Printed: 05/22/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
495256			B. WING 05		05/0	/09/2017		
AUTUMN CARE OF CHESAPEAKE 715		715 ARG		STATE, ZIP CODE  A 23320				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATION) OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENT	rs		K 000				
	masonry structure T Sprinkler Status: Fu An unannounced St Safety Code Survey accordance with 42 Part 483: Requirem Facilities. The facilit compliance using the regulations. The face	tandard Recertification was conducted on the conducted of	PA 13 on Life 5/9/17 in gulation, Care					
SS=E	Egress Doors Doors in a required equipped with a late use of a tool or key using one of the folkarrangements: CLINICAL NEEDS CLOCKING Where special locking clinical security need only one locking deveach door and proving rapid removal of occiocks; keying of all locat all times; or other available to the staff 18.2.2.2.5.1, 18.2.2.5.	means of egress shath or a lock that requifrom the egress side owing special locking DR SECURITY THREADS arrangements for ds of the patient are price shall be permitted sions shall be made supants by: remote cocks or keys carried a such reliable means	the used, d on for the ontrol of by staff	K 222				

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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(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 495256 B. WING 05/09/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF CHESAPEAKE 715 ARGYLL ST CHESAPEAKE, VA 23320 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 222 K 222 Continued From page 1 Where special locking arrangements for the safety needs of the patient are used, all of the K - 222Clinical or Security Locking requirements are being met. In addition, the locks must be 1. The side exit between Hall 300 and 400 has electrical locks that fail safely so as to release upon loss of power to the device; the building is been corrected and the countdown sequence protected by a supervised automatic sprinkler and release meet K222 standards. system and the locked space is protected by a complete smoke detection system (or is The rear exit across from therapy has been constantly monitored at an attended location within the locked space); and both the sprinkler corrected and is opening and detection systems are arranged to unlock the doors upon activation. 2. The Maintenance director/designee will 18.2.2.2.5.2. 19.2.2.2.5.2. TIA 12-4 check all entrance/egress of our facility twice a **DELAYED-EGRESS LOCKING ARRANGEMENTS** week for 12 weeks, then once a week going Approved, listed delayed-egress locking systems forward. installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and 3. The administrator/designee will audit the biordinary hazard contents in buildings protected weekly checks for twelve weeks. throughout by an approved, supervised automatic fire detection system or an approved, supervised 4. Maintenance door checks/audits will be automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 reported to the monthly QAPI meeting for ACCESS-CONTROLLED EGRESS LOCKING compliance and make any changes as **ARRANGEMENTS** necessary. Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be 5. June 22, 2017, date of correction. permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING **ARRANGEMENTS** Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This Standard is not met as evidenced by:

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(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING 01 - MAIN BUILDING 01 AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 495256 B. WING 05/09/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **AUTUMN CARE OF CHESAPEAKE** 715 ARGYLL ST CHESAPEAKE, VA 23320 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 222 Continued From page 2 K 222 Based upon observations there are items that are installed on the doors that restricts the full operation of the doors so occupants can egress to an exit. Findings include On 9 May 2017 at 1055 AM, it is observed that the side exit between Hall 300 and 400 does not go into countdown sequence and release. On 9 May 2017 at 1128 AM, it is observed that the rear exit across from therapy is not opening properly. The above deficiencies were observed by the Environmental Services Director. K 345 K 345 NFPA 101 Fire Alarm System - Testing and SS=E Maintenance K345 Fire Alarm System - Testing and Maintenance 1. The annual fire inspection has been A fire alarm system is tested and maintained in accordance with an approved program complying completed as well as correcting any compliance with the requirements of NFPA 70, National concerns. Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system 2. The Maintenance director/designee will acceptance, maintenance and testing are readily ensure that an annual fire alarm inspection is available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 completed. 3. The Administrator/designee will audit for completion of the fire alarm inspection. This Standard is not met as evidenced by: 4. Maintenance director/designee will report to Based upon observations, the fire alarm system is not being maintained properly. monthly QAPI meeting for 3 months. Findings include 5. June 22, 2017, date of correction.

