### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier**: Signature Healthcare of Fentress County  
**Street Address, City, State, Zip Code**: 208 Duncan St N, Jamestown, TN 38556  
**Identification Number**: 445362  
**Date Survey Completed**: 08/13/2012

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| **K 018** | **SS=E** | **NFPA 101 LIFE SAFETY CODE STANDARD** | Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of ¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3.   
Roller latches are prohibited by CMS regulations in all health care facilities. | 1. The door closure to Station 3 Supply Room was replaced on 8/29/12.  
2. A 100% audit was completed by the Maintenance Director on 9/6/12 to ensure all other door closures were secured in accordance with K 018 and concerns were addressed as identified.  
3. An in-service was provided on 9/6/12 to the Maintenance Team by the Administrator regarding proper door closures in accordance to K 018. The Maintenance Director will complete a 100% audit monthly to ensure door closures in accordance to K 018.  
4. The Maintenance Director will report findings of the above stated audit to the Administrator and QA Committee monthly for 3 months for further follow-up and recommendations. | 9/14/12 |

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

**Finding Included**: Observation of station 3 supply room on 8/13/12 at 10:32 AM, revealed the door closure missing not allowing the door to close with in the door frame.  

This finding was acknowledged by the administrator and verified by the maintenance director during the exit conference on 8/13/12.

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**Laboratory Director or Provider/Supplier Representative's Signature**: [Signature]  
**Title**: [Title]  
**Date**: 9/14/12

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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 discoverable 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 discoverable 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**

**NFPA 101 LIFE SAFETY CODE STANDARD**

Smoking regulations are adopted and include no less than the following provisions:

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.

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 to all areas where smoking is permitted. 19.7.4

This STANDARD is not met as evidenced by:

- Based on observations, it was determined the facility failed to provide metal containers with self-closing cover devices into which ashtrays.

The findings included:

1. Observation of the kitchens' back entrance on 8/13/12 at 10:42 AM, revealed the metal ash tray attached to the outside wall was broken.

**K 066**

1. The broken metal ash tray was removed on 8/13/12 by the Maintenance Director. The non-safety ash trays in the Resident's smoking room were removed and replaced with safety ash trays on 9/4/12.

2. A 100% audit was completed by the Maintenance Director on 9/6/12 to ensure there were no other broken ash trays and all non-safety ash trays were removed in accordance with K 066. No other concerns were identified.

3. An in-service was provided on 9/6/12 to the Maintenance Team by the Administrator regarding providing metal containers with self-closing covering devices into which ashtrays can be emptied and are readily available to all area where smoking is permitted in accordance with K 066. The Maintenance Director will complete a 100% audit monthly to ensure ash trays are in accordance with K 066.

4. The Maintenance Director will report findings of the above stated audit to the Administrator and QA Committee monthly for 3 months for further follow-up and recommendations.
K 066  Continued From page 2

2. Observation of the resident smoking room on 8/13/12 at 11:21 AM, revealed non-safety ash trays in use.

These observations were acknowledged by the administrator and verified by the maintenance director during the exit conference on 8/13/12.