STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

445165

(x2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01
B. WING

(x3) DATE SURVEY COMPLETED
05/18/2010

NAME OF PROVIDER OR SUPPLIER

WESLEY HIGHLAND MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE
3549 NORRISWOOD
MEMPHIS, TN 38111

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

K 038
SS=D
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 observation, it was determined the facility failed to provide an exit access that is readily accessible at all times.
The findings included:
Observations during a tour of the facility on 5/17/10 at 10:09 AM, revealed the 1st floor West exit was consisted of a concrete pad outside of the exit door. There was no hard path or surface to a public right of way. In weather conditions including rain, the surface of the exit path to the public way would impede ambulatory residents and be impassible for non-ambulatory residents.

K 050
SS=E
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 announcement may be used instead of audible alarms. 19.7.1.2

COMPLETION DATE:
06-14-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Charlotte Pierce Actr 06/14/10

TITLE

/deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that proper 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.

FORM CMS-2567(02-09) Previous Versions Obsolete
Event ID:BW8X21
Facility ID:TN7332
If continuation sheet Page 1 of 4
**NAME OF PROVIDER OR SUPPLIER**  
WESLEY HIGHLAND MANOR

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
3549 NORRISWOOD  
MEMPHIS, TN 38111

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<th>COMPLETION DATE</th>
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| K 050         | Continued From page 1  
This STANDARD is not met as evidenced by:  
Based on observation, it was determined the facility failed to familiarize staff members with proper fire drill procedures.  
The findings included:  
Observations during a fire drill conducted in room 231 on 5/17/10 at 2:25 PM, a staff member announced the incorrect room number (room 230) over the intercom system. Staff members also failed to completely close the doors to resident rooms 203, 239, and 242.  
NFPA 101 LIFE SAFETY CODE STANDARD  
All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications.  
9.6.1.3  
This STANDARD is not met as evidenced by:  
Based on observation, it was determined the facility failed to maintain all smoke detectors.  
The findings included:  
1. Observations during a tour of the facility on 5/17/10 at 9:58 AM, revealed 1 of the 3 smoke detectors in the dietary area was closer than the 3 foot requirement from the air supply diffuser.  
2. Observations during a tour of the facility on 5/18/10 at 8:58 AM, the smoke detector located outside of the 2nd floor Assistant Director of Nursing's office was closer than the 3 foot requirement from the air supply diffuser. | K 050 | 1. A fire drill was conducted on 5/25/2010.  
2. A fire drill will be conducted on each shift each month until compliance is achieved. After 3 months, one fire drill will be conducted for each shift every quarter or as needed. Following each fire drill, Maintenance Director/Designee will conduct in-service.  
3. Fire drill dates for the remainder of the year have been placed on the calendar.  
4. Administrator and Maintenance Director will monitor for compliance each month by signing off on fire drill report and report to QA committee quarterly. | 06-14-10 |
| K 054         | SS=D  
NFPA 101 LIFE SAFETY CODE STANDARD | K 054 | | |

COMPLETION DATE:
All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3

1. The dietary smoke detector was moved 3 feet from air supply diffuse on 5/18/2010 by Security Fire. The Assistant Director of Nursing smoke detector was moved 3 feet from the air supply diffuser on 5/18/2010 by Security Fire.

2. Smoke detector checks will be placed on Planned Maintenance calendar.

3. Annual checks will be done.

4. Maintenance Director and Administrator will monitor and report to QA committee quarterly.

COMPLETION DATE: 06-14-10
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<tr>
<td>K067</td>
<td>NFPA LIFE SAFETY CODE STANDARD</td>
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<td></td>
<td>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</td>
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<td>This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain all fire dampers on 1 of 2 (First floor) floors.</td>
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<td>The findings included: Observations during a tour of the first floor on 5/17/10 at 9:45 AM, revealed 5 of 6 fire dampers in the first floor dining area were held open with unapproved devices instead of the required fusible links.</td>
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<tr>
<td></td>
<td>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</td>
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<td>This STANDARD is not met as evidenced by: Based on observation and record review, it was determined the facility failed to maintain the</td>
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**K 144**  
**Continued From page 3**  
emergency generator supply.

The findings included:

Observation of the emergency generator on 5/17/10 at 11:56 AM, revealed the generator was located outside of the facility. There was no battery powered task illumination provided.

Record review in the maintenance director's office on 5/18/10 at 7:50 AM, the facility was unable to provide documentation that the generator was tested under load for a minimum of 30 minutes per month as required.

**K 144**
SS=F
NFPA LIFE SAFETY CODE STANDARD

Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1

1. On 5/20/2010, the illuminated battery powered generator light was installed by Eagle Electric.
2. The Maintenance Department/Designee will perform weekly tests for operation of generator.
3. Load tests for 30 minutes for emergency back up power for the facility will be performed monthly.
4. Maintenance Director will report to QA committee quarterly.

**COMPLETION DATE:** 06-14-10