On 9 May 2017 at 1030 AM, it is observed that

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01

495256

(X3) DATE SURVEY COMPLETED

05/09/2017

NAME OF PROVIDER OR SUPPLIER

#### **AUTUMN CARE OF CHESAPEAKE**

B. WING \_\_\_\_\_\_STREET ADDRESS, CITY, STATE, ZIP CODE

715 ARGYLL ST CHESAPEAKE, VA 23320

		CHESAPEAKE, \	/A 23320	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGL OR LSC IDENTIFYING INFORMATION)	JLATORY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIO DATE
K 345	the annual fire alarm inspection record is no available at the time of the survey.  The above deficiencies were observed by the			
K 500 SS=E	Environmental Services Director.  NFPA 101 Building Services - Other  Building Services - Other  List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirementhat are not addressed by the provided K-tag but are deficient. This information, along with applicable Life Safety Code or NFPA standacitation, should be included on Form CMS-2	ts gs, h the rd	1. Excessive lint buildup under the cloth dryers and inside the rear dryer room have removed.  Excessive dust buildup in the return gri rear service hallway has been removed.	las been
K 511 SS=D	This Standard is not met as evidenced by: Based upon observations, there is evidence the building services equipment is not being properly maintained.  Findings include  On 9 May 2017 at 1120 AM, it is observed th there is excessive lint buildup under the cloth dryers and inside the rear dryer room.  On 9 May 2017 at 1125 AM, it is observed th there is excessive dust buildup in the return in the rear service hallway.  The above deficiencies were observed by the Environmental Services Director.  NFPA 101 Utilities - Gas and Electric  Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas O	nat nes sat grill e K 511	<ol> <li>The maintenance director/designee service staff about the necessity of multiple cleanings; fire hazard that is caused if leallowed to build up.</li> <li>Staff shall make a written record and retent/dust buildup in machine dryers are return grill multiple times daily.</li> <li>The maintenance director/designee audit for twelve weeks the written record and retermoving dust/lent buildup.</li> <li>Maintenance door checks/audits will reported to the monthly QAPI meeting compliance and make any changes as necessary.</li> <li>June 22, 2017, date of correction.</li> </ol>	ent is emove nd the shall ord of

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(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA A. BUILDING 01 - MAIN BUILDING 01 IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION 495256 05/09/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **AUTUMN CARE OF CHESAPEAKE** 715 ARGYLL ST CHESAPEAKE, VA 23320 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 511 Continued From page 4 K 511 electrical wiring and equipment complies with NFPA 70. National Electric Code. Existing K511 installations can continue in service provided no 1. The plate warmer in Hall 300 has been hazard to life. repaired with an approved power cord. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Electric panels in the electrical room on 300 hall are clear of any obstacle. This Standard is not met as evidenced by: The electrical panels in the back hall near Hall based upon observations, there is evidence that 300 are clear of any obstacle. the electrical equipment is not being properly maintained. 2. Maintenance Director/Designee will inspect Findings include all plate warmer power cords in building and replace any unapproved power cords. On 9 May 2017 at 1112 AM, it is observed that the plate warmer in Hall 300 has an unapproved Maintenance director/designee shall in-service power cord installed. staff about keeping all electrical panels clear On 9 May 2017 at 1115 AM, it is observed that the from any obstacle. electrical panels in the electrical room on Hall 300 are blocked and inaccessible. Maintenance director/designee shall inspect all electric panels 5 x a week for 12 weeks to On 9 May 2017 at 1117 AM, it is observed that the electrical panels in the back hall near Hall 300 are ensure no obstacles are blocking access to blocked and inaccessible. electric panels. The above deficiencies were observed by the 3. Administrator will audit inspections for Environmental Services Director. thoroughness and corrections if needed for 12 weeks. 4. Maintenance Director/designee will report to the monthly QAPI meeting for three months the results of audits. 5. June 22, 2017, date of correction.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION  A. BUILDING 02 - BUILDING 02		(X3) DATE SURVEY COMPLETED		
495256			B. WING		05/09/2017		
AUTUMN CARE OF CHESAPEAKE 715 A			715 AR	GYLL ST	STATE, ZIP CODE  VA 23320		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 00	0 INITIAL COMMENT	rs		K 000			
	Description of struct masonry structure of the status: Further Status: Further Status: Further Status: Further Status: Further Status: Further States States Code Survey accordance with 42 Part 483: Requirements for the states of the states	ture: The facility is a Type V (111).  Illy sprinklered - NFP tandard Recertification was conducted on Second Code of Federal Regents for Long Term Coy was surveyed for the LSC 2012 Existing illity was not compliant or Participation Medical Code of the Safety from Fire.)  In Title 42 Code of the Safety from Fire.)  In Title 42 Code of the Safety from Fire.	on Life 5/9/17 in gulation, Care Ince with care and Ill not be res the unless	K 222			
	Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of ocks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.  18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6  SPECIAL NEEDS LOCKING ARRANGEMENTS				TITLE		/ r

