

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

Printed: 07/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495359	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/20/2017
NAME OF PROVIDER OR SUPPLIER DOGWOOD VILLAGE OF ORANGE COUNTY H		STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO 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 The Facility is a Two story skilled nursing facility. The Facility is Type II (111) construction and is fully sprinklered. An unannounced Life Safety Code recertification survey was conducted on 6/27/16 in accordance with 42 Code of Federal Regulations, Part 483.150 and 410 to 480: Requirements for Long Term Care Facilities. The Facility was surveyed for compliance using the LSC 2012 Life Safety Code Existing Regulations. The Facility was found not to be in compliance with the Requirements for Participation for Medicare and Medicaid. The Findings that follow demonstrate non-compliance with title 42 Code of Regulations, Part 483.150 and 410 to 480 (Life safety from Fire)	K 000		
K 363	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open	K 363	1. The facility accomplished corrective action for the smoke door located by WM2 that was identified during our most recent Life Safety Survey on 6/20/17. That Door hinges were tightened which allowed the door to shut and seal as required. 2. The other doors of the facility have the potential to be affected by the same deficient practice. The facility inspected the other doors of the facility on 7/10/17 to ensure that shut and seal as required	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Admiral

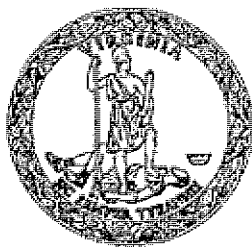
7-10-17

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.

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

Printed: 07/05/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495359	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/20/2017
NAME OF PROVIDER OR SUPPLIER DOGWOOD VILLAGE OF ORANGE COUNTY H			STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960		
(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 363	Continued From page 1 devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This Standard is not met as evidenced by: Based on observation the facility failed to maintain corridor doors. This has the possibility to affect 25% of the residents. The Findings include: On 6/27/2017 at approximately 10:14 AM hours, it was identified by observation the smoke door by room WM2 did not shut and seal.	K 363	3. The Maintenance Department will be in-serviced by 7/10/17 on the importance of maintaining resident safety by ensuring that the doors of the facility shut and seal as required. 4. To ensure compliance the Director of Maintenance Services or designee will round weekly for 4 weeks and then monthly for 3 months to ensure that the smoke doors shut and seal as required. Variances will be corrected. The audits will be reviewed by the Administrator or designee for trends and report to monthly QAPI for additional oversight and recommendations.	7/10/17	



COMMONWEALTH of VIRGINIA

Virginia Department of Fire Programs

Melvin D. Carter
EXECUTIVE DIRECTOR

State Fire Marshal's Office
Northern Region
471 James Madison Hwy Ste.101
Culpeper, VA 22701
Phone: 540/317-7670
Fax: 540/727-7041

Kathaleen Creegan-Tedeschi, Director
Office of Licensure/Certification
Division of Long Term Care
Virginia Department of Health
9960 Mayland Drive
Perimeter Center Suite 401
Henrico, VA 23233

RE: Dogwood Village Of Orange County Health And Rehab
120 Dogwood Lane
Orange, VA 22960
File Number: N-0113-001
CMS Certification Number: 495359
Event ID Number: JUZ921

The attached report is forwarded to you with the following comments:

I. SURVEY [X]

- [] Recommend certification based on compliance with Life Safety Code.
[X] Recommend certification based on acceptable POC.
[] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
[] Recommend certification based on compliance with LSC by requested continuous waiver.
[] Recommend certification based on compliance with LSC by requested Time Limited waiver.
[] Recommend certification based on satisfactory results from application of the FSES.
[] Do not recommend certification.

II. POST SURVEY []

- [] All deficiencies corrected:
[] All deficiencies not corrected:
[] Recommend certification based on acceptable POC
[] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
[] Recommend certification based on approved or requested continuous waiver.
[] Recommend certification based on approved or requested Time Limited waiver.
[] Do not recommend certification.

If you have any questions or if we may be of further assistance, please contact me at 804-371-0220

Sincerely,
Ronald C Reynolds - JJC
Ronald C. Reynolds
Deputy State Fire Marshal

Survey Date: 06/27/2017 SOD Sent: 7/5/17 POC Rec'd: 7/11/17 POC to HQ: 07/20/2017
Highest Scope/Severity: D

N-0113-001

**FIRE SAFETY SURVEY REPORT 2012 CODE – HEALTH CARE
Medicare – Medicaid**

1. (A) PROVIDER NUMBER **49-5359** ^{K1}
1. (B) MEDICAID I.D. NO. _____ ^{K2}

PART I – Life Safety Code, New and Existing
PART II – Health Care Facilities Code, New and Existing
PART III – Recommendation for Waiver
PART IV – Crucial Data Extract

OPTIONAL – Chapter 4 – NFPA 101A - Fire Safety Evaluation System for Health Care Occupancies – CMS-2786T

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY Dogwood Village Of Orange County Health and Rehab	2. (A) MULTIPLE CONSTRUCTION (BLDGs) A. BUILDING <u>1 of 1</u> B. WING _____ C. FLOOR _____	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE) 120 Dogwood Lane Orange, Va 22960	A. <input checked="" type="checkbox"/> Fully Sprinklered (All required areas are sprinklered)
			B. <input type="checkbox"/> Partially Sprinklered (Not all required areas are sprinklered) C. <input type="checkbox"/> None (No sprinkler system) ^{K0180}
3. SURVEY FOR <input checked="" type="checkbox"/> MEDICARE <input checked="" type="checkbox"/> MEDICAID	4. DATE OF SURVEY 6/27/17 ^{K4}	DATE OF PLAN APPROVAL 2/75&2/81 ^{K6}	SURVEY UNDER 5. <input checked="" type="checkbox"/> 2012 EXISTING ^{K7} 6. <input type="checkbox"/> 2012 NEW

5. SURVEY FOR CERTIFICATION OF

1. HOSPITAL 2. SKILLED/NURSING FACILITY 4. ICF/IID UNDER HEALTH CARE 5. HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. <input checked="" type="checkbox"/> ENTIRE FACILITY 2. <input type="checkbox"/> DISTINCT PART OF (SPECIFY) _____	3. <input type="checkbox"/> IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED? a. <input type="checkbox"/> YES b. <input type="checkbox"/> NO
6. BED COMPOSITION a. TOTAL NO. OF BEDS IN THE FACILITY <u>164</u>	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE <u>164</u>
b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE _____	e. NUMBER OF NF or ICF/IID BEDS CERTIFIED FOR MEDICAID _____

7. A. THE FACILITY MEETS THE STANDARD, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. COMPLIANCE WITH ALL PROVISIONS 2. ACCEPTANCE OF A PLAN OF CORRECTION 3. RECOMMENDED WAIVERS 4. FSES 5. PERFORMANCE BASED DESIGN
B. THE FACILITY DOES NOT MEET THE STANDARD

SURVEYOR (Signature) <i>Robert Palm</i>	TITLE Asst. Fire Marshal	OFFICE Northern SFMO	DATE 6/27/17
SURVEYOR ID <u>33168</u> ^{K10}			
FIRE AUTHORITY OFFICIAL (Signature) <i>J. N. ...</i>	TITLE Fire Marshal Manager	OFFICE Northern SFMO	DATE 08/03/17

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.