

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

Printed: 12/05/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495256	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 11/29/2018
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF CHESAPEAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320		
(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 masonry structure with a construction type of V(111) Sprinkler status: Fully Sprinklered An unannounced recertification Life Safety Code survey was conducted 05/02/2018 in 11/29/18 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	K347 Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based upon review of smoke detection system sensitivity results are not documented. Findings include On 11/29/18 between 9:00 AM and 12:00PM, it was observed that the facility does not have documentation for smoke detection sensitivity testing. The above deficiency was observed by the Director of Maintenance.	K 347	Smoke detector test function test was conducted annually with no negative outcome. Smoke detector sensitivity test was conducted with no negative outcome. Maintenance director has been in-serviced on this requirement. Smoke detector sensitivity test was scheduled to be conducted once every two years. Maintenance director will audit these results weekly for three months to insure completion. Findings will be documented and concerns will be shared with the QA committee.	
K 521 SS=F	HVAC CFR(s): NFPA 101	K 521	1/18/2019	

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

TITLE

(X6) DATE

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: 12/05/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495256	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 11/29/2018
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF CHESAPEAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320		
(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 521	<p>Continued From page 1</p> <p>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</p> <p>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.</p> <p>Findings include</p> <p>On 11/29/18 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 Director of Maintenance.</p>	K 521	<p>K521</p> <p>A smoke damper test was scheduled to be completed in a timely manner.</p> <p>Maintenance director has been in- served on this requirement.</p> <p>A smoke damper test was scheduled to be completed once every four years.</p> <p>Maintenance director will audit these results weekly for three months to insure completion.</p> <p>*Findings of these inspections will be documented and shared with the QA committee.</p> <p>1/18/2019</p>		

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

Printed: 12/05/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495256	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/29/2018
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF CHESAPEAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320		
(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 masonry structure with a construction type of V(111) Sprinkler status: Fully Sprinklered An unannounced recertification Life Safety Code survey was conducted 11/29/2018 11/29/2018 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 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based upon review of smoke detection system sensitivity results are not documented. Findings include On 11/29/18 between 9:00 AM and 12:00 PM, it was observed that the facility does not have documentation for smoke detection sensitivity testing. The above deficiency was observed by the Director of Maintenance.	K 347	K347 Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. Smoke detector test function test was conducted annually with no negative outcome. Smoke detector sensitivity test was conducted with no negative outcome. Maintenance director has been in-serviced on this requirement. Smoke detector sensitivity test was scheduled to be conducted once every two years. Maintenance director will audit these results weekly for three months to insure completion. Findings will be documented and concerns will be shared with the QA committee.	
K 521 SS=F	HVAC CFR(s): NFPA 101	K 521	1/18/2019	

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

TITLE

(X6) DATE

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: 12/05/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495256	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/29/2018
NAME OF PROVIDER OR SUPPLIER AUTUMN CARE OF CHESAPEAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 715 ARGYLL ST CHESAPEAKE, VA 23320		
(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 521	<p>Continued From page 1</p> <p>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</p> <p>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.</p> <p>Findings include</p> <p>On 11/29/18 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 Director of Maintenance.</p>	K 521	<p>K521</p> <p>A smoke damper test was scheduled to be completed in a timely manner.</p> <p>Maintenance director has been in-serviced on this requirement.</p> <p>A smoke damper test was scheduled to be completed once every four years.</p> <p>Maintenance director will audit these results weekly for three months to insure completion.</p> <p>Findings of these inspections will be documented and shared with the QA committee.</p> <p>1/18/2019</p>	