<table>
<thead>
<tr>
<th>F 371</th>
<th>483.35(l) FOOD PROCURE, STORE/PREPARE/ERVE - SANITARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>The facility must:</td>
<td></td>
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<tr>
<td>1. Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</td>
<td></td>
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<tr>
<td>2. Store, prepare, distribute and serve food under sanitary conditions</td>
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</tbody>
</table>

This REQUIREMENT is not met as evidenced by:

Based on observation and interview the facility failed to maintain the dietary equipment in a sanitary manner.

The findings included:

Observation on May 9, 2011, beginning at 9:45 a.m., with the executive chef present, revealed the following:

1. The four burner range top spill pan was foil lined with a heavy greasy layer of burnt black debris under the foil and on the surface of the foil.
2. The four burner range back splash had an area of black burnt debris present.
3. The four burner range had a grill. The left side and the rear of the grill surface had an accumulation of blackened debris present.
4. The six burner range back splash had an accumulation of blackened debris present.

Interview on May 9, 2011, beginning at 9:45 a.m., with the executive chef, confirmed the four burner

Survey Date: May 9-11, 2011

The Plan of Correction is submitted as required under State and Federal Law.

The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct.

The four and six burner ranges were both cleaned on May 9, 2011.

All dietary staff were inserviced on May 10, 2011 on proper cleaning of equipment.

Director of Food Services and/or Executive Chef will do a QA weekly for 4 weeks and as needed to ensure ongoing compliance.

6/1/11
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

445392

(x) PROVIDER/SUPPLIER/JIA IDENTIFICATION NUMBER:

(x) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

05/11/2011

05/13/2011

STREET ADDRESS, CITY, STATE, ZIP CODE

MURFREESBORO, TN 37129

NAME OF PROVIDER OR SUPPLIER

ADAMSPLACE, LLC

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID TAG

PREFIX ID

TAG

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(x) COMPLETION DATE

F 371 Continued From page 1

F 371

range top spill pan had a heavy greasy layer of

F 425 Resident #6 received Coumadin as

burnt black debris under the foil and on the

ordered by the physician on May 5, 7,
surface of the foil that lined the spill pan. Further

F 425

splash had an area of black burnt debris. Further

10, 2011.

interview confirmed the four burner range back

An audit of all medication available

splash had an accumulation of blackened
in medication cart was completed

back splash had an accumulation of blackened
debrits.

5/10/11 for all patients with a

debrits.

pharmacy order for Coumadin to

A. BUILDING

ensure that the pharmacy had

P. 371

an accumulation of blackened
debrits.

dispensed the required number of

B. WING

pills, according to MD order, for

debrits.

medication pass.

debrits.

debrits.

debrits.

debrits.
F 425  All licensed nursing staff were inserviced regarding procedures for obtaining medications from the pharmacy or back-up medication box. DON reviewed pharmacy dispensing procedures with the providing Pharmacist to ensure that medications are dispensed in sufficient quantity as ordered by the physician.

A quality assurance study will be completed monthly X 3 and as needed to ensure ongoing compliance. The QA studies will be reviewed by the DON and findings will be reported to the QA committee.

6/1/11
Deviations of Deficiencies and Plan of Correction

<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>F 425</td>
<td></td>
<td></td>
<td>Continued From page 3 interview confirmed LPN #1 had not notified the pharmacy of the lack of medication. Interview by speaker phone with the LPN #2 on May 10, 2011, at 11:45 a.m., with the facility unit manager present revealed LPN #2 did not have Coumadin 7.5 mg available in the medication cart for May 8, 2011. Further interview confirmed LPN #2 had not notified the pharmacy of the lack of medication. Interview with the Director of Nursing on May 11, 2011, at 7:40 a.m., in the private dining room confirmed the pharmacy failed to dispense the quantity of Coumadin necessary to meet the patient's need as ordered by the physician.</td>
<td>F 425</td>
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