COMMONWEALTH of VIRGINIA

Virginia Department of Fire Programs

Michael T. Reilly
EXECUTIVE DIRECTOR

Brian M. McGraw, P.E.
STATE FIRE MARSHAL

State Fire Marshal's Office
Western Region/Division 3
124 North South Street
Farmville, VA 23901
Phone: (434) 392-3277
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06/07/2019

Ms. Leah Queen,
Curis At Waynesboro Nursing & Rehab Center
1221 Rosser Ave
Waynesboro, VA 22980

Dear Ms. Queen

This concerns the unannounced Recertification Life Safety Code survey of the referenced facility conducted on 06/04/2019 in accordance with 42 Code of Federal Regulation, Part 416: Requirements for Ambulatory Surgical Centers. The facility was surveyed for compliance using the Life Safety Code 2012 Existing regulation.

All institutional buildings must meet all applicable Life Safety Code (NFPA 101) requirements in accordance with 42 Code of Federal Regulation, Part 416: Requirements for Ambulatory Surgical Centers certification requirements issued by the Centers for Medicare and Medicaid Services (CMS), in order to participate in the Medicare/Medicaid programs. The findings listed on the attached form, CMS 2567, "Statement of Deficiencies and Plan of Correction", demonstrate non-compliance with Title 42 Code Federal of Regulations, 416.44(b) et seq Life Safety from Fire.

Prior to making expenditures to correct the noted deficiencies, you should have an approved plan of correction. It is strongly recommended that you check with local officials, since compliance with this report does not excuse you from complying with local codes and ordinances.

If any deficient practice is identified within either the Health or Life Safety Code requirements, a Plan of Correction (POC) developed by the provider must be returned to the surveying entity by 06/17/2019. To be considered acceptable, the POC must include five (5) components:

1. Address the corrective action taken for the identified problem
2. Address how facility will identify similar occurrences of the problem
3. Identify measures/systemic changes to ensure deficient practice will not recur
4. Indicate how facility will monitor its performance
5. Date of correction.

NOTE: If correction/compliance by the 90th day after the survey is not possible, the facility's POC must be accompanied by a Time-Limited Waiver request with appropriate justification. The waiver request and supporting documentation will be reviewed by the State Fire Marshal's Office and the Virginia Department of Health for a final recommendation to CMS. Please be aware, the timeline involved in the Time Limited Waiver request and final approval process does not delay the potential imposition of enforcement actions.

If concerns regarding a citation are not resolved, in accordance with §488.331, the facility has one (1) opportunity to question cited deficiencies through the current Virginia Department of Health's informal dispute resolution (IDR) process . To be considered, the IDR request must be received by the State Fire Marshal's Office within 10 calendar days of your receipt of the enclosed survey findings. An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions taken by CMS or DMAS.

Survey Results

The results of this survey are reflected on the enclosed Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

If you have any questions or if we may be of assistance to you, please call (540) 580-0175.

Sincerely,

Kenneth Kent,
State Fire Marshal's Office

Attachment
/
cc: file

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT WAYNESBORO NURSING & REHAB CENT	1221 ROSSER AVE WAYNESBORO, VA 22980

(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: 25557 Description of Structure: This is a 1 story, fully sprinklered building of unprotected non-combustible construction. Interior walls are metal studs with gypsum wallboard. Roof is metal decking over steel bar joists with a suspended acoustical ceiling system. Construction Type: II(000) Sprinkler status: Fully Sprinklered. An unannounced recertification Life Safety Code survey was conducted 06/04/2019 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 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 protective plates that do not exceed 48 inches from the bottom of the door.	K 321	1) The door to the second dryer room has a self-closing bracket installed on 6/7/19. 2) No additional issues noted throughout the building regarding self-closing doors.	7/16/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeff Queen	Executive Director	6/20/19

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 321	Continued From page 1 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: 25557 Based upon observations and interviews the facility failed to maintain the smoke resisting partitions and doors in a hazardous area. This has the ability to affect all occupants in the effected compartment of the building. The findings include: On 06/04/2019 at approximately 11:45 AM it was observed that the door to the second dryer room was not self closing. The Facility Maintenance Director and Administrator witnessed this evidence by interview and observation on 06/04/2019 at approximately 12:30 PM during the exit interview.	K 321	3) Administrator, Maintenance Director and Maintenance Assistant was in-serviced on 6/6/19 on K321. 4) Maintenance Director and/or designee will complete weekly audits on the self-closing doors for 6 weeks and randomly thereafter to ensure doors have proper closing devices. The results of the evaluation will be discussed and revised as needed during the monthly Safety Committee Meetings.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking	K 324	1) Kitchen Hood Inspection was completed on 6/13/19.	7/16/19

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K 324	Continued From page 2 Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Surveyor: 25557 Based upon observations and interviews the facility failed to maintain the cooking equipment is protected in accordance with NFPA 96. This has the ability to affect the occupants effected smoke compartment. The findings include: On 06/04/2019 at approximately 11:54 AM it was observed that the kitchen hood system remote pull station had a service tag indicating the system was last serviced in September 2018. The Facility Maintenance Director and Administrator witnessed this evidence by interview and observation on 06/04/2019 at approximately 12:30 PM during the exit interview.	K 324	2) No other issues were noted in the kitchen and/or on the inspection report completed on 6/13/19. 3) Administrator, Maintenance Director and Maintenance Assistant and John Rippey with Star City Fire Protection was in-serviced on 6/7/19 on K324. 4) The next hood System inspection is scheduled for December 2019 and on the schedule for Star City Fire Protection to have services completed. The results of the evaluation will be discussed and revised as needed during the monthly Safety Committee Meetings.	

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K 353 K 353 SS=F	Continued From page 3 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 This REQUIREMENT is not met as evidenced by: Surveyor: 25557 Based upon observations and interviews the facility failed to test and maintain the building fire sprinkler system. This has the ability to affect all occupants of the building. The findings include: On 06/04/2019 at approximately 11:07 AM it was observed that two fire sprinkler heads in the "B" oxygen storage room were located less than 6 feet on center. (NFPA 13, 8.6.3.4.1) On 06/04/2019 at approximately 11:47 AM it was observed that two fire sprinkler heads in the rear of the main dryers were located less than 6 feet on center. (NFPA 13, 8.6.3.4.1) On 06/04/2019 at approximately 11:49 AM it was	K 353 K 353	1) Fire sprinkler heads in B-wing oxygen room and outside dryer area are to be corrected by 7/16/19 to be in compliance with K353 for sprinkler heads to be 6 feet part. 2) No other Fire Sprinkler heads were observed to be less than 6 feet apart throughout the building. 3) Administrator, Maintenance Director and Maintenance Assistant and John Rippey with Star City Fire Protection was in-serviced on 6/7/19 on K353. 4) Maintenance Director and/or designee will do walk through audits with Star City Fire Sprinkler Company on a quarterly bases and 1 year to ensure all Fire Sprinkler heads are in compliance with K353. The results of the evaluation will be discussed and revised as needed during the monthly Safety Committee Meetings.	7/16/19

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	495147	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/04/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT WAYNESBORO NURSING & REHAB CENT	**1221 ROSSER AVE** **WAYNESBORO, VA 22980**

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K 353	Continued From page 4 observed that the fire sprinkler head in the rear of the second dryer area, have visible corrosion on the sprinkler head and frame. (NFPA 25, 5.2.1.1.1) The Facility Maintenance Director and Administrator witnessed this evidence by interview and observation on 06/04/2019 at approximately 12:30 PM during the exit interview.	K 353		