STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTH AND REHAB CENTER OF GR	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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: 35701 The facility is one story of construction Type II (111). The building is fully sprinklered. An unannounced Life Safety Code recertification survey was conducted on 05/24/2019 in accordance with 42 Code of Federal Regulations, Part 483.70: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the 2012 Life Safety Code existing regulation. 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 Federal Regulations, 483.70(a) et seq (Life Safety from Fire.)	K 000	This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.	
K 222 SS=D	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 safety needs of the patient are used, all of the	K 222	1. The lock on the gate located in the 300 courtyard was installed on the egress side of the gate on May 24, 2019 by the Maintenance Director. 2. An audit was completed on May 30, 2019 by the Maintenance Director to ensure exit all exit doors were clear for exit. 3. Staff were inserviced on May 30 by the Maintenance Director regarding clear access for exits. 4. An audit of all exits will be completed weekly for one month by the Maintenance Director to ensure ease of egress.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Brown | TITLE: administrator | (X6) DATE: 6/4/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTH AND REHAB CENTER OF GR	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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 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: Surveyor: 35701	K 222	5. Findings or updates will be reported by the Maintenance Director to the Quality Assurance Performance Improvement Committee monthly. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Rehabilitation Director, Medical Director, Maintenance Director, Housekeeping Director, Admissions Director, Dietary Manager, Social Services Director, Activities Director, Employee Relations Director, Central supply Coordinator and C.N. A.	6/7/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/24/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTH AND REHAB CENTER OF GR	**355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973**

(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 2 Based on observation, the facility failed to maintain egress doors. This has the potential to affect one smoke compartment. The Findings include: It was observed on 05/24/2019 at 1:05 PM, the locking arrangement on the gate located in the 300 courtyard was not installed on the egress side of the gate.	K 222		
K 325 SS=D	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by:	K 325	1. Test was completed on Alcohol Based Hand Dispenser that were seen on the survey on May 28, 2019 by the Maintenance Director and are in good working order. 2. Test were completed on all Alcohol Based Hand Rub Dispensers on May 28, 2019 by the director of Maintenance/Designee. 3. Housekeeping staff and assistant Maintenance Director were inserviced on testing the Alcohol Based Hand Rub Dispensers by the Maintenance Director on May 28, 2019. 4. Each Alcohol Based Hand Dispenser will be tested on each refill by the Maintenance Director/Designee and a monthly audit will be conducted by the Maintenance Director to ensure Alcohol Based Hand Rub Dispensers have been tested. The Maintenance Director will audit 10 Alcohol Based Hand Rub Dispensers weekly for 1 month , 5 weekly for 2nd month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTH AND REHAB CENTER OF GR	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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 325	Continued From page 3 Surveyor: 35701 Based on interview and observation, the facility failed to test the ABHR dispensers in accordance with the manufacturers care and use instructions. This has the potential to affect all residents and staff. The Findings include: An interview with the maintenance supervisor on 05/24/2019 at 12:21 PM revealed the facility was not conducting tests on the ABHR dispensers in accordance with the manufacturers care and use instructions each time a new refill was installed. Observation of the the ABHR dispenser located in the service hall near the maintenance supervisors office revealed the dispenser was dispensing excessive amounts of solution when operated.	K 325	5. Findings or updates will be reported by the Maintenance Director to the Quality Assurance Performance Improvement Committee monthly. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Rehabilitation Director, Medical Director, Maintenance Director, Housekeeping Director, Admissions Director, Dietary Manager, Social Services Director, Activities Director, Employee Relations Director, Central supply Coordinator and C.N. A.	6/7/2019
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced	K 341	1. On May 31, 2019 Chapman Electric moved smoke detector located in the service hall greater than 36 inches of the HVAC vent. 2. All other smoke detectors were greater than 36 inches from the vent. 3. The Administrator inservice Maintenance staff May 30 2019 on fire alarm devices being located greater than 36 inches from return vents. 4. All new fire alarms will be installed greater than 36 inches from vents. 5. . Findings or updates will be reported by the Maintenance Director to the Quality Assurance Performance Improvement Committee monthly. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTH AND REHAB CENTER OF GR	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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 341	Continued From page 4 by: Surveyor: 35701 Based on observation, the facility failed to install fire alarm devices in accordance with NFPA 72. This has the potential to affect one smoke compartment. The Findings include: It was observed on 05/24/2019 at 1:00 PM, a smoke detector located in the service hall was installed within 36 inches of an HVAC vent.	K 341	Coordinator, Rehabilitation Director, Medical Director, Maintenance Director, Housekeeping Director, Admissions Director, Dietary Manager, Social Services Director, Activities Director, Employee Relations Director, Central supply Coordinator and C.N. A.	6/7/209
K 921 SS=D	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel	K 921	1. Administrator and Maintenance Director scheduled for a Corporate Maintenance Director to complete the testing for physical integrity, resistance, leakage current and touch current on portable patient care related electrical equipment on May 30, 2019. 2. All fixed and portable patient care related electrical equipment will be tested for physical integrity, resistance, leakage current and touch current by a corporate 3. Maintenance Director on June 3, 2019 through June 6, 2019. Maintenance Director will be inserviced on the electrical testing equipment on June 4, 2019 by corporate maintenance director. 4. Maintenance Director will complete an audit of patient electrical equipment monthly and will ensure testing is complete.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTH AND REHAB CENTER OF GR	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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 921	Continued From page 5 responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on interview, the facility failed to maintain electrical equipment. This has the potential to affect all residents. The Findings include: An interview with the maintenance supervisor on 05/24/2019 at 12:53 PM revealed the facility was not conducting physical integrity, resistance, leakage current and touch current test for fixed and portable patient care related electrical equipment.	K 921	Findings or updates will be reported by the Maintenance Director to the Quality Assurance Performance Improvement Committee monthly. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Rehabilitation Director, Medical Director, Maintenance Director, Housekeeping Director, Admissions Director, Dietary Manager, Social Services Director, Activities Director, Employee Relations Director, Central supply Coordinator and C.N. A.	6/7/2019