DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 2/23/13

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FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445024 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 01/08/2013 |

NAME OF PROVIDER OR SUPPLIER
NHC HEALTHCARE, JOHNSON CITY

STREET ADDRESS, CITY, STATE, ZIP CODE
3209 BRISTOL HWY
JOHNSON CITY, TN 37601

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K 018<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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 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<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure corridor doors closed to a positive latch. (NFPA 101, 19-3.6.3.)<br><br>The findings include:<br><br>Observation and interview with the Maintenance Director, on January 8, 2013 at 2:00 p.m. confirmed the corridor resident room door to room 321 failed to close to a positive latch. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on | K 018 | K 018<br><br>Corrective Action:<br><br>1. Repair striker plate to ensure positive latch on room 321.<br><br>Identifying other Areas:<br><br>1. Will check every patient room door in building to ensure a positive latch.<br><br>Measure and changes to be taken:<br><br>1. Will fix all doors found not to have a positive latch<br><br>Monitoring Performance:<br><br>1. Maintenance supervisor will use a QA monitor to ensure that all doors in building are checked monthly for 2 months. After two months of monitoring, QA frequency may be reduced depending on results. | 2/23/2013 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
2/4/2013

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 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.



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| K 018 | Continued From page 1<br>January 8, 2013. | K 018 | | |
| K 021<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:<br><br>a) the required manual fire alarm system;<br><br>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and<br><br>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2<br><br>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure corridor fire doors closed to a positive latch. (NFPA 101, 19-3.6.3.)<br><br>The findings include:<br><br>Observation and interview with the Maintenance Director, on January 8, 2013 at 2:00 p.m. confirmed the corridor fire doors by rooms 419 and 315 failed to close to a positive latch. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on | K 021 | K 021<br><br>Corrective Action:<br><br>1. Fire doors by rooms 419 & 315 will have their latches adjusted or replace to ensure a positive latch.<br><br>Identifying other Areas:<br><br>1. Every fire door in building will be checked to ensure positive latch<br><br>Measure to be taken and changes implemented:<br><br>1. Will fix/adjust all latching mechanisms in other doors found to not have a positive latch.<br><br>Monitoring Performance:<br><br>1. Maintenance supervisor will check every fire door monthly for 2 months during fire drill to ensure a positive latch. After two months, frequency of checks may be reduced depending on results. | 2/23/2013 |



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| K 021 | Continued From page 2 January 8, 2013. | K 021 | | |
| K 029 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure hazardous area's fire rated construction is maintained.<br>The findings include:<br>Observation and interview with the Maintenance Director, on January 8, 2013 at 2:00 p.m. confirmed the following:<br>1) Unsealed penetrations through the attic's cinderblock smoke barrier at multiple locations,<br>2) 2 of 2 attic access doors failed to close to a positive latch and were not provided with self-closing doors,<br>3) The storage closet ceiling next to room 140 had ceiling penetration, and<br>4) An unsealed penetration in the ceiling of the linen closet by room 232.<br><br>These findings were verified by the Maintenance Supervisor and acknowledged by the | K 029 | K 029<br><br>Corrective Action:<br><br>1. Unsealed penetrations through the attic's smoke barrier, storage closet next to room 140 and ceiling of the linen closet by room 232 will be sealed.<br><br>2. Attic access doors will be fitted with a self closing mechanism and fixed to ensure positive latch.<br><br>Identifying other Areas:<br><br>1. Maintenance director and maintenance personnel will inspect building to identify other smoke barrier penetrations.<br><br>Measure to be taken and changes implemented:<br><br>1. Maintenance supervisor and maintenance personnel will conduct annual penetration inspection and require outside contractors to sign and follow rules of our Above Ceiling Penetration Policy.<br><br>Monitoring Performance:<br><br>1. Maintenance supervisor will use QA monitor to ensure fire wall penetrations are checked annually and will ensure that outside contractors follow Above Ceiling Penetration Policy. | 2/23/2013 |



