STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	02/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF SUFFOLK	**2580 PRUDEN BOULEVARD SUFFOLK, VA 23434**

(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: 22353 Description of structure: 1 Story V(000) Sprinkler status: Fully Sprinklered An unannounced Life Safety Code survey was conducted 02/27/2018 to verify compliance 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 211 SS=F	Means of Egress - General CFR(s): NFPA 101 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 REQUIREMENT is not met as evidenced by: Surveyor: 22353 Based upon observations, interviews & discussions The Activity Room Exit door was missing the Exit Sign identifying it as the egress door & the doors from the kitchen and the dining room were not controlled by the Fire Alarm System for automatic closing in alarm condition. They were open by door closers not operating	K 211	Preparation and submission of this POC is required by state and federal law. This POC does not constitute an admission for purposes of general liability, professional malpractice or any other court proceeding. K200 1. Exit sign was installed in the activities room and kitchen doors are no longer held open by door closers. 2. All doors and exit signs have been audited to ensure they have been installed. 3. Administrator or Designee will in-service maintenance, dietary staff, and supervisors to the proper use of the kitchen door closers.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3-9-18

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.

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K 211	Continued From page 1 properly. Findings include that between the hours of 2:30 pm and 5 pm on 02/26/18 & 8:30 am and 12 noon on 02/27/18 accompanied by the Facilities Maintenance Director, the following items were noted: there was no exit sign designating the exit from the Activities room at the exit door & the doors from the kitchen and the dining room were not controlled by the Fire Alarm System for automatic closing in alarm condition. They were open by door closers not operating properly. The Facilities Maintenance Director confirmed these findings. The above observations were witnessed by the Facilities Maintenance Director.	K 211	4. Maintenance Director or Designee will randomly audit the kitchen doors weekly for the next three months to make sure they are not held open with the door closers. Maintenance Director or Designee will randomly audit the exit signs weekly for the next three months to make sure they are installed. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 4/13/18	
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Surveyor: 22353 Based upon observations, interviews & discussions there are doors that were found that	K 223	K223 1. Residents doos were fixed to latch when closed and close the gaps between door and door stop. 2. All resident doors have been corrected to properly close and latch. 3. The administrator will in-service the maintenance director on the door latching when closed and the spacing between door and door stop. 4. The Maintenance Director or designee will audit two resident doors weekly for three months for latching when closed.	

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K 223	Continued From page 2 did not have positive latching or requires excessive force to latch the doors and doors have gaps between the door and door stop that could allow smoke to pass through the doors. Findings include that between the hours of 2:30 pm and 5 pm on 02/26/18 & 8:30 am and 12 noon on 02/27/18 accompanied by the Facilities Maintenance Director, the following items were noted: the patient room doors to the corridors did not latch when closed. It was determined that this was caused by door frame protectors installed on the door frames. The Facility Maintenance Director confirmed these findings. The above observations were witnessed by the Facility Maintenance Director.	K 223	The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 4/13/18	
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Surveyor: 22353 Based upon observations, interviews & discussions the Exit Discharge from the Activities room exit door did not have a hard surface path to the public way. Findings include that between the hours of 2:30 pm and 5 pm on 02/26/18 & 8:30 am and 12 noon on 02/27/18 accompanied by the Facilities Maintenance Director, the following items were	K 271	K271 1. A hard walking surface way placed between the activities room exit door and the public walk way. 2. All exit doors have been audited for a hard walking surface with no negative findings. 3. Administrator or designee will in-service maintenance director on hard surfaces leading from an exit to a public way. 4. Maintenance Director will audit two exit doors a week for three months for a hard walking surface.	

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K 271	Continued From page 3 noted: there was no hard walking surface from the exit door (exit discharge) to the public way. The Facilities Maintenance Director confirmed these findings. The above observations were witnessed by the Facilities Maintenance Director.	K 271	The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 4/13/18	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 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: 22353 Based on observations Emergency & Exit Lights had no record of annual or monthly testing. Findings include that between the hours of 2:30 pm and 5 pm on 02/26/18 & 8:30 am and 12 noon on 02/27/18 accompanied by the Facilities Maintenance Director, the following items were noted: At the time of this survey there were no records of testing of the emergency and exit light that had battery back up. The Facilities Maintenance Director confirmed these findings. The Facilities Maintenance Director confirmed these findings.	K 291	K291 1. Emergency exit lights with battery backups were tested. 2. All emergency exit lights have been tested for proper operation. 3. Administrator or designee will in-service maintenance director on testing emergency exit lights with battery backups. 4. Maintenance Director will randomly audit all emergency exit lights monthly for three months . The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 4/13/18	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small	K 324	K324 1. Kitchen hood was inspected on 2/20/18. 2. Kitchen hood will be inspected on by 8/20/18.	

