FREDERICKSBURG
HEALTH AND REHAB

3900 Plank Road
Fredericksburg, VA 22407
phone 540 786 8351
fax 540 786 5599
fredericksburgrehab.com

July 2, 2018

Mr. Tony Dennis
Commonwealth of Virginia
Virginia Department of Fire Programs
State Fire Marshal's Office, Division II
471 James Madison Highway, Suite 10
Culpeper, VA 22701

Dear Mr. Dennis,

Please see the enclosed Plan of Corrections for the Life Safety Code survey conducted at our nursing center on 6/11/2018. Please note our date of correction is July 11, 2018.

If you have any questions regarding the enclosed, please call at (540) 786-8351.

Sincerely,

Kimberly Owens
Administrator

Attachment

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
	495240	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/11/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD FREDERICKSBURG, VA 22407**

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K 000	INITIAL COMMENTS Surveyor: 29282 Description of structure: The facility is a one story with a construction type of V (000). Sprinkler status: The facility is a fully sprinklered building. An unannounced Life Safety Code recertification survey was conducted 6/11/17 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the 2012 Life Safety Code 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 Regulations, 483.70(a) et seq (Life Safety from Fire.)	K 000	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts of the alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal law.	
K 325 SS=F	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30	K 325	K 325 1. Central Supply clerk tested and documented all hand sanitizer dispensers on 6/22/18. 2. An audit of hand sanitizer dispensers was completed on 6/22/18 by the Central Supply Clerk.	

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

[signature] ADMINISTRATOR July 2, 2018

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 325	Continued From page 1 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on document review and interview it was determined the health care facility failed to test alcohol based hand sanitizers. This has the possibility to affect 100% of the residents. The Findings Include: On 6/11/2018 at approximately 1:45 PM, it was revealed by document review the facility did not conduct tests of alcohol base hand sanitizers after each refill. An interview on 6/11/2018 at approximately 1:45 PM with the maintenance director confirmed this evidence.	K 325	3. Maintenance director re-educated the central supply clerk on testing hand sanitizer dispensers, to ensure each dispenser is tested after refill. Housekeeping staff will be educated on the testing of hand sanitizer dispensers when refilled. Central supply clerk or designee will record each time a dispenser is refilled and document the location, date of refill, and results of tests. Maintenance director will audit dispenser log to ensure they are checked when refilled. Audits will be completed weekly for 4 weeks, with corrective action taken immediately.	
K 353 SS=E	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	K 353	4. Results of audits will be reviewed in the monthly Quality Assurance Performance Improvement (QAPI) meeting. Any trends or issues will be addressed and re-education to take place as needed.	7/11/18

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K 353	Continued From page 2 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: 29282 Based on observations it was determined the health care facility failed to maintain components of the fire protection system. This has the possibility to affect 70% of the residents. The Findings Include: On 6/11/2018 at approximately 2:04 PM, it was identified by observation there was a missing ceiling tile in the dish room. On 6/11/2018 at approximately 2:05 PM, it was identified by observation there appeared to be corrosion on the sprinkler head in the dish room. On 6/11/2018 at approximately 2:22 PM, it was identified by observation there were missing ceiling tiles in the laundry room. On 6/11/2018 at approximately 2:41 PM, it was identified by observation there was a missing ceiling tile in PT printer room.(Corrected on site) On 6/11/2018 at approximately 3:08 PM, it was identified by observation there were wires resting on the sprinkler piping in the East 2 hallway. On 6/11/2018 at approximately 3:53 PM, it was identified by observation there was a missing	K 353	1. Maintenance staff replaced the ceiling tiles in the dish room, the laundry room, and housekeeping room on 6/12/18. Fire system contractor replaced the sprinkler head in the dish room on 6/27/18. Maintenance staff placed wires away from sprinkler piping in the East 2 hallway to prevent contact. 2. Maintenance staff checked areas above ceiling tiles in the communication room and other corridors to ensure the area of above sprinkler piping were clear. 3. Maintenance staff will be re-educated to ensure fire system is protected, including ensuring areas around sprinkler piping is clear. Maintenance staff will brief contractors prior to start of work required above ceiling tile to ensure fire system piping is protected. Maintenance will inspect areas worked by contractors at the completion of work to ensure areas are clear.	

