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 A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED
	495420		03/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBEMARLE HEALTH AND REHABILITATION	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

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K 000	INITIAL COMMENTS Surveyor: 35701 The Facility is a single story dually certified facility. The Facility is Type V (111) construction and is fully sprinklered. An unannounced recertification Life Safety Code survey was conducted on 03/01/2017 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 not to be in compliance with the Requirements for Participation for Medicare and Medicaid. The Findings that follow demonstrate non-compliance with title 42 Code of Regulations. Part 483.150 and 410 to 480 (Life safety from Fire).	K 000	**Albemarle Health and Rehab Annual Live Safety Code** survey ending: **3/1/2017** The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. **Final Date of Completion 4/5/2017**	
K 211 SS=D	NFPA 101 Means of Egress - General 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 Standard is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain the exit discharge. The Findings include: It was observed on 03/01/2017 at 1:10 PM, the exit discharge near the kitchen was obstructed by wheelchairs and a flat bed cart.	K 211	**3/1/17** **How the corrective action will be accomplished for the resident(s) affected.** Items noted were removed day of inspection 3/1/17 **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Maintenance Director or designee will monitor daily for compliance. **Measures in place to ensure practices will not occur.**	

			Maintenance Director will in-service staff and contractors on exit blocking/discharge.. **How the facility plans to monitor and ensure correction is achieved and sustained.** Non-compliance will be submitted to QA/safety committee for review and correction as needed	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[illegible]	Administrator	3/14/17

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 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing 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 Standard is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain the sprinkler system. The Findings include: It was observed on 03/01/2017 at 12:36 PM, a sprinkler head located in the foyer of suite 201/202 was painted.	K 353	**How the corrective action will be accomplished for the resident(s) affected.** Painted sprinkler head to be replaced in foyer of suite 201/202 by 3/24/17 **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Maintenance Director or designee to monitor monthly and after contractors is painting occurs. **Measures in place to ensure practices will not occur.** Contractor to check quarterly when doing sprinkler inspection. **How the facility plans to monitor and ensure correction is achieved and sustained.** QA/safety committee to be notified of any found to be repaired at time of findings.	
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie 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.	K 372	**3/3/17** **How the corrective action will be accomplished for the resident(s) affected.** 100 Unit electrical closet conduit opening and cables fire caulked and sealed. Spray foam removed from penetrations and fire caulked in electrical room near HR office, all completed 3/3/17 **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Maintenance Director or designee to monitor/remove/replace any unapproved spray foam on penetrations with approved fire caulk on quarterly rotation	

			Measures in place to ensure practices will not occur. Maintenance Director to in-service any contractors on correct way to seal any penetrations with approved materials. **How the facility plans to monitor and ensure correction is achieved and sustained.** Violations to be reported to QA/Safety committee for follow up and compliance.	

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K 372	Continued From page 2 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 Standard is not met as evidenced by: Surveyor: 35701 Based on observation and interview, the facility failed to maintain the smoke barrier. The Findings includes: It was observed on 03/01/2017 at 12:22 PM, unsealed penetrations in the smoke barrier located in the 100 Unit electrical closet in the attic at the conduit openings of IT data cables and fire alarm cables. It was observed on 03/01/2017 at 1:30 PM, unapproved spray foam was used to seal penetrations in the electrical room located in the main hall near the human resources office. An interview with the maintenance supervisor on 03/01/2017 at 1:35 PM revealed documentation was not available to support the use of or clarify that the spray foam used was approved.	K 372	3/3/17 **How the corrective action will be accomplished for the resident(s) affected.** 100 Unit electrical closet conduit opening and cables fire caulked and sealed. Spray foam removed from penetrations and fire caulked in electrical room near HR office, all completed 3/3/17 **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Maintenance Director or designee to monitor/remove/replace any unapproved spray foam on penetrations with approved fire caulk on quarterly rotation **Measures in place to ensure practices will not occur.** Maintenance Director to in-service any contractors on correct way to seal any penetrations with approved materials. **How the facility plans to monitor and ensure correction is achieved and sustained.** Violations to be reported to QA/Safety committee for follow up and compliance.	
K 711 SS=D	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan	K 711	4/5/17 **How the corrective action will be accomplished for the resident(s) affected.** Horizontal exits added to floor plans with written instruction sheet completed 3/24/17.. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.**	

			Maintenance Director to monitor and make changes if needed to stay current. In-service staff of changes made. **Measures in place to ensure practices will not occur.** Drawing/written section to be updated, added to floor plans, and reviewed by Maintenance Director **How the facility plans to monitor and ensure correction is achieved and sustained.** QA/Safety committee to review annually, make any changes needed to meet current code.	

