



CONSULATE HEALTH CARE  
OF WINDSOR

July 19, 2019

Mr. Rusty Chase  
Deputy State Fire Marshal  
Virginia State Fire Marshals Office  
Division 5 – Hampton  
1919 Commerce Drive  
Suite 400  
Hampton, VA 23666

Dear Mr. Chase,

Attached is our plan of correction based upon survey conducted July 11, 2019. Please note that our POC will serve as our allegation of compliance and does not constitute admission or agreement by the provider of alleged deficiencies but instead is prepared for the sole purpose of compliance with State and Federal Regulations.

If you have questions or need further documentation please feel free to contact me at 757-242-4770.

Respectfully,


Rhoades Kreutter  
Executive Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495347</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/11/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>CONSULATE HEALTH CARE OF WINDSOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487</b>		
(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 1 story/stories frame structure with a construction type of II (000)  Sprinkler status: Fully Sprinklered  An unannounced recertification Life Safety Code survey was conducted 07/11/2019 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 found not to be in compliance with the Requirements for Participation Medicare and Medicaid.	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101  Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based upon review of doors with self closing devices are not being tested.  Findings include	K 223	<ol style="list-style-type: none"> <li>The doors with self-closing devices will be tested and documented. Rated doors noted during the survey will be made to self-close or close. Rated doors with deficient holes and penetrations noted during the survey will be repaired.</li> <li>Additional doors with self-closing devices will be reviewed for testing and documentation, and additional rated doors will be reviewed for proper self-closing and closing, and deficient holes and penetrations.</li> <li>The Executive Director educated the Maintenance Director on the importance of NFPA 101 Doors with Self-Closing Devices specific to properly testing and maintaining doors with self-closing devices and rated doors, and will continue to monitor in accordance with NFPA standards.</li> <li>Any findings will be reported to the monthly QAPI Committee for further review.</li> <li>Date of Compliance: 08/08/2019</li> </ol>	

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

TITLE

(X6) DATE

 *Executive Director* 07/19/19

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.

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

Printed: 07/12/2019  
FORM APPROVED  
OMB NO. 0938-0391

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K 223	Continued From page 1  On 07/11/19 between 09:00 AM and 12:00 PM it was observed that the facility does not have documentation for testing doors with self closing devices.. The above deficiency was observed by the Director of Maintenance.  On 07/11/19 between 09:00 AM and 12:00 PM it was observed rated doors throughout the facility will not self close or close. The above deficiencies were observed by the Director of Maintenance.  On 07/11/19 between 09:00 AM and 12:00 PM it was observed numerous rated doors throughout the facility have deficiencies in the doors with holes and penetrations. The above deficiencies were observed by the Director of Maintenance.	K 223		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____  Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353	1. The painted sprinkler head in the Blue unit valve room will be replaced by a qualified vendor. 2. Additional sprinkler heads will be reviewed for being free of paint. 3. The Executive Director educated the Maintenance Director on the importance of NFPA 101 Sprinkler System- Maintenance and Testing specific to keeping sprinkler heads free of paint, and will continue to monitor in accordance with NFPA standards. 4. Any findings will be reported to the monthly QAPI Committee for further review. 5. Date of Compliance: 08/08/2019	

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K 353	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based upon observations of the sprinkler system that the required maintenance of the system is not being maintained.  Findings include  On 07/11/19 between 09:00 AM and 12:00 PM, it was observed the sprinkler head located in the Blue unit valve room had been painted. The above deficiencies were observed by the Director of Maintenance.	K 353		
K 521 SS=E	HVAC CFR(s): NFPA 101  HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2  This REQUIREMENT is not met as evidenced by: Based upon interviews the facility does not have documentation that the fire dampers have been inspected and tested within the last four years.  Findings include  On 07/11/19 between 9:00 AM and 12:00 PM it was observed that the facility does not have documentation that the fire dampers have been inspected and tested within the last four years. The above deficiency was observed by the	K 521	<ol style="list-style-type: none"> <li>1. The required four year fire damper testing will be completed by a qualified vendor.</li> <li>2. There is only one required four year fire damper testing, therefore no additional reviews were needed.</li> <li>3. The Executive Director educated the Maintenance Director on the importance of NFPA 101 HVAC specific to completing the required four year fire damper testing. The required four year fire damper testing will be added to the facility's TELS Preventative Maintenance (PM) Calendar, and will continue to be monitored in accordance with NFPA standards.</li> <li>4. Any findings will be reported to the monthly QAPI Committee for further review.</li> <li>5. Date of Compliance: 08/08/2019</li> </ol>	

