**K 062 SS=E**

**NFPA 101 LIFE SAFETY CODE STANDARD**

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.

The findings included:

1. Observations on 6/21/11 at 9:20 AM, revealed the 2 sprinklers located in Southeast exit canopy were corroded.

2. Observations on 6/21/11 at 11:19 AM, revealed the 4 sprinklers in the main mechanical room were corroded.

These findings were verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/21/11.

**K 067 SS=E**

**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. 19.6.2.1, 9.2, NFPA 90A, 19.5.2.2

Signature HealthCARE of Columbia does not believe and does not admit that any deficiencies existed, before, during, or after the survey. Signature HealthCARE of Columbia reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Signature HealthCARE of Columbia reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which Signature HealthCARE of Columbia does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Signature HealthCARE of Columbia offers its responses, credible allegations of compliance as part of its ongoing efforts to provide quality of care to residents.

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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 discloseable 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 discloseable 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 program participation.
<table>
<thead>
<tr>
<th>Id</th>
<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Id</th>
<th>Prefix Tag</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 062</td>
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**Laboratory Director's or Provider/Supplier Representative's Signature**

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 disclosed 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 requisite to continued program participation.
**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier Identification Number**: 445465

**Provider’s Name**: Signature Healthcare of Columbia

**Address**: 1410 Trotwood Avenue, Columbia, TN 38401

**Date Survey Completed**: 06/21/2011

<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Precise by Full Regulatory or LSC Identifying Information)</th>
<th>Provider’s Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
</table>
| K 062     | SS  | **NFPA 101 Life Safety Code Standard**<br>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.8, 4.6.12, NFPA 13, NFPA 25, 9.7.6 | 4. This corrective action will be monitored by:<br>— Maintenance supervisor will review documentation of both monthly facility rounds and quarterly Century Fire Protection inspections. All results of these inspections will be presented to the QA Committee monthly for review and recommendations.<br>— Members of the QA Committee: Administrator, DON, Medical Director, Medical Records Director, two ADONs, Restorative Nurse Manager, Respiratory Therapist, Dietary Manager, Activity Director, Social Services Director, MDS Coordinator, Housekeeping Director, Rehab Services Manager, Maintenance Director | K 067
| SS  | **NFPA 101 Life Safety Code Standard**<br>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 | All heating, ventilating, and air conditioning will comply with the provisions of section 9.2 and are installed in accordance with the manufacturer’s specifications.<br>1. Corrective action for areas affected: HVAC fire damper inspection completed by Sandrell Heating & Air on 6/20/11. An inspection report was provided to the facility and is maintained on record. | 7/8/11 |

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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 disclosable 30 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 067 Continued From page 1
This STANDARD is not met as evidenced by:
Based on record review, it was determined the facility failed to maintain the heating, ventilating and air conditioning system (HVAC).

The findings included:

Record review on 6/21/11 at 12:12 PM, revealed the HVAC fire dampers 4 year inspection was overdue.

This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/21/11.

K 076 SS=E
NFPA 101 LIFE SAFETY CODE STANDARD
Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.

(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.

(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4

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

The findings included:

2. Identification of other areas that could be affected by the deficient practice:
   All residents have the potential to be affected.

3. Measures put in place to ensure deficient practice does not reoccur:
   Maintenance supervisor will review for compliance, annually.

4. This corrective action will be monitored by:
   The maintenance supervisor will review inspection report each year and all results will be presented to the QA Committee monthly for review and recommendations. Members of the QA Committee: Administrator, DON, Medical Director, Medical Records Director, two ADONS, Restorative Nurse Manager, Respiratory Therapist, Dietary Manager, Activity Director, Social Services Director, MDS Coordinator, Housekeeping Director, Rehab Services Manager, Maintenance Director.
K 067 Continued From page 1
This STANDARD is not met as evidenced by:
Based on record review, it was determined the facility failed to maintain the heating, ventilating and air conditioning system (HVAC):
The findings included:
Record review on 6/21/11 at 12:12 PM, revealed the HVAC fire dampers 4 year inspection was overdue.
This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/21/11.

