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
	495359	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____________	09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD VILLAGE OF ORANGE COUNTY H	**120 DOGWOOD LANE ORANGE, VA 22960**

(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 two story skilled nursing facility. The facility is Type II (111) construction and is fully sprinklered. An unannounced Life Safety Code recertification survey was conducted on 09/26/2019 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 to be not in compliance with the Requirements for Participation for Medicare and Medicaid. The Findings that follow demonstrate noncompliance with title 42 Code of Regulations. Part 483.150 and 410 to 480 (Life safety from Fire).	K 000		
K 222 SS=D	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	K 222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Executive Director	10-18-19

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 This REQUIREMENT is not met as evidenced by:	K 222	1. The delayed egress exit door located near the basement stairwell has now been identified as a delayed egress door. The identifying information was installed on 10-10-19. 2. The other exit doors of the facility have the potential to be affected by this deficient practice. The facility inspected the other doors of the facility on 10-10-19 to ensure that the doors were identified as required. This deficient practice affects the residents and staff of the facility. 3. The Maintenance Department was re-educated on 10-11-19 about the requirements of having the delayed egress exit doors being so identified. 4. To ensure compliance, the Director of Maintenance (or designee) will audit weekly for 4 weeks then monthly for 3 months to ensure that the delayed egress exit doors are identified as required. This information will be forwarded to QAPI for review.	10-18-19

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K 222	Continued From page 2 Surveyor: 35701 Based on observation, the facility failed to maintain egress doors. This has the potential to affect all residents and staff on the basement level. The Findings include: It was observed on 09/26/2019 at 1:02 PM, the exit door located near the basement stairwell was a delayed egress door that releases on a 15 second delay. Observation revealed the door was not identified as a delayed egress door that opens after 15 seconds.	K 222		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain exit signs. This has the potential to affect all residents and staff located on the service level. The Findings include: It was observed on 09/26/2019 at 11:46 AM, the exit sign located at the employee entrance and loading dock misdirects the egress path of travel to a non exiting area.	K 293	1. The exit sign located at the employee entrance and loading dock was adjusted to ensure that the correct direction was provided for proper egress to exit the building. This was corrected on 9-27-19. 2. The other exit signs have the potential to be affected by this deficient practice which affects the residents and staff of the facility. The other exit signs were inspected on 10-10-19. 3. The Maintenance Department was re-educated on 10-11-19 about the importance of having exit signs provide the correct direction of egress from the building. 4. To ensure compliance, the Director of Maintenance (or designee) will audit weekly for 4 weeks then monthly for 3 months to ensure that the exit signs are providing the correct direction for egress from the building. This information will be forwarded to QAPI for review	10-18-19

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K 353	Continued From page 3	K 353		
K 353 SS=D	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 _________________________ 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 all residents and staff. The Findings include: It was observed on 09/26/2019 at 11:10 AM, a ground wire was tied to the sprinkler pipe located in the West ground floor electrical room.	K 353	1. The ground wire that was tied to the sprinkler pipe located in the West Ground electrical room was removed and reattached as required on 9-26-19. 2. This deficient practice affects the residents and staff of the facility. The Maintenance department inspected the sprinkler system pipes of the facility on 10-10-19 to ensure that there were no more ground wires tied to the sprinkler system pipes. 3. The Maintenance Department was re-educated on 10-11-19 about the importance of not having ground wires tied to the pipes of the sprinkler system. 4. To ensure compliance, the Director of Maintenance (or designee) will audit weekly for 4 weeks then monthly for 3 months to ensure that the sprinkler system pipes do not have ground wires tied to them. This information will be forwarded to QAPI for review.	10-18-19
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls	K 362	1. The unapproved spray foam that sealed the penetrations in the corridor wall above ceiling and around electrical conduits near room EG5 was removed and replaced with	

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K 362	Continued From page 4 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 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: Surveyor: 35701 Based on observation, the facility failed to maintain the construction of corridor walls. This has the potential to affect one smoke compartment. The Findings include: It was observed on 09/26/2019 at 11:30 AM, an unapproved spray foam was used to seal penetrations in the corridor wall above ceiling and around electrical conduits near room EG5.	K 362	the appropriate approved spray foam on 9-27-19. 2. The Maintenance Department inspected the other smoke barriers of the facility on 10-11-19 to ensure that the approved spray foam is used to seal the penetrations between those smoke barriers. 3. The Maintenance Department was re-educated on 10-11-19 about the importance of ensuring that the correct approved spray foam is used to seal the penetrations between smoke barriers. 4. To ensure compliance, the Director of Maintenance (or designee) will audit weekly for 4 weeks then monthly for 3 months to ensure that the correct approved spray foam is used to seal the penetrations between smoke barriers. This information will be forwarded to QAPI for review.	10-18-19
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that	K 374	1. The facility adjusted the smoke doors located near room East Ground 5 to ensure that they closed as required. The facility also repaired the latch on the door located in the South Main hallway near the med room that was not completely closing as required.	

