

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


Printed: 05/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495404	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE GLEBE B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2019
--------------------------------------------------	-------------------------------------------------------------------------	--------------------------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER THE GLEBE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 GLEBE ROAD DALEVILLE, VA 24083
--------------------------------------------------	----------------------------------------------------------------------------------------

(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	<p>INITIAL COMMENTS</p> <p>Surveyor: 34730 Construction Type : V (111)</p> <p>Description of structure: The facility is a single story building of wood frame construction with concrete slab floors.</p> <p>Sprinkler status: The facility is fully sprinklered. The system is supplied by municipal water supply.</p> <p>An unannounced recertification Life Safety Code survey was conducted 05/07/2019 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.</p> <p>The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)</p>	K 000	<p>This Plan of Correction is our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly</p>	
K 222 SS=F	<p>Egress Doors CFR(s): NFPA 101</p> <p>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</p>	K 222	<p>K 222 SS=F Egress Doors CFR(s):NFPA 101</p> <p>On 5-07-19 at approximately 11:36 am, the Fire Marshall, Administrator, and Director of Facilities noted the temporary exit door with a delayed egress locking device in the activities room did not release when tested</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator of Health Services	(X6) DATE 5/16/19
-------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------	-----------------------------

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: 05/13/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495404	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE GLEBE B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2019
NAME OF PROVIDER OR SUPPLIER THE GLEBE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 GLEBE ROAD DALEVILLE, VA 24083		
(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 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 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	K 222	The door was repaired on 5/8/19 and is functioning properly. The facility inspected all remaining doors and verified that they are functioning properly. The facility has initiated monthly inspections of all exit doors. Any doors not functioning properly will be repaired immediately, and a recording of the inspections along with repairs will be maintained by the facilities maintenance department. The inspections will be recorded and reported to the facilities Safety Committee. The Safety Committee will be responsible for monitoring and oversight.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495404	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE GLEBE B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2019
NAME OF PROVIDER OR SUPPLIER THE GLEBE		STREET ADDRESS, CITY, STATE, ZIP CODE 250 GLEBE ROAD DALEVILLE, VA 24083		
(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 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: 34730 Based on observation and inspection the facility failed to maintain exit doors. This has the ability to affect all occupants of the building. Findings include: On 5-07-19 at approximately 11:08 am it was observed through observation and inspection that the temporary exit door with a delayed egress locking device in the activities room did not release when tested. The facility Administrator and Maintenance staff witnessed this evidence by observation and interview.	K 222		
K 353 SS=F	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 _____	K 353	Sprinkler System - Maintenance and Testing CFR(s):NFPA 101 On 5-07-19 at approximately 11:36 am, the Fire Marshall, Administrator, and Director of Facilities noted that the sprinkler riser and control valves in the H 265 housekeeping closet on the front hall were obstructed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495404	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE GLEBE B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2019
NAME OF PROVIDER OR SUPPLIER THE GLEBE			STREET ADDRESS, CITY, STATE, ZIP CODE 250 GLEBE ROAD DALEVILLE, VA 24083	
(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 353	Continued From page 3 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: 34730 Based on observation and inspection the facility failed to maintain the sprinkler system. This has the ability to affect all occupants of the building. Findings include: On 5-07-19 at approximately 11:36 am it was observed through observation and inspection that the sprinkler riser and control valves in the H 265 housekeeping closet on the front hall are obstructed. The facility Administrator and Maintenance staff witnessed this evidence by observation and interview.	K 353	Obstructions were immediately removed from the closet immediately, prior to the Fire Marshall's exit. The facility initiated an inspection of all closets No obstructions were found. The facility initiated a monthly inspection of all closets. Any obstructions will be removed immediately, with a recording of the inspections maintained by the facilities maintenance Department. The inspections will be recorded and reported to the facilities Safety Committee. The Safety Committee will be responsible for monitoring and oversight.	
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918	K 918 Electrical System - Essential Electric System Maintenance and Testing CFR(s) NFPA 101 On 5-07-19 at approximately 11:30 am the Fire Marshall spoke with the Director of Facilities regarding the Generator Preventative Maintenance report dated 11-1-18. The Director of Facilities stated that maintenance on the Generator was performed on 11-1-18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495404	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE GLEBE B. WING _____		(X3) DATE SURVEY COMPLETED 05/07/2019
NAME OF PROVIDER OR SUPPLIER THE GLEBE			STREET ADDRESS, CITY, STATE, ZIP CODE 250 GLEBE ROAD DALEVILLE, VA 24083		
(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 918	<p>Continued From page 4</p> <p>months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34730</p> <p>Based on observation and inspection the facility failed to maintain the generator system. This has the ability to affect all occupants of the building.</p> <p>Findings include:</p> <p>On 5-07-19 at approximately 11:30 am it was observed during the record review that the Generator Preventative Maintenance report dated 11-1-18 has deficiencies, and documentation could not be provided to show that they have been corrected.</p> <p>The facility Administrator and Maintenance staff witnessed this evidence by observation and interview.</p>	K 918	<p>However, failed to provide the Fire Marshall with a record of the service performed.</p> <p>The Director of Facilities immediately contacted the generator maintenance vendor and obtained a copy of the service record, dated 1-11-18.</p> <p>The Director of Facilities will ensure that all service records are obtained and maintained in a service record binder.</p> <p>The Director of Facilities will be responsible for monitoring and oversight of the service record Binder</p>		