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K 353	Continued From page 3 ceiling tile in the housekeeping sink room.	K 353	4. Results of the inspections will be reviewed in the monthly QAPI meeting. Any noted trends will be addressed immediately. Continued monitoring and/or further corrective action will be determined by the QAPI committee.	7/11/18
K 511 SS=E	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: 29282 Based on observation the facility failed to prevent electrical hazards. This has the possibility to affect 60% of the residents. The Findings Include: On 6/11/2018 at approximately 2:10 PM, it was identified by observation there was an open electrical box on the air conditioning unit in room 84. On 6/11/2018 at approximately 2:11 PM, it was identified by observation there was an open electrical box on the air conditioning unit in room 80. On 6/11/2018 at approximately 2:12 PM, it was identified by observation there was then the required clearance around the panel box in the communications room. On 6/11/2018 at approximately 2:25 PM, it was	K 511	K 511 1. Maintenance staff replaced the cover to the electrical boxes in rooms 84, 80, 72, and 6 on 6/12/18. Maintenance staff removed all items around the panel to ensure clearance in the to communications room on 6/12/18. Maintenance staff replaced the knock out from the junction box across from room 60 on 6/12/18. Maintenance staff discarded the power strip from the MDS office on 6/11/18. Maintenance replaced the cover plate on the outlet in the NP office on 6/12/18.	

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K 511	Continued From page 4 identified by observation there was an open electrical box on the air conditioning unit in room 72. On 6/11/2018 at approximately 2:21 PM, it was identified by observation there was a knock out missing from a junction box above ceiling across from room 60. On 6/11/2018 at approximately 3:35 PM, it was identified by observation there was an open electrical box on the air conditioning unit in room 6. On 6/11/2018 at approximately 3:38 PM, it was identified by observation there were exposed wires on a power strip in the NDS office. On 6/11/2018 at approximately 3:40 PM, it was identified by observation there was a missing cover plate in the NP office.	K 511	K 511 (Cont) 2. Residents residing in the facility are at risk for same deficient practices. 3. Staff will be re-educated on fire safety, including preventing and reporting electric hazards. Maintenance staff and Department Heads will conduct daily rounds Monday – Friday to observe, report and/or correct issues relating to fire safety or electrical hazards. Rounds will be discussed daily in the morning stand up and stand down meetings Monday thru Friday. Staff who observe issues relating to fire safety will correct and/or report the issue to maintenance, using the maintenance log book.	
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to control dryer lint accumulation. This has the possibility to affect 30% of the residents.	K 521		

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K 521	Continued From page 5 The Findings Include: On 6/11/2018 at approximately 2:35 PM, it was identified by observation there was an excessive accumulation of dryer lint behind the dryers in the laundry room.	K 521	K 511 (Cont) Maintenance will review log book Monday thru Friday and make corrections. Rounds will be an ongoing quality assurance process Monday – Friday. Maintenance director or designee is on call 24 hours per day for emergencies. 4. Results of audits will be reviewed in the monthly QAPI meeting. Any trends or issues will be discussed and addressed immediately. K 521 1. Housekeeping supervisor removed the lint behind the dryers in the laundry room on 6/12/18. 2. Housekeeping supervisor checked dryer lint traps and areas around the dryers in the laundry room.	7/11/18
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to maintain control of the proper use of electrical components. This has the possibility to affect 70% of the residents.	K 920		

