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
	495233	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAUQUIER HEALTH REHABILITATION & NURS	360 HOSPITAL DRIVE WARRENTON, VA 20186

(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 single story skilled nursing facility. The facility is Type V (111) construction and is fully sprinklered. An unannounced recertification Life Safety Code survey was conducted on 11/15/2019 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	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.	
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 November 11, 2019 b) Who provided system test Siemens Building Technologies c) Water system supply source City of Warrenton Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K 353	On November 11, 2019, Siemens Building Technologies inspected the facility sprinkler system, signaling devices, valve tamper switches and water-flow devices. All residents have the potential to be impacted by the deficient practice. The administrator or designee will conduct a monthly review of all required inspections and due dates to ensure the facility schedules inspections in sufficient time to remain in compliance. Audits will be conducted monthly for three months then quarterly thereafter to ensure all inspections are completed as required. Findings will be reviewed, trended and deficient patterns reported to QAPI. Corrective action was completed on 11/11/19 and report received on November 23, 2019.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katy Reeves	Administrator	12/2/19

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 353	Continued From page 1 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 two smoke compartments. The Findings include: It was observed on 11/15/2019 at 10:49 AM, cables was tied to the sprinkler pipe hangers located in the attic above the TV room near the 100 hall nurses station. It was observed on 11/15/2019 at 10:57 AM, a sprinkler head located in the attic above the 100 hall near room 110 was covered with debris.	K 353	On November 21, 2019, the Facilities Engineer removed cable tied to the sprinkler pipe. A hanger was installed to provide support for the cable. On November 15, 2019, debris covering the sprinkler head was removed. All residents have the potential to be impacted by the deficient practice.	
K 372 SS=D	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: Surveyor: 35701 Based on interview and observation, the facility failed to maintain the smoke barrier construction.	K 372	Members of the maintenance/EVS staff will ensure semi-annual preventive maintenance procedure to inspect and resolve/correct any issues discovered at the time of inspection. To ensure compliance throughout the year, a monthly inspection of attic sprinkler heads will be conducted. Audits will be conducted monthly for three months then quarterly thereafter to ensure all inspections are completed as required. Findings will be reviewed, trended and deficient patterns reported to QAPI. Corrective action will be completed by December 30, 2019.	

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K 372	Continued From page 2 This has the potential to affect all residents and staff. The Findings include: An interview with the maintenance supervisor on 11/15/2019 at 10:29 AM revealed the smoke/fire damper testing and inspection reports was not available for review at the time of survey. It was observed on 11/15/2019 at 11:32 AM, the smoke barrier wall located in the attic of the 300 hall was compromised by an incomplete installation of a duct system designed to supply heat in the attic for the sprinkler system.	K 372	The system Director of Facilities was contacted on November 20, 2019, and asked to schedule the test. All residents have the potential to be impacted by the deficient practice. The administrator or designee will conduct a monthly review of all required inspections and due dates to ensure the facility schedules inspections in sufficient time to remain in compliance. Audits will be conducted monthly for three months then quarterly thereafter to ensure all inspections are completed as required. Findings will be reviewed, trended and deficient patterns reported to QAPI. Corrective action will be completed by December 30, 2019.	
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 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 compartment doors. This has the potential to affect two smoke compartments.	K 374	On November 21, 2019, the vents for the duct system were removed and a new dry wall installed to erect the required smoke barrier wall. All residents have the potential to be impacted by the deficient practice. Facility maintenance engineers will ensure any construction or renovation proposed for the facility will receive appropriate approval prior to work commencing and will be inspected once construction/renovations are completed. The administrator or designee will review plans and permits for any construction/ renovations made at the facility and final inspection reports to ensure all work is	

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K 374	Continued From page 3 The Findings include: It was observed on 11/15/2019 at 10:42 AM, the smoke door located in the TV room across from the 100 hall nurses station identified as a 20 minute fire door was not completely closing.	K 374	completed according to regulations. Work to correct the deficient practice was completed on November 23, 2019. On November 20, 2019, work was completed to correct the improperly closing of the fire door. The door was adjusted and oiled and inspected to ensure it closes properly. All residents have the potential to be impacted by the deficient practice. Fire doors will be inspected monthly to ensure proper operation. Audits will be conducted monthly for three months then quarterly thereafter to ensure inspections are being completed and doors are operating properly. Results will be tracked and trended and patterns of issues reported to QAPI. Corrective action will be completed by December 30, 2019. On November 26, 2019, all fire doors were inspected to ensure proper operation. Fire doors will continue to be inspected by facility maintenance staff monthly and reports maintained in binders in the maintenance office.	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors 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: Surveyor: 35701 Based on interview, the facility failed to document the fire door testing requirements in accordance with NFPA 101. This has the potential to affect all residents and staff. The Findings include: An interview with the maintenance supervisor on 11/15/2019 at 10:05 AM revealed the testing of fire doors was being conducted. Further interview revealed the testing of fire doors was not being documented.	K 761		

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K 761	Continued From page 4 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6 7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. 7.2.1.15.3 The inspection and testing interval for fire-rated and nonrated door assemblies shall be permitted to exceed 12 months under a written performance-based program in accordance with 5.2.2 of NFPA 80, Standard for Fire Doors and Other Opening Protectives. 7.2.1.15.4 A written record of the inspections and testing shall be signed and kept for inspection by the authority having jurisdiction. 7.2.1.15.5 Functional testing of door assemblies	K 761	All residents have the potential to be impacted by this deficient practice. Fire doors will be inspected monthly to ensure proper operation. Audits will be conducted monthly for three months then quarterly thereafter to ensure inspections are being completed and doors are operating properly. Results will be tracked and trended and patterns of issues reported to QAPI. Corrective action will be completed by December 30, 2019.	