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K 711	Continued From page 3 addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This Standard is not met as evidenced by: Surveyor: 35701 Based on the review of records, the facility failed to maintain the emergency evacuation plan. The Findings include: A review of records on 03/01/2017 at 11:08 AM revealed the horizontal exits was not identified in the evacuation plan.	K 711		

K 754 SS=D	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This Standard is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain trash containers.	K 754	3/1/17 **How the corrective action will be accomplished for the resident(s) affected.** Container overfill on 100 hallway corrected day of inspection, 3/1/17. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Unit Manager/charge nurse or designee to monitor daily. If overfill noted, Housekeeping Director will be notified to remove and replace container. **Measures in place to ensure practices will not occur.** Staff will be in-serviced as to fill level not to be exceeded. **How the facility plans to monitor and ensure correction is achieved and sustained.** Violations will be reported to QA/safety committee for immediate compliance.	

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K 754	Continued From page 4 The Findings include: It was observed on 03/01/2017 at 12:15 PM, a regulated medical waste container located in the 100 Unit soiled utility room was overfilled exceeding the capacity of the container.	K 754		

K 902 SS=E	NFPA 101 Gas and Vacuum Piped Systems - Other Gas and Vacuum Piped Systems - Other List in the REMARKS section any NFPA 99 Chapter 5 Gas and Vacuum Systems 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 5 (NFPA 99) This Standard is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to properly store oxygen cylinders in accordance with NFPA 99 2012 edition. The Findings include: It was observed on 03/01/2017 at 11:39 AM, 23 E cylinders of oxygen was stored in the 400 Unit Central Supply oxygen storage room. Electrical switches was observed installed below 5 feet from the surface of the floor without physical protection. It was observed on 03/01/2017 at 12:12 PM, 24 E cylinders of oxygen was stored in the 100 Unit Central Supply oxygen storage room. Electrical switches was observed installed below 5 feet from the surface of the floor without physical protection.	K 902	3/9/17 **How the corrective action will be accomplished for the resident(s) affected.** Metal covers installed over switches on 100, 200, 300 and 400 central supply 02 oxygen storage rooms on 3/9/17. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** Maintenance Director or designee to check weekly for damage. In-service staff to report damage via work order system if noted on off shifts. **Measures in place to ensure practices will not occur.** In-service maintenance assistant, contractors of any electrical repairs that protective cover must be in place. Verify if any work completed in oxygen storage rooms. **How the facility plans to monitor and ensure correction is achieved and sustained.** QA/safety committee to be notified of any damage or non-compliance to be repaired.	

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K 902	Continued From page 5 It was observed on 03/01/2017 at 12:39 PM, 27 E cylinders of oxygen was stored in the 200 Unit Central Supply oxygen storage room. Electrical switches was observed installed below 5 feet from the surface of the floor without physical protection. NFPA 99 2012 edition: 5.1.3.3.2* Design and Construction. Locations for central supply systems and the storage of positive-pressure gases shall meet the following requirements: (1) They shall be constructed with access to move cylinders, equipment, and so forth, in and out of the location on hand trucks complying with 11.4.3.1.1. (2) They shall be secured with lockable doors or gates or otherwise secured. (3) If outdoors, they shall be provided with an enclosure (wall or fencing) constructed of noncombustible materials with a minimum of two entry/exits. (4) If indoors, they shall be constructed and use interior finishes of noncombustible or limited-combustible materials such that all walls, floors, ceilings, and doors are of a minimum 1-hour fire resistance rating. (5)*They shall be compliant with NFPA 70, National Electrical Code, for ordinary locations. (6) They shall be heated by indirect means (e.g., steam, hot water) if heat is required.	K 902		

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K 902	Continued From page 6 (7) They shall be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full, or empty. (8)*They shall be supplied with electrical power compliant with the requirements for essential electrical systems as described in Chapter 6. (9) They shall have racks, shelves, and supports, where provided, constructed of noncombustible materials or limited-combustible materials. (10) They shall protect electrical devices from physical damage.	K 902		