**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/Clinic Identification Number:** 445150

**Name of Provider or Supplier:** Poplar Point Health & Rehabilitation

**Street Address, City, State, Zip Code:**
131 N Tucker
Memphis, TN 38104


<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>
</tr>
</thead>
<tbody>
<tr>
<td>K 018</td>
<td>SS=D</td>
<td></td>
<td>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinkler 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 19.3.6.3.3 are permitted. 19.3.6.3</td>
<td><strong>K 018</strong> SS=D</td>
</tr>
</tbody>
</table>

**Disclaimer:**
The filing of this plan of correction is filed as Poplar Point Health and Rehabilitation does not constitute the fact deficiencies did in fact exist. This limits this plan of correction is filed as evidence of the facility's desire to comply with the requirements and provide high quality care.

This Plan of Correction has been developed in compliance with State and Federal regulations. This plan affirms Poplar Point Health and Rehabilitation 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 existence or scope of significance, of any cited deficiency.

**Laboratory Director's or Provider/Supplier Representative's Signature**

**Title**

**Date**

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 requisite to continued program participation.
POPLAR POINT HEALTH & REHABILITATION

3. The facility's Maintenance Team checked each entrance door inside the facility on 1/7/14. Also, the Administrator in-serviced Maintenance Director and Assistants, 1/14/14 about no kick down door stops are permitted in facility.

4. The Administrator, Maintenance Director and Quality Assurance Team Members will conduct randomly rounds beginning 1/13/14 to ensure facility is in compliance. Any non-compliance doors will be immediately brought into compliance. Also, results will be reported to the QAA team monthly which consists of Medical Director, FNP, DON, ADON, RN Nurses, NHA, Dietary Manager, Therapy Leader, Maintenance, Housekeeping, MDS, Care Plan Team, Social Services, Activities, Business Office, Admission Director.

K 038
NFPA 101 LIFE SAFETY CODE STANDARD

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 exit egress from the building to a public way for 3 of 6 exit discharges.

The findings included:

Observations of the exit discharge areas on 1/7/14 revealed the following:

a. At 10:00 AM - exit by resident room 114 - the egress path to the public way did not have a solid level surface and had been flooded with water, mud and debris. Evidence of water and mud were present and had run under the door into the stairway landing and down to the basement.

b. At 11:30 AM - exit by resident room 108 - the egress path from the exit discharge did not have a solid level surface to a solid level surface to a public way on 1/14/14.
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>DATE</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 038</td>
<td>Continued From page 2 &lt;br&gt;a solid level surface to a public way. &lt;br&gt;c. At 12:00 PM - exit by room 227 - the egress path from the exit discharge did not have a solid level surface to a public way. These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 1/7/14. NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>01/07/2014</td>
<td>4. The Administrator, DON, Department Heads and Nurses will conduct random rounds starting 1/13/14 to ensure this practice does occur to prevent reoccurrence. Any further non-compliance will be corrected through similar process.</td>
</tr>
<tr>
<td>K 052</td>
<td>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.14</td>
<td>01/07/2014</td>
<td>K 052 NFPA 101 LIFE SAFETY CODE STANDARD &lt;br&gt;SS=D &lt;br&gt;A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.14 &lt;br&gt;1. The facility’s maintenance team connected the telephone line to the security agency in the alarm system at the 100 Hall Nurses Station remote fire alarm annunciator and installed a new battery. 1/14/14 &lt;br&gt;2. All residents have potential to be affected by the telephone line to the security agency being disconnected from the fire alarm system. 1/17/14 &lt;br&gt;3. The Administrator in-serviced Maintenance Team members about checking telephone lines to the security agency during each fire drill and ensure connections are made on 1/14/14. Preventive maintenance will be provided to replace battery every six months and included into TELS program. The Administrator and Safety Committee Team members will make random rounds with Maintenance to ensure compliance beginning 1/14/14.</td>
</tr>
<tr>
<td>ID</td>
<td>PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>ID</td>
</tr>
<tr>
<td>----</td>
<td>------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td>----</td>
</tr>
<tr>
<td>K 052</td>
<td>Continued From page 3 nurses station remote fire alarm annunciator would not reset upon completion of the test.</td>
<td>K 052</td>
<td>4. The Administrator and members of the maintenance team will make randomly rounds and report findings during the monthly QAA session which consists of DON, ADON, Dietary, Housekeeping, Maintenance, Administrator, Medical Director, Social Services, Activities, Medical Records, Human Resources, Restorative and Nursing beginning February 2014.</td>
</tr>
<tr>
<td>K 064</td>
<td>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 064</td>
<td>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</td>
</tr>
<tr>
<td>K 064</td>
<td>This STANDARD is not met as evidenced by: National Fire Protection Association (NFPA) 10 Portable Fire Extinguishers 1998 edition 4-3 Inspection. 4-3.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.</td>
<td>K 064</td>
<td>1. The Maintenance Director obtained and installed documentation that provides monthly inspections on 43 of 43 fire extinguishers on 1/8/14.</td>
</tr>
<tr>
<td>K 064</td>
<td>Based on observation, document review and interview, it was determined the facility could not provide documentation of monthly inspections on 43 of 43 fire extinguishers. The findings included: Observations on the 100 hall on 1/6/14 at 12:25 PM, revealed there was no annual or monthly inspection records attached to the fire extinguisher.</td>
<td>K 064</td>
<td>2. All residents have the potential to be affected by this practice.</td>
</tr>
<tr>
<td>K 064</td>
<td></td>
<td>K 064</td>
<td>3. The Administrator in-serviced Maintenance Team Members about ensuring monthly inspection tags are not removed from fire extinguishers on 1/14/14. Randomly rounds will be conducted by The Administrator and Maintenance Director to ensure monthly documentations are recorded on each fire extinguisher during randomly rounds beginning 1/21/14.</td>
</tr>
<tr>
<td>K 064</td>
<td></td>
<td>K 064</td>
<td>4. The Administrator and Maintenance Director will report findings of randomly rounds monthly to the facility’s QAA Committee, which consists of Medical Director, DON, ADON, Dietary, Housekeeping, Maintenance, Social Services, Activities, Human Resources, Nursing and Therapy.</td>
</tr>
</tbody>
</table>
K 064  Continued From page 4

