Culpeper
Health & Rehabilitation Center
A MEDICAL FACILITIES OF AMERICA HEALTH & REHABILITATION CENTER

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Culpeper, Virginia 22701
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1/21/20

Time Limited Waiver Request

Due to time restriction for submitting a plan of correction & the extensive scope of work required to make the repair & the importance of life safety; we are requesting a time-limited waiver for tag ***K 372*** pertaining to correcting penetrations in our fire & smoke walls to allow time to coordinate with drywall/ firewall contractors who will complete the work. Due to the scale of the job we respectful request a time-limited waiver to complete the necessary repairs in order to bring CHRC into compliance. Any questions please reach out to Administrators or Maintenance Director listed below.

Compliance date will be 6/10/2020

Administrator:
Emmanuel Motley (540)-520-4258

Maintenance Director:
Tim McCurdy (540)-423-7515

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495279	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CULPEPER HEALTH & REHABILITATION CENTER	602 MADISON ROAD CULPEPER, VA 22701

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K 000	INITIAL COMMENTS The facility is located in a single story building of Type V(000) construction. The facility is fully sprinklered. An unannounced recertification Life Safety Code survey was conducted on January 9, 2020 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term 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. The findings that follow demonstrate non-compliance with Title 42 Code of Federal Regulations, 483.90(a) et seq (Life Safety from Fire).	K 000	Plan Of Correction for 1/09/2020 Life Safety Inspection The facility desires that this plan of correction be considered for the facilities allegation of compliance. These statements are not an admission to and do not constitute an agreement with the alleged deficiencies herein. The date of compliance is 2/15/2020	
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, it was revealed that a floor scrubber was being stored in an exit corridor. Findings include: On 1-9-20 at approximately 12:40 pm it was revealed that a floor scrubber was stored in an exit corridor and was partially	K 211	K211 1. The equipment addressed in the survey that was found in the exit corridor will be removed from the corridor. 2. Maintenance will conduct an audit of the facility to ensure this is the only occurrence of this issue. 3. Maintenance Director will conduct an in-service for floor tech staff regarding means of egress & where it is ok to store their equipment. 4. Maintenance staff will monitor corridors for compliance starting daily for one week, then weekly for 3 months, then quarterly after that. when this issue occurs will be submitted quarterly during our Quality Assurance Safety Committee. 5. Compliance date 2/15/2020	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1/21/20

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 211	Continued From page 1 blocking the exit corridor. The Assistant Director confirmed these findings.	K 211		
K 222 SS=E	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 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	K 222	K222 1. The maintenance staff will affix proper delay egress signage to main entrance doors. Maintenance staff checked unit 3 doors with a push/pull gauge & found they are opening with 18 to 30 pounds of applied force which is allowed according to NFPA 101 7.2.1.4.5 Door leaf Operating Force for existing doors in an existing building. 2. Maintenance staff will check all other exterior entrances for appropriate signage, door leaf opening force with push/pull gauge & update door audits accordingly. 3. Maintenance will conduct annual fire door audits & continue daily exterior door checks in accordance with our work order/ preventive maintenance system. 4. Fire doors will be checked annually to ensure life safety compliance. Door issues found during annual inspection will have a work order submitted to correct the issue & all findings will be submitted on the next Quality Assurance Safety Committee. 5. Compliance date: 2/15/2020	

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K 222	Continued From page 2 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: Based on observation, it was revealed that the facility is not maintaining the egress doors. Findings include: 1) On 1-9-20 at approximately 12:15 pm it was revealed the front exit doors are hard to open at Unit 3. 2) On 1-9-20 at approximately 12:45 pm it was revealed the main entrance/exit doors have no 15 second time delay signs.	K 222		

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K 222	Continued From page 3 The Assistant Administrator confirmed these findings.	K 222		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation, it was revealed that the facility is not maintaining the smoke barrier walls. Findings include: On 1-9-20 between the hours of noon and 1:30 pm it was revealed there were unsealed or improperly sealed openings and penetrations in the smoke barrier walls. Examples found were Unit 2 to Dining, Unit 1 Hallway by soiled untility, Admin to Unit 2 corridor, and Conference room. The Assistant Administrator confirmed these findings.	K 372	K 372 1. Maintenance will use contractor to go through the entire facility & repair fire & smoke walls. 2. Maintenance will assess the facility's fire & smoke walls to develop a scope of work & to ensure contractor corrects all walls in question. 3. Maintenance will conduct an annual fire wall inspection in accordance with our preventive maintenance system. 4. Maintenance Director will monitor contractor's work during & after work is done to ensure nothing was missed & penetrations were sealed correctly. Contractor will submit report when complete to document where & when work was done. As well what kind of system was used to fill the penetration. 5. 6/10/2020	
K 761 SS=E	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors	K 761		

