STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495369	A. BUILDING 01 - BUILDING 01 B. WING _____	9/5/19 09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CONVALESCENT CENTER AT PATRIOTS COLONY	6000 PATRIOTS COLONY DRIVE WILLIAMSBURG, VA 23188

(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	K 000		

Description of structure: The building consists of a one story building with a wing on each side.
Construction Type is V (111)
Sprinkler status: fully sprinkled

An unannounced recertification Life Safety Code survey was conducted on September 5, 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 edition of NFPA-101, Life Safety Code (Existing) regulations. The facility was in compliance with the Requirements for Participation in Medicare and Medicaid.

K 222 SS=D	Egress Doors CFR(s): NFPA 101	K 222	1. The door to/from the Magnolia Suite was temporarily corrected on 9/5/2019 and the lock was replaced on 9/6/2019. Delayed egress signs were posted on the door from the Azalea Wing and the Magnolia Suite. 2. All delayed egress doors in the facility were checked by the director of facilities to ensure signage is in place and the doors release when tripped by the wanderguard system. 3. A scheduled work order has been created by the director Of facilities to verify all appropriate delayed egress related signage is in place. Signage will be verified weekly by the director of facilities/ designee in perpetuity.	

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

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		9/17/19

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 222	Continued From page 1 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 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	K 222	4. Results from weekly testing will be reviewed by Facility Director and/or designee for three months. All findings will be reported to the QA Committee for continued improvement and analysis.	10/20/19

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K 222	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was revealed that the delayed egress doors were not being maintained. Findings include: At 2:25 pm on September 5, 2019 it was revealed that there was no delayed egress sign on the door from the Azalea Wing. These findings were confirmed by interview with the Director of Facilities. At 2:35 pm on September 5, 2019 it was revealed that there was no delayed egress sign from the Magnolia Suite, and that the door was not releasing when tripped by the anti elopement "Wanderguard" system. These findings were confirmed by interview with the Director of Facilities.	K 222		
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or	K 362	1. The unsealed penetrations above the ceiling across from room 2028, above the drop ceiling by the electrical room and above the drop ceilings by room 133, 134, 123 and in the Dogwood Wing were inspected by the facility director and the facility's outside contractor was notified and will be on site 9/19 and 9/20 to correct the identified issues. 2. The contractor has been engaged and will inspect fire walls above the corridor ceilings throughout the convalescent center to identify and correct any penetrations.	

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K 362	Continued From page 3 fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was revealed that the facilities corridor walls are not being maintained. 60 of 60 patients and staff are effected. Findings include: At 1:22 pm on September 5, 2019 it was revealed that there were unsealed penetrations above the ceiling across from room 202B Magnolia Wing. These findings were confirmed by interview with the Director of Facilities. At 1:25 pm on September 5, 2019 it was revealed that there was a penetration above the drop ceiling by the electrical room. These findings were confirmed by interview with the Director of Facilities. At 1:30 pm on September 5, 2019 it was revealed that there were penetrations above the drop ceilings by room 133, 134, 123, in the Dogwood Wing. These findings were confirmed by interview with the Director of Facilities.	K 362	All findings will be reported to the QA Committee for continued improvement and analysis. 3. A formal above ceiling inspection plan will be implemented by the facility's director for projects involving work above the drop ceiling. The program will ensure that the integrity of the firewall is maintained. 4. The facility services director or designee will complete observations monthly for three months to ensure any contractor doing work in the ceiling has a certificate posted on their ladder.	10/20/19
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping	K 511	1. The electrical receptacle in the hallway near room 136 was remounted by the maintenance technician and circuits in panels LBB, LBC, HCC, HBB in the storage room by the kitchen were labeled on 9/6/19 by the maintenance technician.	

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K 511	Continued From page 4 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: Based on observation and interview, it was revealed that the facility failed to properly comply with the electrical code. Findings include: At 2:10 pm on September 5, 2019 it was revealed that there was an electrical receptacle in the hallway that was loose and needed to be remounted in the Dogwood Wing by room 136. These findings were confirmed by interview with the Director of Facilities. At 2:25 pm on September 5, 2019 it was revealed that there were unlabeled circuits in panels LBB, LBC, HCC, HBB in the storage room by the kitchen. These findings were confirmed by interview with the Director of Facilities.	K 511	2. On 9/6/19, a 100% audit was completed on all receptacles in the corridors/resident rooms/ common areas and the electrical panels by the director of facility services/designee to ensure all receptacles are secure and circuits are labeled 3. A scheduled work order has created to inspect all common area receptacles monthly by the maintenance technician or designee as well as to ensure all circuits are labeled. Report to be reviewed by Facilities Director. 4. Director of Facilities will review all reports as well as check 12 receptacles weekly for 4 weeks and report out findings in QAPI quarterly.	10/20/19
K 902 SS=D	Gas and Vacuum Piped Systems - Other CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Other List in the REMARKS section any NFPA 99 Chapter 5 Gas and Vacuum Systems requirements that are not addressed by the provided K-Tags, but are deficient. This	K 902	1. Full and empty signs were installed in the medication room by the facility's director on 9/5/19 2. A 100% audit was completed by the facilities director/ designee of all areas that contain portable oxygen to ensure signs are in place.	

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K 902	Continued From page 5 information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was revealed that the oxygen cylinder storage area in the Medication room by the Nurses Station is not being maintained. Findings include: At 2:15 pm on September 5, 2019 it was revealed that there were portable oxygen bottles stored in the Medication room by the Nurses Station that were not labled as empty or full (NFPA 99, 11.3), which could result in an excess amount of oxidizing gas in this storage area. These findings were confirmed by interview with the Director of Facilities.	K 902	3. A scheduled work order has been created by the facilities director to verify all appropriate oxygen related signage is in place. 4. Results from the scheduled work order will be reviewed weekly four 4 weeks and monthly for 3 months by Facilities Director or designee as well as weekly observations for 8 weeks to ensure signage is in place. All findings will be reported to the QA Committee for continued improvement and analysis.	10/20/19