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG <b>02 - BUILDING 02</b>	(X3) DATE SURVEY COMPLETED			
		495256			B. WING _		05/0	5/09/2017		
ŀ	NIAME OF F	ROVIDER OR SUPPLIER		PTDEET ADI	DDEED OITY	STATE, ZIP CODE	00/0	3/2017		
l		N CARE OF CHESA	DEAKE							
	AUTUM	VOARE OF CHESA	PEARE		RGYLL ST APEAKE, \					
	(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		
	K 222	Continued From pa	ige 1		K 222	J.				
			ng arrangements for	the	1000	- 5.5				
			patient are used, all		-			1		
		Clinical or Security L	ocking requirements	are	1	K - 222		1		
		being met. In addition	on, the locks must be							
		electrical locks that t	fail safely so as to re	lease		I. The side exit between Hall $100$	and 200	has		
			to the device; the bui		ł	peen corrected and the countdo	wn sequei	nce		
		protected by a super	rvised automatic spri	nkler		and release meet K222 standards				
		system and the lock	ed space is protected	d by a	-	The state of the contract of the state of th		1		
		complete smoke det	tection system (or is		2. The Maintenance director/designee will					
		constantly monitored					_			
		within the locked spa	ace); and both the sp	rinkler	check all entrance/egress of our facility twice a					
		and detection system doors upon activation		nlock the	week for 12 weeks, then once a week going					
		18.2.2.2.5.2, 19.2.2.2			f	orward.		1		
		DELAYED-EGRESS								
		ARRANGEMENTS	LOOKING		3. The administrator/designee will audit the bi-					
		Approved, listed dela	ayed-egress locking s	systems		veekly checks for twelve weeks.				
	1	installed in accordan	ce with 7.2.1.6.1 sha	II be						
		permitted on door as ordinary hazard cont	ents in buildings prot	and ected		. Maintenance door checks/audi				
	-	throughout by an app	proved, supervised a	utomatic	reported to the monthly QAPI meeting for					
		fire detection system	or an approved, sup	ervised	compliance and make any changes as					
		automatic sprinkler s	ystem.		n	ecessary.				
		18.2.2.2.4, 19.2.2.2.4		CINIC						
		ACCESS-CONTROL ARRANGEMENTS	LED EGHESS LOCI	VING	5.	. June 22, 2017, date of correctio	n.			
		Access-Controlled Eg	gross Door assambli							
	1	nstalled in accordance	ce with 7 2 1 6 2 shall	ll be	1		1			
		permitted.	00 Willi 7.2.1.0.2 Sila	ii be				1		
	1 .	18.2.2.2.4, 19.2.2.2.4	1							
		ELEVATOR LOBBY E		ING						
	1	ARRANGEMENTS								
	E	Elevator lobby exit ac	cess door locking in							
	á	accordance with 7.2.1	1.6.3 shall be permitt	ed on						
		door assemblies in bu			-					
		y an approved, supe								
		letection system and		vised						
		automatic sprinkler sy				9				
		8.2.2.2.4, 19.2.2.2.4 his Standard is not								
	1 1	THE CHARLES IN THE	THE AS BUILDINGS AN	teria I			1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1,	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - BUILDING 02</b>		(X3) DATE SURVEY COMPLETED	
		495256	495256		WING		9/2017	
	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY,	STATE, ZIP CODE			
TO SERVE TO THE PROPERTY OF THE SERVE SERVER				RGYLL ST APEAKE, '				
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
K 222 K 281 SS=D	installed on the door operation of the door to an exit.  Findings include On 9 May 2017 at 10 the side exit between go into countdown significant or the side of the side exit between go into countdown significant or the side of the side exit between go into countdown significant or the side of the side exit between go into countdown significant or the side of the	ations there are item rs that restricts the functions so occupants can 055 AM, it is observe n Hall 100 and 200 occupants equence and release ies were observed boces Director.	ed that does not e.	K 222	K281			
	Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This Standard is not met as evidenced by: Based upon observation, there is evidence that the emergency lighting is not being properly maintained.  Findings include On 9 May 2017 at 1143 AM, it is observed that				<ol> <li>The emergency light in the b now operative.</li> <li>The Director of Maintenance check all fire exit lights twice as weeks.</li> <li>The Administrator/designee weekly Fire Exit lights for prope</li> <li>Maintenance Director/design the monthly QAPI meeting for the</li> </ol>	/designee week for : will audit r orientat ee will re	e will 12 the bi- ion. port to	
K 345 SS=E	the emergency light is inoperative.  The above deficiencie Environmental Servic NFPA 101 Fire Alarm Maintenance  Fire Alarm System - TA fire alarm system is accordance with an a	es were observed by ses Director. System - Testing and	the d	K 345	results of audits.  5. June 22, 2017, date of correct		GIS GIE	

