LUCY CORR

CARE THAT CONTINUES WITH YOU

May 24, 2019

Darnell Weatherington
Deputy State Fire Marshal
State Fire Marshal's Office
Division 1 Office
1005 Technology Park Drive
Glen Allen, Virginia 23059

Mr. Weatherington:

Please find enclosed the Plan of Correction (POC) for the locations listed as "MAIN BUILDING", "DALE NORTH", and "BERMUDA WING NURSING STATION" for citations you issued on the annual Life Safety Inspection at the Health Care Center Lucy Corr that occurred on May 7, 2019. All items contained within the POC will be completed by June 11, 2019.

If you have any questions regarding the enclosed POC, please contact me directly.

Regards,

Renee Allen

Renee Allen, Administrator
Rallen@lucycorr.org
(804) 706-5730

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 01 B. WING	(X3) DATE SURVEY COMPLETED
	495079		05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE CENTER LUCY CORR	6800 LUCY CORR BLVD CHESTERFIELD, VA 23832

(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 Description of structure: The facility is 2 story building with a construction type of II (111) Sprinkler status: Fully Sprinklered An unannounced routine recertification Life Safety Code survey was conducted on 7 May 2019, 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 in 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 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Smoke detectors must be properly inspected and maintained Based on observation the smoke detectors are not being properly maintained. On 7 May 2019 at approximately 1345 hrs it was observed that: * The smoke detector in room 220 was not properly mounted on its ceiling base.	K 347	**Corrective Action** The detectors in rooms 220 & 225 were fixed. A facility Incident & Accident Report was completed for this finding. **Identification of Deficient Practice and Corrective Action** All facility ceiling mounted smoke detectors could be affected. The maintenance staff will conduct a 100% audit of all smoke detectors. Any negative findings will be corrected upon discovery and a facility I&A form completed. **Systemic Change(s)** Policy on inspection was reviewed and no changes are needed at this time. Maintenance staff will be in-serviced on the proper inspection and frequency of smoke detectors. **Monitoring** The Maintenance Director is responsible for maintaining compliance. Weekly visual audits will be done to monitor compliance. Negative findings will be corrected upon discovery. A facility I&A will be completed for negative findings and all I&A findings will be reported to the facility Quality Assurance Committee. **Completion Date**: 6/11/2019	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Renee Allen TITLE Administrator (X6) DATE 5/24/19

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 347	Continued From page 1 CORRECTED * The smoke detector in room 225 was not properly mounted on its ceiling base. CORRECTED These observations were witnessed by the facility's Director of Maintenance.	K 347		
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 _____ 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: The automatic sprinkler system is not being inspected on a regular bases. Based on observation the sprinkler system is not being properly maintained. * On 7 May 2019 at approximately 1115 hrs. it was observed that the sprinkler heads in the second floor pantry lobby and hallway are coated.	K 353	**Corrective Action** The sprinkler heads located in the 2nd floor pantry lobby and hallway has been cleaned. The sprinkler in the dietician's office has been cleaned. A facility Incident and Accident form has been completed to document these findings. **Identification of Deficient Practice and Corrective Action** All other facility sprinkler heads may have been affected. The maintenance staff will conduct a 100% visual inspection of all sprinkler heads. Any unclean heads will be corrected immediately. A facility I&A form will be filled out for any negative findings. **Systemic Changes** The facility policy on sprinkler head maintenance has been reviewed and no changes are needed at this time. Maintenance staff will be in-serviced on policy and procedure. **Monitoring** The Maintenance Director is responsible for compliance. Weekly, the Director or their designee will do random unit inspections for sprinkler heads. Negative findings will be corrected immediately and a facility I&A form will be completed. Weekly audits and I&A forms will be forwarded to the QA committee for tracking and trending. **Completion Date**: 6/11/2019	

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K 353	Continued From page 2 * On 7 May 2019 at approximately 1415 hrs. it was observed that the sprinkler heads in the Dietician's office are coated. These observations were witnessed by the facility's Director of Maintenance.	K 353		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interviews the Portable fire extinguishers are not being properly maintained. On 7 May 2019 at approximately 1315 hrs it was observed that the kitchen fire extextinguishers are not being maintained. * The pin is pulled on the UL 300 fire extinguisher in the kitchen. CORRECTED * The pin is pulled on the10 pound ABC fire extinguisher in the kitchen. CORRECTED These observations were witnessed by the facility's Director of Maintenance.	K 355	**Corrective Action** The pins for UL300 fire extinguisher and the 10 pound extinguisher have been corrected and a facility I&A form completed. **Systemic Changes** All kitchen area extinguishers may have been affected and each will be inspected by maintenance staff with negative findings fixed immediately and a facility I&A filled out. **Identification of Deficient Practice and Corrective Action** Policy for extinguishers has been reviewed with no changes needed. Maintenance staff will be in-serviced on policy. **Monitoring** The Maintenance Director is responsible for compliance. Weekly, the director or his designee will inspect all kitchen extinguishers. Negative findings will be corrected immediately and a facility I&A form completed. All findings will be sent to the QA committee for analysis. **Completion Date**: 6/11/2019	
K 363 SS=E	Corridor - Doors 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	K 363	**Corrective Action** The following doors have been adjusted to allow for them to latch: • 2nd floor hallway door near room 501 • Storage room by Chaplin's Office • Dale/Clover Hill door by sprinkler control valve for the dry system • Accounting storage room door	