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K 324	Continued From page 4 appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Surveyor: 22353 Based upon review of documentation, observations and interviews, the kitchen hood system has not been maintained. Findings include that between the hours of 2:30 pm and 5 pm on 02/26/18 & 8:30 am and 12 noon on 02/27/18 accompanied by the Facilities Maintenance Director, the following items were noted: there was only one inspection of the range hood fire suppression system in the last 12 months, 2 are required. The Facilities Maintenance Director confirmed these findings. The Facility Maintenance Director confirmed these findings.	K 324	3. Administrator or designee will in-service maintenance director on inspecting the kitchen hood twice a year. 4. Maintenance Director will randomly audit the kitchen hood monthly for three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 4/13/18	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345		

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K 345	Continued From page 5 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 22353 Based upon observations, interviews & discussions the Fire Alarm System records indicate all of the Fire Alarm and associated ancillary equipment attached to it are not being properly tested annually. Findings include that between the hours of 2:30 pm and 5 pm on 02/26/18 & 8:30 am and 12 noon on 02/27/18 accompanied by the Facilities Maintenance Director, the following items were noted: The review of the Fire Alarm Maintenance report indicated that all of the components of the Fire Alarm System, were not indicated on the annual test report as being tested within the last 12 months. The Facilities Maintenance Director confirmed these findings. The above observations were witnessed by the Facilities Maintenance Director.	K 345	K345 1. the fire alarm's attached ancillary equipment was tested. 2. All fire equipment has the potential to be effected by this practice. 3. Administrator or designee will in-service maintenance director on inspecting and testing the fire alarm's attached ancillary equipment . 4. Maintenance Director will randomly audit the testing and maintenance of the fire alarms attached ancillary equipment monthly for three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 4/13/18	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in	K 351	K351 1. Central supply room supplies were removed to create an 18" clearance to the ceiling, sprinkler heads were corrected for proper gap, and electrical wiring no longer touches sprinkler pipes.	

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

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K 351	Continued From page 6 accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Surveyor: 22353 Based upon observations, interviews & discussions the Fire Sprinkler System was not completely/properly installed in the building. Findings include that between the hours of 2:30 pm and 5 pm on 02/26/18 & 8:30 am and 12 noon on 02/27/18 accompanied by the Facilities Maintenance Director, the following items were noted: In the central supply room , the storage was stacked to within 18" of the ceiling; the sprinkler heads throughout the facility are not installed properly - gaps between the ceiling and the eschutchins which open into the attic space; throughout the attic spaces, observed various electrical and communication systems wiring laying on the sprinkler piping & in the attic spaces opberved some of the sprinkler piping not properly suppored. The Facilities Maintenance Director confirmed these findings. The above observations were witnessed by the Facilities Maintenance Director.	K 351	2. All supply rooms, sprinkler heads, and the attic, were audited to ensure an 18"clearance to ceiling, proper gaps for sprinkler heads, and ensured no wiring was touching sprinkler pipes. 3. Administrator or designee will in-service department heads on inspecting supply rooms for 18" clearance between ceiling and top shelf. Administrator or designee will in-service maintenance director on sprinkler head gaps and sprinkler piping being free of electrical wires. 4. Maintenance Director will randomly audit supply rooms weekly for three months, and sprinkler head gaps and piping monthly randomly for three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 4/13/18	
K 362	Corridors - Construction of Walls	K 362		

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K 362 SS=F	Continued From page 7 CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Surveyor: 22353 Based upon observations & discussions there are open penetrations in the draft stopping wall in the attic which will allow the passage of smoke & flames from one smoke compartment to another. Findings include that between the hours of 2:30 pm and 5 pm on 02/26/18 & 8:30 am and 12 noon on 02/27/18 accompanied by the Facilities Maintenance Director, the following items were noted: Observed open penetrations in the draft stopping wall in the attic which will allow the passage of smoke & flames from one smoke compartment to another. The Facilities Maintenance Director confirmed these findings.	K 362	K362 1. Open penetrations in the draft stopping wall has been fixed. 2. The facility conducted an audit of the fire walls to ensure no penetrations. 3. Administrator or designee will in-service maintenance director on draft stopping walls and penetrations in them. 4. Maintenance Director will randomly audit draft stopping walls monthly for three months. The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. 5. 4/13/18	

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K 362	Continued From page 8 The the Facility Maintenance Director confirmed these findings.	K 362		