During an interview on the 100 hall on 1/6/14 at 12:25 PM, the maintenance director was asked, if he had a record of monthly inspections for the fire extinguishers. The maintenance director stated, "The fire extinguisher technician had removed them on 1/3/14, and took the cards with him. He stated all fire extinguishers were due for the five year exchange." The maintenance director was asked again if he had any other documentation of monthly inspections. The maintenance director stated he did not.

During document review the facility provided documentation from the fire extinguisher company that the 43 fire extinguishers would be exchanged.

This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 1/7/14.

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
**K 076** Continued From page 5

This **STANDARD** is not met as evidenced by: Based on observations, it was determined the facility failed to keep compressed gas bottles in a secure condition to prevent damage.

The findings included:

1. Observations of the activities storage room in the basement on 1/7/14 at 8:50 AM, revealed an unsecured helium tank.

2. Observations of the central supply storage room in the basement on 1/7/14 at 9:30 AM, revealed 5 of 8 oxygen tanks were unsecured.

These findings were verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 1/7/14.

**K 104**

NFPA 101 LIFE SAFETY CODE STANDARD  
SS=E

Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.

This **STANDARD** is not met as evidenced by: Based on observations, it was determined the facility failed to maintain rated assemblies.

The findings included:

1. Observations of the service room door by the second floor dinning area on 1/6/14 at 12:10 PM,

<table>
<thead>
<tr>
<th><strong>K 076</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The facility has secured helium tank in activities and 8 of 8 oxygen tanks in central supply on 1/7/14 by the Maintenance Department.</td>
</tr>
<tr>
<td>2. All residents have a potential to be affected by unsecured oxygen and/or helium tanks.</td>
</tr>
<tr>
<td>3. The Administrator, Central Supply, Activities and Maintenance Director makes randomly rounds through the week to ensure oxygen and helium tanks are secured beginning 1/20/14. The Administrator in-serviced Central Supply, Activities, Maintenance and Nurse Management about securing all oxygen and helium tanks on 1/20/14.</td>
</tr>
<tr>
<td>4. The Administrator, DON and Maintenance will report randomly rounds monthly to the facility’s QAA Committee, which consists of Administrator, DON, ADON, Nurses, Therapy, Maintenance, MDS, Activities, Social Services, Dietary, Human Resources and Medical Records.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>K 104</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maintenance team has filled penetrations in the following areas on 1/7/14: service room door by the second floor dinning area; three penetrations of the activities storage room corridor wall; elevator room in the basement above the door; and the fire alarm panel room in the basement. The Maintenance team and Administrator made rounds in the facility to identify and correct any penetrations on 1/13/14.</td>
</tr>
<tr>
<td>2. All residents have the potential to be affected by penetrations in the facility.</td>
</tr>
</tbody>
</table>
K 104 Continued from page 6 revealed a penetration through the door.

2. Observations of the activities storage room in the basement on 1/7/14 at 9:00 AM, revealed 3 penetrations through the inside of the corridor wall.

3. Observations of the elevator room in the basement on 1/7/14 at 9:20 AM, revealed penetrations above the door.

4. Observations of the fire alarm panel room in the basement on 1/7/14 at 9:30 AM, revealed penetrations through the wall located above the fire alarm panel.

These findings were verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 1/7/14.

K 147 NFPA 101 LIFE SAFETY CODE STANDARD SS=D

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 install ground fault interrupting circuits (GFIC) within 6 feet of sinks in 3 of 3 shower rooms. One of the five receptacles in the activities storage room in the basement did not have a cover.

The findings included:

1. Observation of the 100, 200, and 300 shower...
### K 147 Continued from page 7

1. Observation of the activities room in the basement on 1/7/13 at 9:10 AM, revealed 1 of 5 receptacles did not have a cover.

2. Observation of the activities room in the basement on 1/7/13 at 9:10 AM, revealed 1 of 5 receptacles did not have a cover.

These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 1/7/14.

### K 147

3. The Administrator and Maintenance Director informed maintenance team about installing GFCIs over sinks in shower rooms and other areas in the facility, January 8, 2014. Randomly rounds to prevent reoccurrence will be conducted by Administrator and Maintenance Director beginning 1/20/14.

4. The Administrator, Safety Committee members and Maintenance Director will report findings of randomly rounds monthly to the QAA Committee, which consists of DON, ADON, Medical Director, Administrator, Human Resources, Nurses, Therapy, Social Services, Activities, Dietary, and MDS team.