COMMONWEALTH of VIRGINIA

Virginia Department of Fire Programs

Michael T. Reilly
EXECUTIVE DIRECTOR

Brian M. McGraw, P.E.
STATE FIRE MARSHAL

State Fire Marshal's Office
Division 1
1005 Technology Park Drive
Glen Allen, VA 23059-4500
Phone: 804/ 371-0220
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09/13/2018

Mr. Matthew Farmer,
Glenburnie Rehab & Nursing Center
1901 Libbie Ave
Richmond, VA 23226

Dear Mr. Farmer

This concerns the unannounced recertification Life Safety Code survey of the referenced facility conducted 09/04/2018 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the Life Safety Code 2000 Existing regulation.

All institutional buildings must meet all applicable Life Safety Code (NFPA 101) requirements in accordance with the federal Long Term Care certification requirements issued by the Centers for Medicare and Medicaid Services (CMS), in order to participate in the Medicare/Medicaid programs. The findings listed on the attached form, CMS 2567, "Statement of Deficiencies and Plan of Correction", demonstrate non-compliance with Title 42 Code Federal of Regulations, 483.70(a) et seq Life Safety from Fire.

Prior to making expenditures to correct the noted deficiencies, you should have an approved plan of correction. It is strongly recommended that you check with local officials, since compliance with this report does not excuse you from complying with local codes and ordinances.

The federal LTC Enforcement Regulations remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) and/or the Virginia Department of Medical Assistance Services (DMAS) for any failure or continued failure to demonstrate compliance with both the Health and Life Safety Code requirements (Title 42, Code of Federal Regulations). For example, a Denial of Payment for New Admissions at the 90th day after a survey, or the Termination of the Provider Agreement at the 180th day after a survey, could be a result of uncorrected Life Safety Code citations as well as Health citations.

If any deficient practice is identified within either the Health or Life Safety Code requirements, a Plan of Correction (POC) developed by the provider must be returned to the surveying entity by 9/24/2918. To be considered acceptable, the POC must include five (5) components:

1. Address the corrective action taken for the identified problem
2. Address how facility will identify similar occurrences of the problem
3. Identify measures/systemic changes to ensure deficient practice will not recur
4. Indicate how facility will monitor its performance
5. Date of correction, not to exceed 45th day after the survey.

NOTE: If correction/compliance by the 45th day after the survey is not possible, the facility's POC must be accompanied by a Time-Limited Waiver request with appropriate justification. The waiver request and supporting documentation will be reviewed by the State Fire Marshal's Office and the Virginia Department of Health for a final recommendation to CMS. Please be aware, the timeline involved in the Time Limited Waiver request and final approval process does not delay the potential imposition of enforcement actions.

If concerns regarding a citation are not resolved, in accordance with §488.331, the facility has one (1) opportunity to question cited deficiencies through the current Virginia Department of Health's informal dispute resolution (IDR) process . To be considered, the IDR request must be received by the State Fire Marshal's Office within 10 calendar days of your receipt of the enclosed survey findings. An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions taken by CMS or DMAS.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

If you have any questions or if we may be of assistance to you, please call (804) 840-3523.

Sincerely,

Franklin Troy Bower

F. Troy Bower
State Fire Marshal's Office

Attachment
/
cc: file

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 09/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495391	A. BUILDING **01 - BUILDING 01** B. WING _____	**09/04/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBURNIE REHAB & NURSING CENTER	**1901 LIBBIE AVE RICHMOND, VA 23226**

(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: 39900 Description of structure: The facility is a two story Type II (111). Sprinkler Status: Fully sprinklered - NFPA 13 An unannounced Standard Recertification Life Safety Code Survey was conducted on 9/4/18 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 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		
K 100 SS=D	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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. This REQUIREMENT is not met as evidenced by: Surveyor: 39900 Based upon observations the kitchen hood vents were not properly kept clean per SFPC 609.3.3.1. Findings include: On 9/4/2018, between 9:30am and 12:30pm, it	K 100	1. The Kitchen hood vents were all cleaned the same day as the inspection survey. 2. There are no other hood vents other than Dietary. 3. Hood Vents will be inspected weekly to insure ongoing cleaning standards are met. 4. Performance will be monitored by the Food Service Manager on a weekly basis K 100	9-4-18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Matthew C Jarman — TITLE: Administrator — (X6) DATE: 9-17-18

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

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K 100	Continued From page 1 was observed that the kitchen hood vents were too greasy.	K 100		
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 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	K 222	K 222 1. The exit doors by the Kitchen bathroom and by the employee breakroom magnetic locks were repaired on 9-5-18 and now are functioning as designed. 2. All exit doors are checked daily to ensure egress requirements are met. 3. Maintenance will maintain inspections, monthly of all egress doors. 4. Compliance will be maintained by monthly inspections.	9-5-18