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K 363	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the fire doors do not provide corridors and storage areas with protection from smoke or heat. * On 7 May 2019 at approximately 1130 hrs. it	K 363	Continued from page 3 A facility Incident & Accident form was completed for these doors that did not latch. **Identification of Deficient Practice and Corrective Action** All facility fire door could possibly be affected. Maintenance staff will inspect all facility fire doors for latching and will immediately correct any negative finds to include completion of a facility I&A form. **Systematic Changes** The facility policy and procedure have been reviewed and no revisions are necessary at this time. Maintenance staff will be in-serviced on the door inspection process. **Monitoring** The Maintenance Director is responsible for compliance. The director or designee will do weekly random audits of facility fire doors for latching. Any negative findings will be corrected at the time of discovery. A facility I&A form will be completed and forwarded to the QA committee for tracking and trending. **Completion date**: 6/11/2019	

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K 363	Continued From page 4 was observed that the fire door on the second floor at the end of the hall near room 501 does not latch. * On 7 May 2019 at approximately 1200 hrs. it was observed that the storage room door in the fine dining room next to the Chaplin's Office does not latch. * On 7 May 2019 at approximately 1445 hrs. it was observed that the fire door between the Dale Unit and Cloverhill Unit near the sprinkler control valve for the dry system does not latch. On 7 May 2019 at approximately 1130 hrs. it was observed that the self latching storage room door in the accounting office does not latch. These observations were witnessed by the facility's Director of Maintenance.	K 363		
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical 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 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and inspections, it was observed that the Electrical Systems is not properly maintained. On 7 May 2019 at approximately 1100 hrs. it was observed that there is exposed electrical wiring on a junction box in the ceiling of the second floor	K 911	**Corrective Action** The electric box located in the ceiling of the outside covered porch has been corrected. A facility I&A form was completed. **Identification of Deficient Practice and Corrective Action** All 4 of our outdoor porches may be affected. The Maintenance Staff will do a 100% audit of all porches for ceiling electrical box covers. Negative findings will be corrected upon discovery and a facility I&A form completed. **Systemic Changes** The facility policy and procedure for electrical work has been inspected and no changes are necessary. Maintenance Staff will be in-serviced on covering exposed electrical boxes **Monitoring** The Maintenance Director is responsible for maintaining compliance. The maintenance	

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K 911	Continued From page 5 porch (missing ceiling fan). CORRECTED These observations were witnessed by the facility's Director of Maintenance.	K 911	Continued from page 5 director or designee will inspect all porches weekly. Negative findings will be fixed if found and a facility I&A form completed and sent to the QA committee for tracking/trending. **Completion date:** 6/11/2019	
K 923 SS=E	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 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	K 923	**Corrective Action** The cylinder containing Helium was secured and stored properly. A facility Incident and Accident report was completed. **Identification of Deficient Practice and Corrective Action** All cylinders in storage may have been affected. The Director of Maintenance will conduct a 100% audit of all stored cylinders. Any negative findings will be corrected immediately and a facility I&A report completed. **Systemic Changes** The policy on storage of compressed gas cylinders has been reviewed and no changes were needed. Central Supply and Maintenance Staff will be in-serviced on the proper storage of cylinders. **Monitoring** The Central Supply Manager is responsible for compliance. The Supply Manager will conduct weekly audits to assure all cylinders are stored safely and per policy. All negative findings will be corrected immediately and a facility I&A report filled out. All findings will be forwarded to the QA committee for tracking and trending. **Completion Date**: 6/11/2019	

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K 923	Continued From page 6 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: Based on observation and interviews, pressurized cylinders are not being properly stored and secured. On 7 May 2019 at approximately 1330 hrs. it was observed that pressurizied cylinders in the warehouse next to the drop down door are not being properly secured. CORRECTED These observations were witnessed by the facility's Director of Maintenance.	K 923		

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K 000	INITIAL COMMENTS Description of structure: The facility is 2 story building with a construction type II protected Sprinkler status: Fully Sprinklered An unannounced routine recertification Life Safety Code survey was conducted on 7 May 2019, 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 in 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 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 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.	K 353	**Corrective Action** The sprinkler heads at the Dale shower room have been cleaned. A facility Incident and Accident report has been completed for this negative finding. **Identification of Deficient Practice and Corrective Action** All sprinkler heads in the facility may be affected. A 100% audit of all sprinkler heads will be conducted by Maintenance staff and negative findings corrected upon discovery and a Facility I&A report filed. **Systemic Changes** Facility policy and procedure for sprinkler inspection and condition has been reviewed and no changes are needed at this time. Maintenance staff will be in-serviced on inspection and condition of sprinklers.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kane Allen
TITLE: Administrator
(X6) DATE: 5/24/19

