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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495370	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGEWATER HOME , INC.	302 NORTH SECOND STREET BRIDGEWATER, VA 22812

(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 a three story dually certified facility. The Facility is Type II (222) construction and is fully sprinklered. An unannounced recertification Life Safety Code survey was conducted on 11/14/2019 in accordance with 42 Code of Federal Regulations, Part 483.150 and 410 to 480: 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 for Medicare and Medicaid. The Findings that follow demonstrate non-compliance with title 42 Code of Regulations. Part 483.150 and 410 to 480 (Life safety from Fire).	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered	K 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

VP HEALTH SERVICES 11/26/19

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 161	Continued From page 1 Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain the requirements type II (222) construction. This has the potential to affect one smoke compartment. The Findings include: It was observed on 11/14/2019 at 12:16 PM, penetrations located in the mechanical room of Harmony was not sealed at the data sleeves and 4 large openings.	K 161	K-161 Address the corrective action taken for the identified problem. Response. ***All openings were sealed.*** Address how facility will identify similar occurrences of the problem. Response. ***Maintenance team will audit spaces between smoke compartments as well as adjacent areas like mechanical/electrical rooms.*** Identify measures/systemic changes to ensure deficient practice will not recur. Response: ***Educate contractors on regulatory requirements. Approval of work will include staff inspecting areas affected with wall penetrations for proper sealing.*** Indicate how facility will monitor its performance. Response: ***Add inspections of these areas to preventative maintenance program*** Date of correction, not to exceed 45th day. Response: ***Conduit pipes stuffed with rock wool. Semi-Annual PM amended in Sprocket by 12/13/2019.***	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		

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K 353	Continued From page 2 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: 35701 Based on observation, the facility failed to maintain the sprinkler system. This has the potential to affect one smoke compartment. The Finding include: It was observed on 11/14/2019 at 11:56 AM, cables was tied to the sprinkler pipe located above ceiling in the 2nd floor core elevator lobby of the Wellness community.	K 353	K353 Address the corrective action taken for the identified problem. Response: ***Cables removed from sprinkler lines.*** Address how facility will identify similar occurrences of the problem. Response: ***Complete audit of sprinkler lines especially above ceilings.*** Identify measures/systemic changes to ensure deficient practice will not recur. Response: ***Contractor will be made aware of this regulation at beginning of projects.*** Indicate how facility will monitor its performance. Response: ***Quarterly PM's for checking smoke compartment dividing walls will be amended to include checking sprinkler lines*** Date of correction, not to exceed 45th day. Response: ***Localized corrections made 11/22/2019, site audit and amended pm in Sprocket, 12/13/2019***	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire	K 355		

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K 355	Continued From page 3 Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain portable fire extinguishers. This has the potential to affect two smoke compartments. The Findings include: It was observed on 11/14/2019 at 11:10 AM, the type K portable fire extinguisher located in the Unity kitchen was past due a 5 year hydro test. It was observed on 11/14/2019 at 11:25 AM, the type K portable fire extinguisher located in the Joy kitchen was past due a 5 year hydro test.	K 355	K 355 Address the corrective action taken for the identified problem. Response. ***Both fire extinguishers replaced with compliant units.*** Address how facility will identify similar occurrences of the problem. Response: ***If vendor cannot replace the extinguishers immediately we will resource another vendor*** Identify measures/systemic changes to ensure deficient practice will not recur. Response: ***Develop relationship with alternative suppliers.*** Indicate how facility will monitor its performance. Response: ***These checks are on a PM. Future team responses to close this PM will require acknowledging all expired units have been replaced.*** Date of correction, not to exceed 45th day. Response: ***2 defective units replaced, 11/22/2019, Identifying and bringing another supplier online, 12/13/2019.***	
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain electrical wiring. This has the potential to affect all residents and staff.	K 511		

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K 511	Continued From page 4 The Findings include: It was observed on 11/14/2019 at 10:50 AM, dead and unused wiring was exposed from a junction box located above ceiling in the 3rd floor core lobby near the elevator. Observation of the above ceiling area revealed a junction box located in the above ceiling area was not closed. It was observed on 11/14/2019 at 11:03 AM to 12:20 PM, dead and unused wiring was observed above ceiling and not in use. It was observed on 11/14/2019 at 11:11 AM, an electrical outlet cover located in Unity dining room near the TV was broken. It was observed on 11/14/2019 at 11:56 AM, a junction box located above ceiling in the 2nd floor core elevator lobby was not covered. It was observed on 11/14/2019 at 12:05 PM, dead and unused wiring was exposed near the fire damper located in the Tranquility mechanical room. It was observed on 11/14/2019 at 12:20 PM, knock outs for the junction box located above ceiling and the fire doors near room 154 in the Harmony community was missing.	K 511	K 511 Address the corrective action taken for the identified problem. Response. ***All unused wiring was removed in the noted areas. Outlet cover replaced.*** Address how facility will identify similar occurrences of the problem. Response: ***Work order submitted to systematically audit all areas, and take corrective measures.*** Identify measures/systemic changes to ensure deficient practice will not recur. Response: ***Assure project demolition documents include removal of any abandoned wiring and j-boxes.*** Indicate how facility will monitor its performance. Response: ***As part of final project checks, we will assure the steps above were taken and no abandoned materials remain.*** Date of correction, not to exceed 45th day. Response: ***Replaced broken receptacle cover, 11/14/2019, Removed abandoned wiring, installed plugs in noted j-box openings, 11/22/2019. Work order submitted for all other areas, 11/22/2019. Work order completed, 12/26/2019.***	
K 711 SS=D	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with	K 711		

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K 711	Continued From page 5 telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on record review, the facility failed to maintain the evacuation and relocation plans. This has the potential to affect all residents and staff. The Findings include: A record review on 11/14/2019 at 10:05 AM revealed the assembly area for a complete evacuation of the building was not identified in the plans. The plans referenced Appendix C as a resource for the identified location. Observation of Appendix C was not identifying the exterior assembly point.	K 711	K 711 Address the corrective action taken for the identified problem. Response. ***Add verbiage about assembly area for a complete evacuation of the building to the Emergency Plan.*** Address how facility will identify similar occurrences of the problem. Response: ***Annual review of Emergency Plan.*** Identify measures/systemic changes to ensure deficient practice will not recur. Response: ***Emergency Plan documentation will be updated to include location and contact information for offsite assembly area for a complete evacuation of the building.*** Indicate how facility will monitor its performance. Response: ***Annual review of Emergency Plan.*** Date of correction, not to exceed 45th day. Response: ***Added verbiage to Emergency Plan notebook, 11/26/19.***	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of	K 923		

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K 923	Continued From page 6 noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain storage requirements for oxygen cylinders. This has the potential to affect all residents using E cylinders of oxygen. The Findings include: It was observed on 11/14/2019 at 11:49 AM, empty E cylinders of oxygen stored in the oxygen storage room was not segregated from full E cylinders of oxygen.	K 923	K923 Address the corrective action taken for the identified problem. Response. ***Segregated empty and full cylinders. Installed a "line of delineation in the room designating full and empty storage areas.*** Address how facility will identify similar occurrences of the problem. Response: ***Facility has only (1) oxygen storage room.*** Identify measures/systemic changes to ensure deficient practice will not recur. Response: ***Educate household team members on requirement.*** Indicate how facility will monitor its performance. Response: ***Implement a quarterly PM to check oxygen room for compliance.*** Date of correction, not to exceed 45th day. Response: ***Segregated existing cylinders, 11/15/2019. Added taped line on floor, 11/22/2019. Create and implement PM in Sprocket, 12/13/2019.***	