CLIVIL	THE TOTT WILD TOTT IL	A MILDIONID OLITY	1020			OIVID IVC	7. 0930-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02		(X3) DATE SURVEY COMPLETED			
495256		B. WING		05/0	05/09/2017			
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
<b>AUTUM</b>	N CARE OF CHESA	PEAKE	715 AF	RGYLL ST				
			CHESA	APEAKE,	/A 23320			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
K 345	Continued From pa	ge 3		K 345				
		ts of NFPA 70, Natio	nal		K345		1	
		NFPA 72, National Fi						
		. Records of system			1. The annual fire inspection ha	s been		
		nance and testing ar	e readily		completed as well as correcting	any com	pliance	
	available.				concerns.	,		
	9.7.5, 9.7.7, 9.7.8, a	nd NFPA 25			concerns.			
					2. The Maintenance director/de	scianoo wi	ii)	
					ensure that an annual fire alarm inspe			
	This Standard is not met as evidenced by: Based upon observations, the fire alarm system is not being maintained properly.				completed.			
					3. The Administrator/designee v		for	
					completion of the fire alarm inspection.			
	Findings include  On 9 May 2017 at 1030 AM, it is observed that the annual fire alarm inspection record is not available at the time of the survey.  The above deficiencies were observed by the Environmental Services Director.							
					4. Maintenance director/designee will report to			
					monthly QAPI meeting for 3 months.			
					5. June 22, 2017, date of correct	ion.		
K 374	NFPA 101 Subdivision of Building Spaces -			K 374		1		
	Smoke Barrie	g -p					1	
							1	
	Subdivision of Buildir	ng Spaces - Smoke I	Barrier				1	
	Doors							
	2012 EXISTING						- 1	
	Doors in smoke barri							
	bonded wood-core de							
	resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors							
			OOIS					
	are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or							
	automatic-closing, do							
	are not required to sv						-	
	egress travel. Door o							
	clear width of 32 inch							
	doors.			+				
	19.3.7.6, 19.3.7.8, 19	.3.7.9					1	

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(X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION A. BUILDING 02 - BUILDING 02 IDENTIFICATION NUMBER: COMPLETED 495256 05/09/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AUTUMN CARE OF CHESAPEAKE 715 ARGYLL ST CHESAPEAKE, VA 23320 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K374 K 374 Continued From page 4 K 374 This Standard is not met as evidenced by: 1. Open penetrations in the attic between Halls Based upon observations the fire rated smoke 100/200 are sealed appropriately according to barrier walls have penetrations, joints and K374. Open penetrations of the sprinkler piping openings that are not fire stopped and could allow smoke to pass from one side of the smoke on the 100 hallway have be sealed barrier to the other side. appropriately and to standards. Findings include 2. Maintenance director/designee will inspect On 9 May 2017 at 1137 AM, it is observed that the fire walls bi annually for any penetrations. there are open penetrations in the attic between Halls 100/200. 3. Administrator/designee will audit the inspections of bi annual fire inspections. On 9 May 2017 at 1137 AM, it is observed that there are open penetrations at the Hall 100 4. Maintenance Director/designee will report to sprinkler piping penetration. the monthly QAPI meeting for three months the The above deficiencies were observed by the results of audits. Environmental Services Director. NFPA 101 Utilities - Gas and Electric 5. June 22, 2017, date of correction. K 511 K 511 SS=D Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code. electrical wiring and equipment complies with NFPA 70, National Electric Code, Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This Standard is not met as evidenced by: Based upon observations, there is evidence that the electrical equipment is not being properly maintained. Findings include

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02		(X3) DATE SURVEY COMPLETED		
495256		B. WING		05/0	9/2017		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY.	STATE, ZIP CODE		
Constitution Control to	N CARE OF CHESA	DEVKE		RGYLL ST	• output of city and representation of city and in city and city a		
ACTOM	TOANE OF CHESA	FLARE					
			CHESI	APEAKE,	VA 23320		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 511	Continued From pa	age 5		K 511			
		112 AM, it is observe	od that the		K511		
	plate warmer in Hell	1 100 has an arrange	u mai me				
		l 100 has an unappro	ovea		1 The plate		
	power cord installed	d.			1. The plate warmer in Hall 100		n
					repaired with an approved power cord.		
					a approved pov	ver cora.	
	The above deficience		y the		2. Maintenance Director/Desig	nee will in	nspect
	Environmental Servi	ices Director.			all plate warmer power cords in building and		
					an place marrier power cords in	Dunumg	anu
					replace any unapproved power	cords.	
					3. Administrator will audit inspe	actions fo	_
					thoroughness and corrections i	r needed.	
					4. Maintenance Director/design	nee will re	nort to
					the monthly QAPI meeting for t	hroo mor	thethe
					results of audits.	mee mon	itris the
					results of addits.		
					5. June 22, 2017, date of correc	tion.	
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