



Anthony T. Williams
State Fire Marshal's Office
6744 Thirlane Road
Roanoke, VA 24019

June 10, 2019

Dear Anthony T. Williams:

Enclosed is the plan of correction for Altavista Home. Thank you for the survey and we appreciate the input to improve the quality of care for the individuals at Altavista Home. Thank you for your time. If you have any questions or need anything please feel free to contact me.

Thank you again,
Leslie Ozz

Program Manager of ICF Homes
Horizon Behavioral Health


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

Printed: 06/03/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49G067	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 1 B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2019
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NAME OF PROVIDER OR SUPPLIER ALTAVISTA GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 101 AVOCA LANE ALTAVISTA, VA 24517
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(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 building with a construction type of V (000). Sprinkler Status: Fully sprinklered - NFPA 13R An unannounced Life Safety Code survey was conducted on 05-31-2019 in accordance with 42 Code of Federal Regulation, Part 483.150 and 410 to 480: Requirements for Intermediate Care Facilities for the Intellectually Disabled. The facility was surveyed for compliance using the LSC 2012 (Existing) regulations. The facility was not in compliance with the Requirements for Participation for 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	K0511 A: Unlabeled Breakers 1. Address the corrective action taken for the identified problem. Breaker box was relabeled by Joe Dowdy, Horizon's Health and Safety Officer on 6/3/19 2. Address how facility will identify similar occurrences of the problem. The breaker box will be assessed by Horizon Maintenance Staff by 6/10/19. 3. Identify measures/systemic changes to ensure deficient practice will not recur. The breaker box will be assessed monthly, or more often if electrical changes are made by Horizon's Health and Safety Officer 4. Indicate how facility will monitor its performance. The breaker box will be assessed monthly, or more often if electrical changes are made by Horizon's Health and Safety Officer 5. Date of correction, not to exceed 45th day after the survey. 6/10/19	6/3/19 6/10/19 6/10/19 6/10/19 6/10/19
K0511	Utilities - Gas and Electric CFR(s): NFPA 101 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. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 This Standard is not met as evidenced by: Based upon observations and interviews the facility failed to ensure that the electrical wiring and equipment complies with NFPA 70, National Electrical Code. This has the ability to affect all occupants of the building. Findings include: On 05-31-2019 at approximately 11:45 am, it is	K0511		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Program Manager	(X6) DATE 6/10/19
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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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(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
K0511	<p>Continued From page 1</p> <p>observed that the electrical panels "A" & Panel "B" in Main Electrical Room are not labeled as required by the Life Safety Code. (NFPA 70, 408.4)</p> <p>At approximately 11:15 am, it is observed that opening wiring, splices, and conduit were found in the attic space near HVAC equipment.</p> <p>The Safety Director and Administrator witnessed this evidence by interview and observation on 05-31-2019 at approximately 1:30 pm during the exit interview.</p>	K0511	<p>B. Open wiring</p> <ol style="list-style-type: none"> 1. Address the corrective action taken for the identified problem. All exposed wires were placed in junction boxes by Joe Dowdy, Horizon's Health and Safety Officer on 6/3/19 2. Address how facility will identify similar occurrences of the problem. The home will be assessed by Horizon Maintenance Staff by 6/10/19 to locate any other occurrences. 3. Identify measures/systemic changes to ensure deficient practice will not recur. The home will be assessed monthly or more often if electrical changes are made by Horizon's Health and Safety Officer. 4. Indicate how facility will monitor its performance. The home will be assessed monthly or more often if electrical changes are made by Horizon's Health and Safety Officer. 5. Date of correction, not to exceed 45th day after the survey. 		<p>6/3/19</p> <p>6/10/19</p> <p>6/10/19</p> <p>6/10/19</p> <p>6/10/19</p>