of 1-hour fire resistance-rated construction, the opening protective shall be permitted to have not less than a 20-minute fire protection rating when tested in accordance with NFPA 252, Standard Methods of Fire Tests of Door Assemblies, without the hose stream test.  
Correction: The facility will install a shutter-type door in the opening in the wall where soiled trays are passed through to the dishroom, to provide the required protection for restriction of smoke and fire. The Maintenance Supervisor was in-serviced.
STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CIA
IDENTIFICATION NUMBER:

445446

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

01/24/2011

NAME OF PROVIDER OR SUPPLIER

DYERSBURG MANOR NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

1900 PARR AVENUE
DYERSBURG, TN 38024

(X4) ID PREFIX
TAG

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

(X5) ID PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X6) COMPLETION DATE

K 211 Continued From page 8
facility installed 1 of 5 alcohol based hand rub
dispensers over an ignition source.

The findings included:

Observation of the 400 hall on 1/24/11 at 5:05
AM, revealed an alcohol based hand rub
dispenser installed over an electrical receptacle
by room 409.

K 211 regarding the requirement to maintain all 2
hour fire barriers. The QA Team, consisting
of the Medical Director, Administrator,
Director of Nursing, MDS Coordinator,
Staffing Coordinator, Medical Records,
Bookkeeper, Food Service Supervisor,
Social Worker, Risk Management Nurse,
Maintenance Supervisor, and Activities
Coordinator, will monitor for compliance
monthly for three months through random
observation audits to ensure compliance. If
compliance is not met, the team will re-
inservice and continue monitoring until
substantial compliance is achieved.
Different members of the QA Team will
participate depending on the nature of the
audit.

Completion Date: 03-15-11

K 147 NFPA 101 LIFE SAFETY CODE
STANDARD SS-D

Requirement:
Electrical wiring and equipment will be in
accordance with NFPA 70, National
Electrical code. 9.1.2.

Correction:
The orange extension cord hanging from the
ceiling in the dining room was removed on
01-24-11. The Maintenance Supervisor was
in-serviced regarding the requirement to
maintain all electrical equipment. The QA
Team, consisting of the Medical Director,
Administrator, Director of Nursing, MDS
Coordinator, Staffing Coordinator, Medical
Records, Bookkeeper, Food Service
Supervisor, Social Worker, Risk
Management Nurse, Maintenance
K 211  
Continued from page 6
facility installed 1 of 5 alcohol based hand rub dispensers over an ignition source.

The findings included:
Observation of the 400 hall on 1/24/11 at 5:05 AM, revealed an alcohol based hand rub dispenser installed over an electrical receptacle by room 409.

K 211  
Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random observation audits to ensure compliance. If compliance is not met, the team will re-inservice and continue monitoring until substantial compliance is achieved. Different members of the QA Team will participate depending on the nature of the audit.

Completion Date: 01-24-11

K 211 NFPA 101 LIFE SAFETY CODE
STANDARD
SS-D

Requirement:
Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:
- The corridor will be at least 6 feet wide
- The maximum individual fluid dispenser capacity will be 1.2 liters (2 liters in suites of rooms)
- The dispensers will have a minimum spacing of 4 ft from each other
- Not more than 10 gallons will be used in a single smoke compartment outside a storage cabinet.
- Dispensers will not be installed over or adjacent to an ignition source
- If the floor is carpeted, the building will be fully sprinklered. 19.3.7.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623
K 211 Continued From page 6
facility installed 1 of 5 alcohol based hand rub dispensers over an ignition source.

The findings included:

Observation of the 400 hall on 1/24/11 at 5:05 AM, revealed an alcohol based hand rub dispenser installed over an electrical receptacle by room 409.

K 211
Correction:
The alcohol based hand rub dispenser installed over an electrical receptacle by room 409 was removed. The Maintenance Supervisor was in-serviced regarding the requirement that dispensers cannot be installed over or adjacent to an ignition source. The QA Team, consisting of the Medical Director, Administrator, Director of Nursing, MDS Coordinator, Staffing Coordinator, Medical Records, Bookkeeper, Food Service Supervisor, Social Worker, Risk Management Nurse, Maintenance Supervisor, and Activities Coordinator, will monitor for compliance monthly for three months through random observation audits to ensure compliance. If compliance is not met, the team will re-inservice and continue monitoring until substantial compliance is achieved. Different members of the QA Team will participate depending on the nature of the audit.

Completion Date: 01-26-11