

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

W-0018-001

Printed: 05/03/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495202	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2018
NAME OF PROVIDER OR SUPPLIER: GRETNA HEALTH AND REHABILITATION CEN		STREET ADDRESS, CITY, STATE, ZIP CODE 595 VADEN DRIVE GRETN, VA 24557		
(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: 21761 Construction Type: V(111) Description of Structure: The facility is a single story, wood frame structure on a concrete slab. Sprinkler Status: The facility is fully sprinklered with NFPA #13 wet and dry pipe systems. System pressure is supplemented by a fire pump, and water is supplied by a static tank. An unannounced standard recertification Life Safety Code survey was conducted 05/02/18 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	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. 1) Magnetic lock replaced, door adjusted, unit tested to ensure proper operation. 2) Maintenance director to check daily (x5) for 30 days and then weekly to ensure proper operation. 3) All doors will be checked weekly and results recorded in TELS PM with any non-compliant repairs made immediately. 4) Any non-operational or non-compliance issues found will be reported to QA/Safety Committee for	
K 222 SS=F	Egress Doors CFR(s): NFPA 101 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	K 222		5/8/2018

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

TITLE

(X6) DATE

[Signature] JEREMY CARROLL

ADMINISTRATOR

5/9/18

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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NAME OF PROVIDER OR SUPPLIER GRETN A HEALTH AND REHABILITATION CEN		STREET ADDRESS, CITY, STATE, ZIP CODE 595 VADEN DRIVE GRETN A, VA 24557		
(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 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 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	K 222	review and procedure modifications if needed. 5) Date of Correction 5/8/2018	5/8/2018

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NAME OF PROVIDER OR SUPPLIER GRETNAL HEALTH AND REHABILITATION CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 595 VADEN DRIVE GRETNAL, VA 24557		
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K 222	Continued From page 2 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 REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain exits. This has the ability to affect all residents and staff in one of four smoke compartments, evidenced as follows: Findings include: On 05/02/18, at approximately 10:57 AM, it was observed during inspection the delayed egress device did not release the egress door from the rear service hall by the Maintenance Office. The Director of Maintenance witnessed this evidence through observation and interview.	K 222			
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that	K 363	1) Door was adjusted to close gap and have proper seal. Completed day of audit 5-2-18. 2) Doors checked monthly for gap to have proper seal against passage of smoke. 3) Maintenance Director to use gauges to record any gaps and correct, adjust as needed to maintain seal against passage of smoke. Annual door check will be performed.	5/2/18	

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K 363	<p>Continued From page 3</p> <p>do not contain flammable or combustible material.</p> <p>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open 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.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 21761</p> <p>Based on observation and interview, it was revealed the facility failed to maintain resident room doors. This has the ability to affect all residents and staff in one of four smoke compartments, evidenced as follows:</p> <p>Findings include:</p> <p>On 05/02/18, at approximately 11:05 AM, it was observed during inspection the door to patient room 32 did not appear to seal against the</p>	K 363	<p>4) QA/Safety Committee to review at monthly meeting to ensure compliance.</p> <p>5) Date of correction 5/2/18</p> <p>All items checked and completed.</p> <p>Date of compliance 5-8-18</p>	<p>5/2/18</p> <p>5/8/2018</p>	

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K 363	Continued From page 4 passage of smoke due to tan excessive gap between the frame and the top door edge. The Director of Maintenance witnessed this evidence through observation and interview.	K 363			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495202	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - P.T. GYM B. WING _____		(X3) DATE SURVEY COMPLETED 05/02/2018
NAME OF PROVIDER OR SUPPLIER GRETNA HEALTH AND REHABILITATION CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 595 VADEN DRIVE GRETNA, VA 24557		
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 21761</p> <p>Construction Type: V(111)</p> <p>Description of Structure: The facility is a single story, wood frame addition to the main building on a concrete slab housing the Physical Therapy Gym only.</p> <p>Sprinkler Status: The facility is fully sprinklered with NFPA #13 wet and dry pipe systems. System pressure is supplemented by a fire pump, and water is supplied by a static tank.</p> <p>An unannounced standard recertification Life Safety Code survey was conducted 05/02/18 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 in compliance with the Requirements for Participation Medicare and Medicaid.</p>	K 000			

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

TITLE

(X6) DATE

 JEREMY CARTER

ADMINISTRATOR

5/5/18

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.