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K 920	Continued From page 6 The Findings Include: On 6/11/2018 at approximately 2:13 PM, it was identified by observation there was a power strip in use within the patient care vicinity in room 83. On 6/11/2018 at approximately 2:21 PM, it was identified by observation there was a power strip in use within the patient care vicinity in room 73. On 6/11/2018 at approximately 2:22 PM, it was identified by observation there was an extension cord in use in room 64. On 6/11/2018 at approximately 2:25 PM, it was identified by observation there was an extension cord in use in room 62. On 6/11/2018 at approximately 2:27 PM, it was identified by observation there were daisy chained power strips in room 71. On 6/11/2018 at approximately 2:30 PM, it was identified by observation there was a power strip in use within the patient care vicinity in room 71. On 6/11/2018 at approximately 2:47 PM, it was identified by observation there were daisy chained power strips in the West 2 nurse station. On 6/11/2018 at approximately 2:56 PM, it was identified by observation there was a power strip in use within the patient care vicinity in room 72. On 6/11/2018 at approximately 2:59 PM, it was identified by observation there was a power strip in use within the patient care vicinity in room 46. On 6/11/2018 at approximately 3:13 PM, it was identified by observation there was a power strip	K 920	K 521 (Cont) 3. Housekeeping staff was re-educated on fire safety within the laundry department, to ensure lint accumulation is not present behind the dryers. Housekeeping supervisor will conduct daily inspections, Monday - Friday to ensure lint accumulation is not present. Issues identified will be corrected immediately. 4. Results of audits will be reviewed during the monthly QAPI meeting. Any trends or discrepancies will be discussed and corrected immediately. K 920 1. Maintenance staff removed power strips from within the patient care vicinity of rooms 83, 73, 64, 62, 71, 72, 46, 6, and 16. Resident equipment and items were re-organized so that electrical outlets or approved multiuse plug	7/11/18

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K 920	Continued From page 7 in use within the patient care vicinity in room 16TL. On 6/11/2018 at approximately 3:18 PM, it was identified by observation there was a power strip in use within the patient care vicinity in room 15. On 6/11/2018 at approximately 3:26 PM, it was identified by observation there was an unapproved multi plug in use in the training room. On 6/11/2018 at approximately 3:34 PM, it was identified by observation there was a power strip in use within the patient care vicinity in room 6. On 6/11/2018 at approximately 3:36 PM, it was identified by observation there were daisy chained power strips in the NDS office. On 6/11/2018 at approximately 3:37 PM, it was identified by observation there was an unsupported power strip in the NDS office. On 6/11/2018 at approximately 3:45 PM, it was identified by observation there was an unsupported power strip in the conference room.	K 920	K 920 (Cont) and items were re-organized so that electrical outlets or approved multiuse plug installed. Maintenance staff removed daisy chains power strips and re-organized equipment at the West 2 nurses station and MDS office. Maintenance staff replaced power strips in the MDS office and Conference Room to ensure support. 2. Residents residing in facility are at risk for this same deficient practice. 3. Maintenance staff will be re-educated on electrical safety, to ensure proper use of electric devices are in place. Department heads and maintenance will conduct rounds Monday – Friday to ensure electrical equipment have proper power cords and/or not used within patient care vicinity. Rounds will be discussed daily in the morning stand up and stand	
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	K 923		

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K 923	Continued From page 8 separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of 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: 29282 Based on observation the facility failed to maintain control of oxygen storage and signage. This has the possibility to affect 50% of the residents. The Findings Include: On 6/11/2018 at approximately 3:00 PM, it was identified by observation there was oxygen stored in the exit corridor by room 53. On 6/11/2018 at approximately 3:04 PM, it was identified by observation there was an oxygen	K 923	K 920 (Cont.) down meetings Monday thru Friday. Rounds will be an ongoing quality assurance process Monday – Friday. 4. Results of audits will be discussed and reviewed in the monthly QAPI meeting. Any trends or issues identified will be addressed and re-education as needed. K 923 1. Maintenance staff removed the oxygen cylinder from the exit corridor by room 53 on 6/11/18. Nursing staff placed oxygen in use sign by the door of room 2 on 6/11/18. 2. Maintenance staff conducted facility rounds on 6/12/18 to ensure oxygen cylinders were stored properly and/or in racks. Nursing staff reviewed residents on oxygen to ensure oxygen in use signs were present for residents on oxygen.	7/11/18

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K 923	Continued From page 9 concentrator in use in room 2 without signage. On 6/11/2018 at approximately 3:28 PM, it was identified by observation there was an oxygen cylinder stored not in a rack in the large courtyard corridor.(Corrected on site)	K 923	K 923 (Cont) 3. Staff will be re-educated on oxygen safety and storage by Maintenance Director of designee. Department heads and maintenance will conduct rounds Monday – Friday to ensure oxygen is stored properly and/or residents using oxygen have oxygen in use signage present. Rounds will be discussed daily in the morning stand up and stand down meetings Monday thru Friday. Rounds will be an ongoing quality assurance process Monday – Friday. 4. Results of audits will be discussed and reviewed in the monthly QAPI meeting. Any trends or issues identified will be addressed and re-education as needed.	7/11/18