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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495349	A. BUILDING 01 B. WING ______	06/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT WYTHEVILLE - BIRD	990 HOLSTON RD WYTHEVILLE, VA 24382

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K 000	INITIAL COMMENTS Description of structure: Two Story Masonry and Steel Structure, Type II (000) Sprinkler status: Fully Sprinklered NFPA 13 An unannounced routine Life Safety Code survey was conducted 06/20/2019 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 222 SS=E	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 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	K 222	1.This was corrected on 6/20/19 after the identified observation. The appropriate sign was placed on the egress door near room 125. 2. Maintenance director / designee will routinely inspect all fire doors and make adjustments / corrections as needed. 3. In-service education to be provided to maintenance director by administrator by July 12, 2019. The maintenance director / designee will inspect fire doors monthly for three months.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7/2/19

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 222	Continued From page 1 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 REQUIREMENT is not met as evidenced by:	K 222	4. Results of the inspections will be discussed at the monthly Quality Assurance committee meeting for three months. The Quality Assurance committee will recommend revisions as needed to sustain compliance Completion: date July 26, 2019.	

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K 222	Continued From page 2 Surveyor; 12956 The Standard is not met as evidenced by: Based on observation and interview, the facility failed to maintain required signage on the delayed egress locking doors in accordance with LSC Section 7.2.1.6.1. This deficient practice could affect one of 5 fire areas, 20 residents, staff and visitors, if in the event of an emergency. Findings include: On 06/20/2019 at approximately 10:25 A.M., it was observed during the building tour inspection and observation that a readily visible sign on the egress door leaf adjacent to the release device that reads "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" was not provided at the door in the egress corridor near room 125. This did not meet the requirements of LSC sections 19.2.2.2.4 and 7.2.1.6.1. This finding was verified by the Director of Maintenance at the time of the observation and the Administrator at the exit conference on 06/20/2019 at 12:00 P.M.	K 222		
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 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	K 321	1. The fire rated doors identified as Central Supply, Dietary, Storage, Tool Room, Kitchen Dry Goods and the Beauty Shop will have self closing closures installed by July 10, 2019 2. The maintenance director / designee will inspect fire doors and make adjustments as needed.	

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K 321	Continued From page 3 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; 12956 The Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the hazardous area doors located in Central Supply, Dietary Storage, Tool-Room Storage, Kitchen Dry Goods, and the Beauty Shop, fully self-closed and latched when tested in accordance LSC Section 8.7.1.3. This deficient practice could affect one of 5 fire areas, 2 residents, staff and visitors, if in the event of an emergency. Findings include: On 06/20/2019 at approximately 9:15 A.M., it was observed during the building tour inspection and observation that the hazardous area doors, located at Central Supply, Dietary Storage, Tool-Room Storage, Kitchen Dry-Goods and the Beauty Shop fire rated doors were not	K 321	3. In- service education to be provided to maintenance director by administrator by July 12, 2019. The maintenance director /designee will inspect fire doors monthly for three months. 4 Results of the inspection will be discussed at the Quality Assurance meetings for three months. The Quality Assurance committee will recommend revisions as needed to sustain compliance. Completion date: July 26, 2019	

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K 321	Continued From page 4 self-closing and positive latching. This did not meet the requirement of LSC Section 19.3.2.1 This finding was verified by the Director of Maintenance at the time of the observation and the Administrator at the exit conference on 06/20/2019 at 12:00 P.M.	K 321		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Surveyor; 12956 This Standard is not meet as evidenced by: Based on observation and interview, the facility failed to ensure that the automatic sprinkler system in the Laundry Storage and Water Tank room were being maintained as required by NFPA 13 where areas of the ceiling finish had been removed. LSC Section 19.3.5.1. This deficient	K 351	1. This was corrected on 6/20/19 after the identified findings. Ceiling tiles were put in place in Laundry Storage room and Water Tank room. 2. Maintenance director / designee will routinely inspect these rooms and other rooms to ensure ceiling tiles are in place as required. 3. In- service education to be provided to maintenance director by administrator by July 12, 2019. The maintenance director /designee will inspect fire doors monthly for three months. 4. Results of the inspection will be discussed at the Quality Assurance meetings for three months. The Quality Assurance committee will recommend revisions as needed to sustain compliance. Completion date: July 26, 2019	

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K 351	Continued From page 5 practice could affect one of 5 fire areas, staff and visitors, if in the event of an emergency. Findings include: On 06/20/2019 between 9:20 and 9:45 A.M., it was observed during the building tour inspection and observation that some of the ceiling tiles had been removed in the Laundry Storage room and Water Tank room protected with automatic sprinklers. This did not meet the requirement of the LSC 19.3.5.1, 9.7 and NFPA 13. This finding was verified by the Director of Maintenance at the time of the observation and the Administrator at the exit conference on 06/20/2019 at 12:00 P.M.	K 351		
K 511 SS=D	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. 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 REQUIREMENT is not met as evidenced by: Surveyor; 12956 This Standard is not meet as evidenced by: Based on observation and interview, the facility failed to ensure that the electrical panel in the Garage was maintained as required by NFPA 70 National Electrical Code where the circuits were	K 511	1. The circuit index identifying the circuits will be installed by July 12, 2019. The circuit breaker opening has been corrected / closed. 2. Maintenance director / designee will routinely inspect the circuit breaker boxes to ensure all are closed. All breaker boxes will be inspected to ensure all have a circuit index as required. 3. In- service education to be provided to maintenance director by administrator by July 12, 2019. The maintenance director /designee will inspect fire doors monthly for three months.	

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K 511	Continued From page 6 not labeled and a circuit breaker opening was not closed. LSC 19.5.1.1. This deficient practice could affect one of 5 fire areas, 20 staff and visitors, if in the event of an emergency. Findings include: On 06/20/2019 at approximately 9:00 A.M., it was observed during the building tour inspection and observation that the circuit index identifying the circuits as to their purpose was not in the electrical panel and that as opening for a circuit breaker was not provided with a circuit breaker or an listed blank cover. This did not meet the requirement of LSC Sections 19.5.1.1, 9.1.2 and NFPA 70. This finding was verified by the Director of Maintenance at the time of the observation and the Administrator at the exit conference on 06/20/2019 at 12:00 P.M.	K 511	4. Results of the inspection will be discussed at the Quality Assurance meetings for three months. The Quality Assurance committee will recommend revisions as needed to sustain compliance. Completion date: July 26, 2019	7/26/19