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| K 029 | Continued From page 3<br>Administrator during the exit conference on January 8, 2013. | K 029 | | |
| K 056<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure all areas were sprinkled.<br>The findings include:<br>Observation and interview the Maintenance Director on January 8, 2013at 11:30 a.m. confirmed Sprinkler protection was not provided in the basement closet where the electrical panels were located.<br>Observation and interview the Maintenance Director on January 8, 2013at 2:30 p.m. confirmed the Sprinkler spray pattern was obstructed by a wooden divider in the closet of room 136.<br>Observation and interview the Maintenance Director on January 8, 2013at 11:30 a.m. confirmed the flexible Aquaflex sprinkler piping | K 056 | K 056<br><br>Corrective Action:<br><br>1. Sprinklers will be added to basement closet.<br><br>2. Obstruction will be cleared from closet 136.<br><br>3. Aquaflex sprinkler will be properly supported in basement HVAC room.<br><br>4. Sprinkler heads will be moved to 6 feet apart.<br><br>5. Corroded sprinkler heads will be replaced.<br><br>6. Wiring attachments will be removed from sprinkler piping.<br><br>Identifying other Areas:<br><br>1. No other areas were identified during the survey. | |



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| K 056 | Continued From page 4<br>was not supported above the ceiling in the basement HVAC room.<br><br>Based on observation and interview, the facility failed to assure sprinkler heads were at least six (6) feet apart( NFPA 13, 5-6.3.4)<br>The findings include:<br>Observation and interview with the Maintenance Director on January 8, 2013 at 1:30 p.m. confirmed two (2) of two (2) sprinkler heads were four (4) feet apart.<br><br>NFPA 25, 5.2.1.1.1 Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the proper orientation (e.g., upright, pendent, or sidewall).<br>NFPA 25, 5.2.1.1.2 Any sprinkler shall be replaced that has signs of leakage; is painted, corroded, damaged, or loaded; or in the improper orientation.<br>Based on observation and interview, the facility failed to assure sprinkler heads were free of corrosion.<br>The findings include:<br>Observation and interview the Maintenance Director on January 8, 2013at 3:30 p.m. confirmed the sprinkler heads were corroded in the utility room across from Station 4 Nurses Station and the Station 3 activity storage room.<br>Sprinkler piping or hangers shall not be used to support non-system components. (NFPA 13 6-1.1.5)<br>The findings include:<br>Observation and interview with the Maintenance Director on January 8, 2013at 3:30 p.m. confirmed wiring above the lay in ceiling was attached to or supported by sprinkler piping | K 056 | Measure to be taken and changes implemented:<br><br>1. Maintenance supervisor and maintenance personnel will remove all top shelves in closets so that obstructions cannot be put on them and check all sprinkler piping after any above ceiling work to ensure that wire attachment are removed.<br><br>2. Outside sprinkler contractor will be brought in to identify and replace corroded sprinkler heads.<br><br>Monitoring Performance:<br><br>1. Maintenance supervisor will use QA monitor to ensure obstructions are not put in closets and ensure wiring attachments not added to sprinkler piping.<br><br>2. Maintenance supervisor will conduct monthly check of all sprinkler heads for 2 months after outside contractor identifies and replaces all corroded sprinkler heads. Frequency of checks may be reduced depending on results of QA. | 2/23/2013 |



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| K 056 | Continued From page 5<br>above the kitchen ceiling and Station 1 nurses station.<br>These findings were verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on January 8, 2013. | K 056 | | |
| K 066<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Smoking regulations are adopted and include no less than the following provisions:<br><br>(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.<br><br>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.<br><br>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.<br><br>(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<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure smoking areas were provided | K 066 | K 066<br><br>Corrective Action:<br><br>1. Current trash can will be replaced with one having a self-closing cover.<br><br>Identifying other Areas:<br><br>1. This is only smoking area on property.<br><br>Measure to be taken and changes implemented:<br><br>1. Will ensure self-closing mechanism remains on trash can<br><br>Monitoring Performance:<br><br>1. Housekeeping personnel will use QA tool to implement monthly checks for 2 months to ensure that self-closing cover remains on trashcan in smoking area. Frequency may be reduced depending on findings. | 2/23/2013 |