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K 222	Continued From page 2 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: Surveyor: 39900 Based upon observations there are 15 second time delay locks that restrict the full operation of the doors so occupants can egress to an exit. Findings include: On 9/4/2018, between 9:30am and 12:30pm, it was observed that the emergency egress door by kitchen bathrooms was not releasing after 15 seconds. On 9/4/2018, between 9:30am and 12:30pm, it was observed that the emergency egress door by the employee lounge was not releasing after 15 seconds.	K 222		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101	K 291		

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K 291	Continued From page 3 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Surveyor: 39900 Based upon observations there are areas that do not have the required emergency lighting. Findings include On 9/4/2018, between 9:30am and 12:30pm, during review of documentation it was observed that there were no records of annual/monthly emergency light inspections. On 9/4/2018, between 9:30am and 12:30pm, it was observed that the exit sign had a dead battery at end of hallway 2nd floor by human resources.	K 291	K 291 1. Emergency light inspections are conducted weekly and new batteries were installed in the two lights addressed in the report, same day as the survey. 2. All lights will be checked weekly and logs will be maintained by Maintenance to record compliance. 3. All Lights will be checked weekly to insure that they illuminate properly. 4. Monitoring of compliance will be conducted by weekly inspections.	9-4-18
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.	K 321	1. 1. The doors to Human Resources, the Boiler room were repaired the day of survey. The door in the Kitchen prop was removed the day of survey and staff was instructed not to prop open again. 2. All doors will be checked Monthly to insure proper closure. 3. Audits conducted monthly. 4. Maintenance will inspect monthly for ongoing compliance.	9-4-18

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K 321	Continued From page 4 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 39900 Based upon observations hazardous areas are not maintained to provide required separation and or fire resistant ratings for the hazardous areas. There are doors that are not self closing and latching, are damaged and doors that do not have the required listing for door hardware that could allow smoke and hot gasses to pass through the doors. Findings include: On 9/4/2018, between 9:30am and 12:30pm, it was observed that the fire rated storage room door by human resources 2nd floor not shutting/latching. On 9/4/2018, between 9:30am and 12:30pm, it was observed that the fire rated door closer was disconnected on boiler room door at main dining room. On 9/4/2018, between 9:30am and 12:30pm, it was observed that the fire rated door to the dry storage room in kitchen was held open with an unapproved device. On 9/4/2018, between 9:30am and 12:30pm, it	K 321		

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K 321	Continued From page 5 was observed that the rated soiled utility door in Bradford was not latching automatically.	K 321		
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: 39900 Based upon observations of the sprinkler system that the required maintenance of the system is not being maintained. Ciling tiles were missing/damaged in multiple locations. Findings include: On 9/4/2018, between 9:30am and 12:30pm, it was observed that there were ceiling tiles missing in the stairwell on the 2nd floor. On 9/4/2018, between 9:30am and 12:30pm, it was observed that there were ceiling tiles missing in the stairwell on the 2nd floor.	K 353		
K 363	Corridor - Doors	K 363		

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K 363 SS=D	Continued From page 6 CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K 363	1. The door to Room # 121's closure latch was repaired day of survey. 2. Doors will be checked for proper closure by Maintenance on a monthly basis. 3. Inspections regarding proper room door closure will occur monthly. 4. Maintenance will monitor via monthly inspections.	9-4-18

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K 363	Continued From page 7 This REQUIREMENT is not met as evidenced by: Surveyor: 39900 Based upon observations of all corridor doors there are doors found that did not have positive latching that could allow smoke to pass through the doors. Findings include: On 9/4/2018, between 9:30am and 12:30pm, it was observed that patient room door number 121 not latching when shut.	K 363		
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: 39900 Based upon observations the fire rated smoke barrier walls have penetrations, joints and openings that are not fire stopped and could allow smoke to pass from one side of the smoke barrier to the other side. Findings include:	K 372	1. The penetration opening in the fire wall was sealed with Fire Caulk the day of survey. 2. All Fire Wall partitions have been inspected and no other penetrations were noted. 3. Inspections of fire wall penetrations will take place subsequent to any construction or new wire cabling by Maintenance to insure all are sealed properly. 4. Monitoring for ongoing compliance as addressed in #3.	9-4-18

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K 372	Continued From page 8 On 9/4/2018, between 9:30am and 12:30pm, it was observed that there was a penetration in the smoke barrier wall above the ceiling at cross corridor doors by human resources 2nd floor.	K 372		