K 076 NFPA 101 LIFE SAFETY CODE STANDARD
Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.
(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.
(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4

This STANDARD is not met as evidenced by:
Based on observation, it was determined the facility failed to protect the oxygen storage room.
The findings included:

K 076 The facility will ensure that medical gas storage and administration areas are protected in accordance with NFPA 99
1. Corrective action for areas affected: Audit of oxygen room revealed that room contains 577 cubic feet. Maintenance staff completed relocation of outlets and switch in the oxygen room to make them five feet above floor on 6/28/11.
2. Identification of other areas that could be affected by the deficient practice:
Maintenance staff completed a facility audit of all oxygen storage rooms on 6/23/11.
3. Measures put in place to ensure deficient practice does not reoccur:
Maintenance supervisor will review audit for compliance every month
<table>
<thead>
<tr>
<th>ID</th>
<th>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</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 076</td>
<td>Continued From page 2</td>
<td>K 076</td>
<td>Observations of the oxygen storage room on 6/21/11 at 10:15 AM, revealed the electrical outlets and the lights on/off switch were not installed 3 feet above the floor. This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/21/11.</td>
<td>4. This corrective action will be monitored by: The maintenance supervisor will review inspection report and all results will be presented to the QA Committee monthly for review and recommendations. Members of the QA Committee: Administrator, DON, Medical Director, Medical Records Director, two ADONs, Restorative Nurse Manager, Respiratory Therapist, Dietary Manager, Activity Director, Social Services Director, MDS Coordinator, Housekeeping Director, Rehab Services Manager, Maintenance Director</td>
<td>6/21/2011</td>
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<tr>
<td>K 130 SS=</td>
<td>NFPA 101 MISCELLANEOUS</td>
<td>OTHER LSC DEFICIENCY NOT ON 2786</td>
<td>This STANDARD is not met as evidenced by: Health Care Emergency Preparedness 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. This STANDARD is not met as evidenced by: Based on record review, it was determined the facility failed conduct the required Health Care Emergency Preparedness Drills. The findings included: Record review on 6/21/11 at 12:10 PM, revealed the facility failed to conduct the required Health Care Emergency Preparedness Drills per the</td>
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Continued From page 2

Observations of the oxygen storage room on 6/21/11 at 10:15 AM, revealed the electrical outlets and the lights on/off switch were not installed 5 feet above the floor.

This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/21/11.

K 130
NFPA 101 MISCELLANEOUS
OTHER LSC DEFICIENCY NOT ON 2786

This STANDARD is not met as evidenced by:
Health Care Emergency Preparedness 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.

This STANDARD is not met as evidenced by:
Based on record review, it was determined the facility failed conduct the required Health Care Emergency Preparedness Drills.

The findings included:

Record review on 6/21/11 at 12:10 PM, revealed the facility failed to conduct the required Health Care Emergency Preparedness Drills per the

The facility will implement one or more specific responses to the emergency preparedness plan semi-annually. This semi-annual drill will rehearse a mass casualty response with emergency services.

1. Corrective action for areas affected: Contacted Director of Maury County Emergency Preparedness on 7/1/11 to request an audit of the Emergency Preparedness Drill be completed

2. Identification of other areas that could be affected by the deficient practice:
All residents have the potential to be affected by deficient practice

3. Measures put in place to ensure deficient practice does not reoccur:
Semi-annual Health Care Emergency Preparedness drill scheduled to be conducted on 7/7/11 and to include all staff in the facility.
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<td>Continued From page 3</td>
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<td>4. This corrective action will be monitored by:</td>
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<td>National Fire Protection Association 99, 11-5.3.9.</td>
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<td>The administrator will audit for completion. The maintenance supervisor will maintain</td>
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<td>This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 6/21/11.</td>
<td></td>
<td>documentation of completion of the Health Care Emergency Preparedness drills and all results will be presented to the QA Committee monthly for review and recommendations.</td>
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<td>Members of the QA Committee: Administrator, DON, Medical Director, Medical Records Director, two ADONs, Restorative Nurse Manager, Respiratory Therapist, Dietary Manager, Activity Director, Social Services Director, MDS Coordinator, Housekeeping Director, Rehab Services Manager, Maintenance Director</td>
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