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| K 066 | Continued From page 6<br>with metal containers with self-closing cover devices (NFPA 101, 19.7.4 (4)).<br>The findings include:<br>Observation and interview with the Maintenance Director, on January 8, 2013 at 3:05 p.m. confirmed the outside smoking area had an open, plastic, trash receptacle.<br>This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on January 8, 2013. | K 066 | | |
| K 068<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to assure the basement gas-fire hot water heater room was located in a one (1) hour fire rated room and was ventilated, taking combustion air and discharging air to the outside of the building.<br>The findings include:<br><br>Observation and interview with the Maintenance Director, on January 8, 2013 at10:15 a.m. confirmed the basement gas-fire hot water heater was not located in a 1-hour rated room and was ventilated to an interior classroom space.<br>This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on January 8, 2013. | K 068 | K 068<br><br>Corrective Action:<br><br>1. Room will be turned into 1 hour rated room with appropriate ventilation to outside. Classroom ventilation grate will be removed.<br><br>Identifying other Areas:<br><br>1. All gas water heaters in building will be checked to ensure that they are in 1 hour rated room.<br><br>Measure to be taken and changes implemented:<br><br>1. Maintenance supervisor will ensure that all hot water heaters remain in 1 hour rated room.<br><br>Monitoring Performance:<br><br>1. Maintenance supervisor will create QA tool to ensure that if work is to be done on any room containing a gas water heater the 1 hour rating is not compromised. | 2/23/2013 |



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| K 075<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to assure soiled linen or trash receptacles did not exceed 32 gallons in capacity (NFPA 101, 19.7.5.5).<br>Based on observation and staff interview, the facility failed to assure soiled linen or trash receptacles exceeding 32 gallons in capacity were located in a room protected as hazardous when not attended (NFPA 110, 19.7.5.5).<br>The findings include:<br>Observation with the Maintenance Director on January 8, 2013 at 4:30 p.m. confirmed 3 soiled linen containers exceeding 32 gallons capacity were left in the alcove across from the entrance near the physical therapy room.<br>This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on January 8, 2013. | K 075 | K 075<br><br>Corrective Action:<br><br>1. Staff will be inserviced to ensure that they know soiled linen barrels are no longer to be stored in alcove.<br><br>Identifying other Areas:<br><br>1. Station 4 is only unit where linen barrels were stored in alcove.<br><br>Measure to be taken and changes implemented:<br><br>1. Nothing other than corrective action noted above.<br><br>Monitoring Performance:<br><br>1. Maintenance supervisor will use a QA monitoring tool for 2 months to ensure that linen barrels are not being stored in alcove. After 2 months, frequency may be reduced depending on the findings. | 2/23/2013 |
| K 147 | NFPA 101 LIFE SAFETY CODE STANDARD | K 147 | | |

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| K 147<br>SS=E | Continued From page 8<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br><br>This STANDARD is not met as evidenced by:<br>NFPA 70, 314.28 (C) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of 250.110<br>Based on observation and interview, the facility failed to assure electrical junction boxes had their covers installed.<br>The findings include:<br>Observation and interview with the Maintenance Director, on January 8, 2013 between 10:00 am and 3:00 p.m. confirmed junction boxes without covers above ceiling in the kitchen by the hot water heater room, Station 1 nurses station, Station 2 north hall by the utility room.<br>This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on January 8, 2013. | K 147 | K 147<br><br>Corrective Action:<br><br>1. Covers will be installed over junction boxes in identified areas.<br><br>Identifying other Areas:<br><br>1. Maintenance personnel will conduct spot checks around building to identify other missing box covers.<br><br>Measure to be taken and changes implemented:<br><br>1. Maintenance staff will follow NEC code when adding any junction boxes in building.<br><br>Monitoring Performance:<br><br>1. Maintenance director will use a QA monitor that will be developed to check areas of building for missing box covers and fix them if found. | 2/23/2013 |