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 A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	495338		04/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF ABINGDON	600 WALDEN ROAD ABINGDON, VA 24210

(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 Surveyor: 12589 Description of structure: One story Type II (111) brick veneer nursing home with a total of two smoke compartments. Sprinkler status: Fully sprinklered An unannounced routine Life Safety Code survey was conducted 04/30/2018 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 in 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 OO Disclaimer This plan of Correction is submitted as required under State and Federal Law. The facility's submission of the Plan of Correction does not constitute and admission of the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statement made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding taken.	
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Surveyor: 12589 Based on observation and interview, the facility failed to provide unobstructed egress from one side of the main egress doors at the main entrance. The findings include:	K 211	K 211 1. A delayed egress system has been ordered by vendor for installation on the right main entrance door. Vendor to install electronic closure and also tied into fire alarm system releasing said door upon activation of fire alarm. Main entrance door will also release upon 15 second delayed egress. Exit door #7 has been serviced and repaired to operate without obstruction while properly functioning and closing freely without restriction. The Door	7/29/18

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephen J Reynolds	Administrator	5/21/18

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 211	Continued From page 1 On April 30, 2018 at 0914 hours, the right side main entrance door was locked. The maintenance director advised the delayed egress system was not installed on the door and it was locked to prevent residents from using the door. This deficient practice could affect one smoke compartment. Based on observation and interview, the facility failed to provide unobstructed egress from Exit #7 near room #2. The findings include: On April 30, 2018 at 1034 hours, the exit door at exit #7 was excessivly hard to open. The maintenance director agreed with the findings and the door was repaired during the inspection. This deficient practice could affect one smoke compartment. Based on observation , interview and a review of record, the facility failed to maintain rated fire doors throughout the facility. The findings include: On April 30, 2018 at 1147 hours, a review of the door inspection reports dated December 12, 2017, several problems were noted throughtout the reports with doors and frames. The maintenance director stated the problems on the report had not been corrected. This deficient practice could affect all of the smoke compartments.	K 211	inspection findings and recommendations identified on December 12th, 2017 specific to citations under General CFR (s) NFPA 101 will be corrected by June 13th, 2018. 2. All other exit doors have been checked and identified as working in proper order. All other fire/smoke doors checked and are working in proper order. 3. Maintenance personnel will check all exit doors monthly to ensure doors are working properly and will have annual inspection and testing of fire and smoke doors by outside vendor annually. 4. The Maintenance personnel will inspect exit doors weekly for four weeks, then monthly for 2 months to ensure doors working properly. The Maintenance Director will report these findings to QAPI committee for review of findings and/or concerns related to the exit doors working in unobstructed egress. The administrator will ensure compliance to K 211	7/29/18
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing	K 321	5. Plan of Correction July 29, 2018 K 321 See Page. 3	

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K 321	Continued From page 2 system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 12589 Based on observation and interview, the facility failed maintain the rating of hazardous area. The findings include: On April 30, 2018 at 1128 hours, penetrations were found above the ceiling in the rated wall ,at the soiled utility room. The penetrations were not sealed. The maintenance director agreed with the findings. This deficient practice could affect one smoke compartment.	K 321	1. Corrected. The penetration found above the ceiling in the fire rated wall at the soiled utility room was properly sealed on day of survey. 2. No other areas have been identified with unsealed penetrations into/from hazardous areas. 3. Maintenance personnel provided education by facility administrator of maintaining proper sealing on all penetrations of hazardous areas. 4. Maintenance personnel will monitor all service vendors, ie., plumbers, telephone, electrical, and electronic personnel that provide services that could penetrate any wall/partition that requires proper sealing/closure to ensure proper smoke and fire resistance. The Maintenance personnel will monitor all installations and work to ensure penetrations are sealed at time of work completion. The maintenance personnel will check various points of walls and ceiling weekly for one month and monthly times 2 months to ensure no penetrations. The Maintenance Director will report findings to QAPI committee. The administrator ensures compliance to K 321. 5. Correction date June 13, 2018	6/13/18
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918	K 918 See page 4	

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K 918	Continued From page 3	K 918	K 918 Electrical Systems 1.Corrected. A new serviceable generator battery has been installed that is serviceable with battery gravity readings that can be checked and verified weekly of having correct reading of electrolyte levels. 2. No other generators on property 3. Battery replaced with authorized battery by Generator Service Vendor. Facility Maintenance Personnel will check battery electrolyte level weekly to ensure appropriate fill ratio and monthly gravity checks to ensure battery performing at proper levels and readings of electrolyte levels. 4. Facility Maintenance Director will report monthly readings to QAPI Committee for three months to ensure compliance to K 918. The administrator will ensure compliance to this K 918. 5. Correction date June 13th, 2018	6/13/18