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K 521	Continued From page 3 Director of Maintenance.	K 521		
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101  Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4  This REQUIREMENT is not met as evidenced by: Based upon observations a self closing metal container was not readily available.  Findings include.  On 07/11/19 between 09:00 AM and 12:00 PM Observed plastic container with cigarette butts at	K 741	<ol style="list-style-type: none"> <li>1. The plastic container with cigarette butts at the main entrance, and the cigarette butts on the ground near the rear loading dock, were removed. Ashtrays made of noncombustible material of safe design, and a metal container with a self closing cover device into which ashtrays can be emptied, will be provided and made available in the smoking area. A fire extinguisher was made readily available in the smoking area. The facility smoking policy will be updated to address employee smoking while on duty.</li> <li>2. Additional areas will be reviewed for plastic containers with cigarette butts, cigarette butts on the ground, ashtrays made of noncombustible material of safe design and metal containers with self closing cover devices in smoking areas, and fire extinguishers in smoking areas. There will only be one updated facility smoking policy for employees while on duty, therefore no additional reviews will be needed.</li> </ol>	

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K 741	Continued From page 4 the front entrance, observed staff smoking on property at the rear loading dock, noted numerous cigarette butts on the ground by rear loading dock. It was observed that an ashtrays of noncombustible material of safe design was not provided in the smoking area and an metal container with a self closing cover device into which ashtrays can be emptied was not readily available. It was observed that a fire extinguisher was not readily available in the smoking area. The facility did not have a current smoking policy that addressed employee smoking while on duty. The above deficiency was observed by the Maintenance Director.	K 741	<ol style="list-style-type: none"> <li>3. The Executive Director will educate staff on the importance of NFPA 101 Smoking Regulations specific to adhering to the facility's updated smoking policy. Quality reviews of selected facility areas will be randomly conducted 3 times weekly for four weeks, and weekly for two months, for adherence to the facility's updated smoking policy, and will continue to be monitored in accordance with NFPA standards.</li> <li>4. Any findings will be reported to the monthly QAPI Committee for further review.</li> <li>5. Date of Compliance: 08/08/2019</li> </ol>	
K 920 SS=D	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) assemblies 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 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8	K 920		

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K 920	Continued From page 5 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based upon observations the electrical systems that there is non-approved power strips being used in patient care areas.  Findings include  On 07/11/19 between 09:00 AM and 12:00 PM it is observed that there is a non approved power strip with multiple daisy chains in use located in the IT / Direct TV / Phone room and non approved multiplug adapter in use at the employee time clock. The above deficiency was observed by the Director of Maintenance.	K 920	<ol style="list-style-type: none"> <li>1. The non approved power strip in the IT/ Direct TV/ Phone room, and non approved multiplug adapter used at the employee time clock were removed.</li> <li>2. Additional areas were reviewed for non approved power strips, and non approved multiplug adapters.</li> <li>3. The Executive Director educated the Maintenance Director on the importance of NFPA 101 Electrical Equipment- Power Cords and Extension Cords specific to the use of non approved power strips and multiplugs, and will continue to monitor in accordance with NFPA standards.</li> <li>4. Any findings will be reported to the monthly QAPI Committee for further review.</li> <li>5. Date of Compliance: 08/08/2019</li> </ol>	