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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: The automatic sprinkler system is not being inspected on a regular bases. Based on observation the sprinkler system is not being properly maintained. * On 7 May 2019 at approximately 1450 hrs. it was observed that the sprinkler heads in the Dale Unit Bathing/Shower room on the right side on the entrance door are coated. These observations were witnessed by the facility's Director of Maintenance.	K 353	Continued from page 1 **Monitoring** The Director of Maintenance is responsible for compliance. The Director or his designee will conduct weekly random rounds on all units for the condition of sprinklers. Any negative findings will be corrected at the time of discovery and an I&A report filed with the QA Committee for tracking and trending. **Completion Date**: 6/11/2019	

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K 000	INITIAL COMMENTS Description of structure: The facility is 2 story building with a construction type of II (111) Sprinkler status:Fully Sprinklered An unannounced routine recertification Life Safety Code survey was conducted on 7 May 2019, 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 in 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 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Smoke detectors must be properly inspected and maintained Based on observation the smoke detectors are not being properly maintained. On 7 May 2019 at approximately 1345 hrs it was observed that the smoke detector in room 108 was not properly mounted on its ceiling base. These observations were witnessed by the	K 347	**Corrective Action** The smoke detector in room 108 has been fixed. A facility Incident & Accident form was completed. **Identification of Deficient Practice and Corrective Action** All smoke detectors may have been affected. A 100% audit of all facility smoke detectors will be completed and all negative findings will be corrected and an I&A form completed **Systemic Changes** Policy for detectors was reviewed and no changes are needed. Maintenance staff will be educated on detectors and inspection **Monitoring** The Maintenance Director is responsible for compliance. Director or staff will do weekly audits of smoke detectors and fix any issues upon discovery and complete an I&A report for the QA committee to track and trend findings. **Completion Date:** 6/11/2019	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Renee Allen TITLE Administrator (X6) DATE 5/24/19

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K 347	Continued From page 1 facility's Director of Maintenance.	K 347		
K 363 SS=E	Corridor - Doors 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	K 363	**Corrective Action** The fire doors leading to the rehab department have been repaired so they will latch. A facility Incident and Accident report was completed for this finding. **Identification of Deficient Practice and Corrective Action** All fire doors may be affected, therefore a 100% audit of all fire doors will be completed by the Maintenance Director or his designee. **Systemic Changes** The policy for fire doors and their operation has been reviewed with no changes needed at this time. The Maintenance staff will be in-serviced on the policy and inspection process. **Monitoring** The Director of Maintenance is responsible for compliance. The director or their designee will be responsible for weekly inspection of random fire doors throughout the facility. Latching failures will be corrected at the time of discovery and a facility I&A report completed and forwarded to the QA Committee for tracking and trending. **Completion Date**: 6/11/2019	

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 05 - BERMUDA WING NRS STATION B. WING	(X3) DATE SURVEY COMPLETED
	495079		05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE CENTER LUCY CORR	6800 LUCY CORR BLVD CHESTERFIELD, VA 23832

(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 363	Continued From page 2 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the fire doors do not provide corridors and storage areas with protection from smoke or heat. * On 7 May 2019 at approximately 1400 hrs. it was observed that the fire door to the Rehabilitation Services unit do not latch. These observations were witnessed by the facility's Director of Maintenance.	K 363		
K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: The Elevator emergency call system is not being	K 531	**Corrective Action** The phone in the elevator has been programmed to automatically dial an emergency extension that is manned by an operator. A facility Incident and Accident report has been completed for this negative finding. **Identification of Deficient Practice and Corrective Action** All facility elevators may have been affected. A 100% audit of all elevator phones will be done and all negative findings will be corrected and a facility I&A report completed. **Systemic Changes** The hardware profile for the elevator phone has been reviewed and updated to redirect that phone to an extension that is manned at all times. **Monitoring** The Director of Maintenance is responsible for compliance. The director or their designee will check the elevator phones weekly. Any failure of that audit will be addressed immediately and a facility I&A report filed with the QA committee for tracking and trending.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **05 - BERMUDA WING NRS STATION** B. WING _____	(X3) DATE SURVEY COMPLETED
	495079		**05/07/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE CENTER LUCY CORR	**6800 LUCY CORR BLVD** **CHESTERFIELD, VA 23832**

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K 531	Continued From page 3 maintained. On 7 May 2019 at 1230 hrs it was observed that the Emergency phone in elevator 1, is inoperative.	K 531	**Completion Date**: 6/11/2019	