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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**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 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
K 000	INITIAL COMMENTS Description of structure: The facility is a one story masonry structure Type V (111). Sprinkler Status: Fully sprinklered - NFPA 13 An unannounced Standard Recertification Life Safety Code Survey was conducted on 5/9/17 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not compliance with the Requirements for Participation Medicare and Medicaid. The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)	K 000		
K 222 SS=E	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING 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 locks; 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	K 222		

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

Administrator 5/31/17

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**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 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
K 222	Continued From page 1 Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be 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:	K 222	K - 222 1. The side exit between Hall 300 and 400 has been corrected and the countdown sequence and release meet K222 standards. The rear exit across from therapy has been corrected and is opening 2. The Maintenance director/designee will check all entrance/egress of our facility twice a week for 12 weeks, then once a week going forward. 3. The administrator/designee will audit the bi-weekly checks for twelve weeks. 4. Maintenance door checks/audits will be reported to the monthly QAPI meeting for compliance and make any changes as necessary. 5. June 22, 2017, date of correction.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**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 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
K 222	Continued From page 2 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 222		
K 345 SS=E	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based upon observations, the fire alarm system is not being maintained properly. Findings include On 9 May 2017 at 1030 AM, it is observed that	K 345	K345 1. The annual fire inspection has been completed as well as correcting any compliance concerns. 2. The Maintenance director/designee will ensure that an annual fire alarm inspection is completed. 3. The Administrator/designee will audit for completion of the fire alarm inspection. 4. Maintenance director/designee will report to monthly QAPI meeting for 3 months. 5. June 22, 2017, date of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**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 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
K 345	Continued From page 3 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.	K 345		
K 500 SS=E	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This Standard is not met as evidenced by: Based upon observations, there is evidence that the building services equipment is not being properly maintained. Findings include On 9 May 2017 at 1120 AM, it is observed that there is excessive lint buildup under the clothes dryers and inside the rear dryer room. On 9 May 2017 at 1125 AM, it is observed that there is excessive dust buildup in the return grill in the rear service hallway. The above deficiencies were observed by the Environmental Services Director.	K 500	K500 1. Excessive lint buildup under the clothes dryers and inside the rear dryer room has been removed. Excessive dust buildup in the return grill in the rear service hallway has been removed. 2. The maintenance director/designee will in service staff about the necessity of multiple cleanings; fire hazard that is caused if lent is allowed to build up. Staff shall make a written record and remove Lent/dust buildup in machine dryers and the return grill multiple times daily. 3. The maintenance director/designee shall audit for twelve weeks the written record of removing dust/lent buildup. 4. Maintenance door checks/audits will be reported to the monthly QAPI meeting for compliance and make any changes as necessary. 5. June 22, 2017, date of correction.	
K 511 SS=D	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code,	K 511		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**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 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
K 511	Continued From page 4 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 On 9 May 2017 at 1112 AM, it is observed that the plate warmer in Hall 300 has an unapproved power cord installed. On 9 May 2017 at 1115 AM, it is observed that the electrical panels in the electrical room on Hall 300 are blocked and inaccessible. On 9 May 2017 at 1117 AM, it is observed that the electrical panels in the back hall near Hall 300 are blocked and inaccessible. The above deficiencies were observed by the Environmental Services Director.	K 511	K511 1. The plate warmer in Hall 300 has been repaired with an approved power cord. Electric panels in the electrical room on 300 hall are clear of any obstacle. The electrical panels in the back hall near Hall 300 are clear of any obstacle. 2. Maintenance Director/Designee will inspect all plate warmer power cords in building and replace any unapproved power cords. Maintenance director/designee shall in-service staff about keeping all electrical panels clear from any obstacle. Maintenance director/designee shall inspect all electric panels 5 x a week for 12 weeks to ensure no obstacles are blocking access to electric panels. 3. Administrator will audit inspections for 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.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING **02 - BUILDING 02** B. WING _____	**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 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
K 000	INITIAL COMMENTS Description of structure: The facility is a one story masonry structure Type V (111). Sprinkler Status: Fully sprinklered - NFPA 13 An unannounced Standard Recertification Life Safety Code Survey was conducted on 5/9/17 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not compliance with the Requirements for Participation Medicare and Medicaid. The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)	K 000		
K 222 SS=E	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING 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 locks; 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	K 222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/31/17

