45th Day 6/23/17

PRINTED: 05/11/2017
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC# 1	TNPL53526	A. BUILDING: 01 - MAIN B. WING ______	05/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNOXVILLE CENTER FOR REPRODUCTIVE HI	1547 WEST CLINCH AVENUE KNOXVILLE, TN 37916

(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) COMPLETE DATE
A 824	1200-8-10-.08 (24) Building Standards (24) The department requires the following alarms that shall be monitored twenty-four (24) hours per day: (a) Fire alarms; (b) Generators (if applicable); and (c) Medical gas alarms (if applicable). This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to maintain the fire alarm. The finding includes: Observation, record review and interview with the laboratory manager on 5/8/17 at 10:00 AM revealed the main fire alarm control panel was yellow tagged by the fire alarm technician, "system has a trouble for phone lines but the phones are good. System needs replaced." The laboratory manager was present when the deficiency was identified and acknowledged during the exit conference on 5/8/17.	A 824	As noted in the findings during the survey on 5/8/17 the fire alarm technician had determined the control panel needed to be replaced. Pending review and approval by the Dept. of Health the panel will be replaced. Quotation and description of equipment is attached.	6/22/17

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 5/16/17