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K 761	Continued From page 4 Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was revealed that the facility is not maintaining the fire and smoke doors, and corridor doors through a comprehensive door maintenance and inspection program. Findings include: During the hours of 12:05 to 1:35 pm it was revealed that doors to rooms 58 and 84 are hard to close, shower room 2 was not latching, Unit 1 fire doors have an excessive gap between them, shower room doors have an excessive gap at the top, food storage room door is not latching, and the dining room double doors have excessive gaps. The Assistant Administrator confirmed these findings.	K 761	K 761 1. Maintenance will correct the latching issues in rooms 58, 84 & the kitchen dry storage as well add astragals to u1 fire doors, shower rooms doors, & dining room double doors to correct gap issues. 2. Maintenance will conduct another facility wide door audit & submit work order to correct issues found 3.Maintenance will conduct the annual fire doors audits to include patient room smoke doors as well. 4.Maintenance will in accordance with our preventive maintenance system conduct annual fire door inspections. Maintenance will also continue to do patient room inspections monthly & when issues are found regarding patient room doors work orders will be submitted to correct issues. All findings will be submitted quarterly during our Quality Assurance Safety Committee. 5. compliance date 2/15/2020	
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed	K 914		

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K 914	Continued From page 5 locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was revealed that the patient receptacle testing records were not arranged in a comprehensive and organized manner for review and analysis. Fiindings include: On 1-9-20 at approximately 11:55 am it was revealed that the notes for testing records were not assembled in a comprehensive fashion. The Assistant Administrator confirmed these findings.	K 914	K 914 1. Maintenance has completed the "patient receptacle testing records" & was stored on computer so was not available the exact day of the inspection because maintenance director was not in facility & maintenance tech did not have full access to director's computer. 2. Check "patient receptacle testing records" to assure its in log form & is in accordance with NFPA standards. 3. In-service maintenance staff on locating department documentation located on director's computer. 4. All maintenance documents are reviewed on a quarterly basis by corporate maintenance to assure logs are completed in a timely manner & comply with regulatory standards & policy. 5. 2/15/2020	
K 919 SS=E	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other	K 919		

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K 919	Continued From page 6 List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, it was revealed that the facility is not maintaining the proper labeling of electrical circuits. Findings include: on 1-9-20 between the hours of 11:45 am and 1:30 pm it was revealed that electrical panels throughout the facility were improperly labeled. Examples include by the Janitors Closet, by the Break Room, in the Mechanical Room Unit 3 and Kitchen left panel G. The Assistant Administrator confirmed these findings.	K 919	K 919 1. Maintenance will have electrical contractor come in & re-label all electric panels in facility. 2. Maintenance will conduct an assessment of the panels in the facility to establish a scope of work for the contractor & to assure all panels get labeled. 3. After work is complete Maintenance will maintain electric panels in accordance with NFPA standards for electric panels. 4. Maintenance will walk with contractor when job is complete. Maintenance director will approve each electric panel as the contractor finishes them to assure, they are all done. Contractor will supply document upon completion pertaining to the work he completes & where in the building he worked. 5. 2/15/2020	
K 928 SS=E	Gas Equipment - Labeling Equipment and Cylind CFR(s): NFPA 101 Gas Equipment - Labeling Equipment and Cylinders Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL." Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name	K 928		

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K 928	Continued From page 7 of manufacturer or supplier. Cylinders and containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, it was revealed that the faciity is not storing oxygen cylinders correctly. Findings include: on 1-9-20 between the hours of 12:15 pm and 1:30 pm it was revealed that In the soiled utility rooms, empty cylinders are not being stored in areas designated for empty cylinders, resulting in confusion as to the amount of oxygen being stored. The Assistant Administrator confirmed these findings.	K 928	K 928 1. Maintenance will remove empty tanks from the Full oxygen bottle room & relocate them to the appropriate spot in the soiled holding. 2. Maintenance will affix proper signage in soiled holding rooms to show where to store empty tanks. 3. Nursing & therapy will in-service staff to assure everyone knows where to store empty tanks. 4. Maintenance staff will monitor oxygen storage rooms & soiled holdings for compliance starting daily for one week, then weekly for 3 months, then quarterly after that & when this issue occurs will be submitted quarterly during our Quality Assurance Safety Committee. 5. 2/15/2020	