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING **02 - BUILDING 02** B. WING _____	**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 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
K 222	Continued From page 1 Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be 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:	K 222	K - 222 1. The side exit between Hall 100 and 200 has been corrected and the countdown sequence and release meet K222 standards. 2. The Maintenance director/designee will check all entrance/egress of our facility twice a week for 12 weeks, then once a week going forward. 3. The administrator/designee will audit the bi-weekly checks for twelve weeks. 4. Maintenance door checks/audits will be reported to the monthly QAPI meeting for compliance and make any changes as necessary. 5. June 22, 2017, date of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING **02 - BUILDING 02** B. WING _____	**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 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
K 222	Continued From page 2 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 100 and 200 does not go into countdown sequence and release. The above deficiencies were observed by the Environmental Services Director.	K 222		
K 281 SS=D	NFPA 101 Illumination of Means of Egress 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 the emergency light in the beauty salon is inoperative. The above deficiencies were observed by the Environmental Services Director.	K 281	K281 1. The emergency light in the beauty salon is now operative. 2. The Director of Maintenance/designee will check all fire exit lights twice a week for 12 weeks. 3. The Administrator/designee will audit the bi-weekly Fire Exit lights for proper orientation. 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.	
K 345 SS=E	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING **02 - BUILDING 02** B. WING _____	**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 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
K 345	Continued From page 3 with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based upon observations, the fire alarm system is not being maintained properly. 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.	K 345	K345 1. The annual fire inspection has been completed as well as correcting any compliance concerns. 2. The Maintenance director/designee will ensure that an annual fire alarm inspection is completed. 3. The Administrator/designee will audit for completion of the fire alarm inspection. 4. Maintenance director/designee will report to monthly QAPI meeting for 3 months. 5. June 22, 2017, date of correction.	
K 374 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9	K 374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING **02 - BUILDING 02** B. WING _____	**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 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
K 374	Continued From page 4 This Standard is not met as evidenced by: Based upon observations the fire rated smoke barrier walls have penetrations, joints and openings that are not fire stopped and could allow smoke to pass from one side of the smoke barrier to the other side. Findings include On 9 May 2017 at 1137 AM, it is observed that there are open penetrations in the attic between Halls 100/200. On 9 May 2017 at 1137 AM, it is observed that there are open penetrations at the Hall 100 sprinkler piping penetration. The above deficiencies were observed by the Environmental Services Director.	K 374	K374 1. Open penetrations in the attic between Halls 100/200 are sealed appropriately according to K374. Open penetrations of the sprinkler piping on the 100 hallway have be sealed appropriately and to standards. 2. Maintenance director/designee will inspect the fire walls bi annually for any penetrations. 3. Administrator/designee will audit the inspections of bi annual fire inspections. 4. Maintenance Director/designee will report to the monthly QAPI meeting for three months the results of audits.	
K 511 SS=D	NFPA 101 Utilities - Gas and Electric 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	K 511	5. June 22, 2017, date of correction.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495256	A. BUILDING **02 - BUILDING 02** B. WING _____	**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 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
K 511	Continued From page 5 On 9 May 2017 at 1112 AM, it is observed that the plate warmer in Hall 100 has an unapproved power cord installed. The above deficiencies were observed by the Environmental Services Director.	K 511	K511 1. The plate warmer in Hall 100 has been repaired with an approved power cord. 2. Maintenance Director/Designee will inspect all plate warmer power cords in building and replace any unapproved power cords. 3. Administrator will audit inspections for thoroughness and corrections if needed. 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.	