Electrical Systems - Essential Electric System Maintenance and Testing
The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.
Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.
6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)
This REQUIREMENT is not met as evidenced by:
Surveyor: 12589
Based on observation , interview and review of records, the facility failed to maintain and

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K 918	Continued From page 4 document generator maitenance in accordance with NFPA 99, 2012 Edition, Section 6.4.1.2, NFPA 70 2011 Edition, Article 700, and NFPA 110, 2010 Edition, Section 8.3.7. This deficient practice could affect all of the smoke compartments. The findings include: On April 30, 2018 at 1114 hours, a record review identified the records for the maintenance of the generator did not specify the specific gravity readings of the battery on a monthly basis and the electrolyte levels on a weekly basis. Furthermore, the battery for the generator was not servicable. The maintenace director agreed with the findings.	K 918	See Page 4	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of	K 920	K 920 1.All extension cords found run through the ceiling in rooms: 36, 54, 57, 67, 28 and room 6 have been removed. Power strips as necessitated in residents rooms are being removed and replaced with two each four receptacle boxes mounted in the wall by a Certified Electrical Vendor by June 13th, 2018. 2 Two other rooms were identified with this deficient practice. Those extension cords in the ceiling have also been removed and/or replaced with electrical receptacle outlets. All rooms found needing power strips are being removed and replaced with two each four receptacle boxes.	6/13/18

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K 920	Continued From page 5 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Surveyor: 12589 Based on observation and interview, the facility failed to not permit the use of extension cords and powerstrips in paitent care rooms. The findings include: On April 30, 2018 at 0920 hours, an extension cord was found run through the ceiling in room 36. The maintenance director agreed with the findings and the cord was removed during the inspection. This deficient practice could affect one smoke compartment. On April 30, 2018 at 0930 hours, a powerstrip was found in room 50 , in the area of the bed. The maintenance director agreed with the findings. This deficient practice could affect one smoke compartment. On April 30, 2018 at 0937 hours, an extension cord was found run through the ceiling in room 54. The maintenance director agreed with the findings. This deficient practice could affect one smoke compartment. On April 30, 2018 at 0941hours, an extension cord was found run through the ceiling in room 57. The maintenance director agreed with the findings. This deficient practice could affect one smoke compartment. On April 30, 2018 at 0943 hours, a powerstrip was found in room 58 , in the area of the bed. The maintenance director agreed with the findings. This deficient practice could affect one	K 920	3. Electrician contractor retained to install an additional two each 4 receptacle units in each Patient room as needed providing adequate receptacles. These receptacle outlets will be installed in each Patient room by no later than June 13th, 2018. 4. Facility Maintenance Personnel will conduct monthly room audits to ensure facility does not utilize extension cords or power strips in the Patient rooms. The Maintenance Personnel will report to the QAPI committee monthly times three months and then quarterly times 3 quarters to ensure no usage of power strips/extension cords in Resident rooms. Administrator ensures compliance to K 920. 5. Corrected by June 13th, 2018	6/13/18

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K 920	Continued From page 6 smoke compartment. On April 30, 2018 at 0945 hours, a powerstrip was found in room 59 , in the area of the bed. The maintenance director agreed with the findings. This deficient practice could affect one smoke compartment. On April 30, 2018 at 0953 hours, a powerstrip was found in room 65 , in the area of the bed. The maintenance director agreed with the findings. This deficient practice could affect one smoke compartment. On April 30, 2018 at 00954 hours, an extension cord was found run through the ceiling in room 67. The maintenance director agreed with the findings. This deficient practice could affect one smoke compartment. On April 30, 2018 at 1007 hours, a powerstrip was found in room 29 , in the area of the bed. The maintenance director agreed with the findings. This deficient practice could affect one smoke compartment. On April 30, 2018 at 1008 hours, an extension cord was found run through the ceiling in room 28. The maintenance director agreed with the findings. This deficient practice could affect one smoke compartment. On April 30, 2018 at 1010 hours, a powerstrip was found in room 26 , in the area of the bed. The maintenance director agreed with the findings. This deficient practice could affect one smoke compartment. On April 30, 2018 at 1012 hours, a powerstrip was found in room 22 , in the area of the bed.	K 920	See Page 5	

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K 920	Continued From page 7 The maintenance director agreed with the findings. This deficient practice could affect one smoke compartment. On April 30, 2018 at 1032 hours, an extension cord was found run through the ceiling in room 6. The maintenance director agreed with the findings. This deficient practice could affect one smoke compartment.	K 920	See Page 5	