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K 374	Continued From page 5 resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain smoke doors. This has the potential to affect one smoke compartment. The Findings include: It was observed on 09/26/2019 at 11:30 AM, the smoke doors located near room EG 5 was not completely closing. It was observed on 09/26/2019 at 12:34 PM, the smoke doors located in the South Main near the med room was not completely closing.	K 374	These doors were corrected on 9-27-19. 2. The other doors of the facility have to be affected by this deficient practice of not closing nor latching as required. The doors were inspected on 10-10-19. 3. The Maintenance Department was re-educated on 10-10-19 about the importance of ensuring that the doors of the facility close and latch as required. 4. To ensure compliance, the Director of Maintenance (or designee) will audit weekly for 4 weeks then monthly for 3 months to ensure that the doors of the facility close and latch as required. This information will be forwarded to QAPI for review.	10-18-19
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	K 511	1. The rack of cups located in the kitchen that obstructed access to the electrical equipment was moved and the electrical outlet located in room South Ground 7 was repaired so that it was properly mounted. Both of these items were corrected on 9-26-19. 2. The other electrical equipment and smoke departments could be affected by this some deficient practice.	

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K 511	Continued From page 6 This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain electrical equipment. This has the potential to affect all kitchen staff and one smoke compartment. The Findings include: It was observed on 09/26/2019 at 11:48 AM, the electrical panel located in the kitchen was obstructed by cup tray racks. It was observed on 09/26/2019 at 12:35 PM, the electrical outlet located in room SM7 along the right wall was not secured and properly mounted.	K 511	3. The Maintenance Department was re-educated on 10-11-19 about the importance of ensuring that electrical equipment not be obstructed and to have electrical outlets properly installed. 4. To ensure compliance, the Director of Maintenance (or designee) will audit weekly for 4 weeks then monthly for 3 months to ensure that the electrical equipment not be obstructed and to have electrical outlets properly installed. This information will be forwarded to QAPI for review.	10-18-19
K 918 SS=D	Electrical Systems - Essential Electric Syste 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 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	K 918	1. The facility will install a battery powered emergency lighting for the West Ground generator room which has the automatic transfer switch as well as for the room for the generator identified as kW55, this was completed on 10-17-19. The generator identified as kW80 will evaluated to ensure that it passes the annual load test. The generator pass the load test on 10-17-19. 2. The other rooms that have the generators located in them and the generators themselves have the potential to be affected by this deficient practice. The rooms where the generators are located were inspected on 9-27-19.	

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K 918	Continued From page 7 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. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, interview and record review, facility failed to maintain emergency generator set locations and equipment . This has the potential to affect all residents and staff. The Findings include: It was observed on 09/26/2019 at 11:10 AM, the automatic transfer switch for the emergency generator was located in the West ground floor electrical. Observation revealed the room was not equipped with battery powered emergency lighting. An interview with the maintenance supervisor confirmed that all areas where emergency generator and equipment are installed was not provided with battery powered emergency lighting. It was observed on 09/26/2019 at 11:19 AM, the emergency generator set location for the emergency generator identified as kW 55 located on the ground level was not provided with battery	K 918	3. The Maintenance Department was re-educated on 10-11-19 about the importance of ensuring that the rooms where the generators are located have battery powered emergency lighting and pass the annual load bank tests. 4. To ensure compliance, the Director of Maintenance (or designee) will audit weekly for 4 weeks then monthly for 3 months to ensure that the rooms where the generators are located have battery powered emergency lighting and they pass the annual load bank tests. This information will be forwarded to QAPI for review.	10-18-19

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K 918	Continued From page 8	K 918		

powerd emergency lighting.

A record review on 09/26/2019 at 12:58 PM revealed the emergency generator identified as kW 80 failed the annual load bank test on 10/12/2018. An interview with the maintenance supervisor confirmed the kW 80 generator was over heating at 80%.

7.3 Lighting.
7.3.1 The Level 1 or Level 2 EPS equipment location(s) shall
be provided with battery-powered emergency lighting. This
requirement shall not apply to units located outdoors in enclosures
that do not include walk-in access.
7.3.2 The emergency lighting charging system and the normal
service room lighting shall be supplied from the load side
of the transfer switch.
7.3.3* The intensity of illumination in the separate building or
room housing the EPS equipment for Level 1 shall be 32.3 lux
(3.0 ft-candles), unless otherwise specified by a requirement
recognized by the authority having jurisdiction.