STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-BATTLEFIELD PARK	250 FLANK ROAD PETERSBURG, VA 23805

(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 a one story brick and wood Type V(111)Construction. Sprinkler Status: Fully Sprinklered NFPA 13 An unannounced recertification Life Safety Code survey was conducted on 6 March 2017 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 Federal Regulation, 483.70(a) et seq (Life Safety From Fire).	K 000	**Preparation and/or execution of the Plan of Correction does not constitute admission of agreement of the Provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because of Federal and State law.** **This plan of correction is the facilities credible allegation of compliance.**	
K 222 SS=E	NFPA 101 Egress Doors 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	K 222	1. Address the corrective action taken for the identified problem. **The door has been replaced.** 2. Address how the facility will identify similar occurrences of the problem. **No other occurrences of the same problem were noted when the doors were checked on 3-7-17. All doors are functioning properly.** 3. Identify measures/systemic Occurrences of the problem. **The Executive Director in-serviced the Maintenance Director on ensuring that all exit doors allow proper egress. The Executive Director has in-serviced the Maintenance Director on ensuring that all exit doors allow proper egress.**	4-28-17

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

Marie Gra 4-13-17 Executive Director 4-13-17

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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	495252	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	03/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-BATTLEFIELD PARK	**250 FLANK ROAD PETERSBURG, VA 23805**

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K 222	Continued From page 1 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 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 Standard is not met as evidenced by:	K 222	4. **How the facility will monitor Performance.** **The Director of Maintenance will audit all exit doors weekly to ensure that the doors allow proper egress. Any corrective measures deemed appropriate will be initiated. Findings will be reported monthly to the QAPI committee for additional oversight and review.**	

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K 222	Continued From page 2 This Standard is not met as evidenced by: Based on observation and inspections the delayed egress system on the EXIT door does not open within the designate alloted time. On 6 March 2017 at approximatly 11:00 it was observed that the EXIT door with the delayed egress near room 230 did not open within the 15 second delayed time period. These observations were witnessed by the facility's Director of Maintenance.	K 222		
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING 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. 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. 19.3.2.1 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)	K 321	1. **Address the corrective action taken for the identified problem** **On the day of inspection, the Maintenance Director repaired the door closure, so as to latch when released from the open position.** 2. **Address how the facility will identify similar occurrences of the problem.** **No other occurrences of the same problem were noted when the door closures were released. All Hazard Room doors were checked on 3-7-17.**	**4-28-17**

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K 321	Continued From page 3 f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This Standard is not met as evidenced by: This Standard is not met as evidenced by: Based on observation and inspections it was observed that there are Hazard Area corridor doors that are not self closing and they do not provide the corridor with protection from smoke or heat. On 6 March 2017 at approximatly 12:00 it was observed that the Soil Linen room door does not latch when released from the open position. These observations were witnessed by the facility's Director of Maintenance.	K 321	3. Identify measures/systemic Occurrences of the problem. The Executive Director in-serviced the Maintenance Director on ensuring that all exit doors close securely in a Hazard room. 4. How the facility will monitor Performance. The Director of Maintenance will audit all Hazard room doors weekly to ensure that they close securely. Any corrective measures deemed appropriate will be initiated. Findings will be reported monthly to the QAPI committee for additional oversight and review.	
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363	1. Address the corrective action taken for the identified problem Resident Room door # 132 was repaired and latched on the same day of the inspection. Door strips have been installed on the room doors that exceeded the half inch gap limitation on the door frames. 2. Address how the facility will identify similar occurrences of the problem. All room doors were checked on 3-15-17 and no other occurrences were noted as far as latching. An audit was conducted on all room doors to ensure that they did not exceed the half inch gap limitation. Any doors found to not latch securely were repaired.	4-28-17

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K 363	Continued From page 4 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 Standard is not met as evidenced by: This Standard is not met as evidenced by: Based on observation and inspections corridors doors do not provide corridors with protection from smoke or heat. On 6 March 2017 at approximatly 12:30 it was observed that the door to resident room 132 can not be latched. On 6 March 2017 at approximatly 12:15 it was observed that there are several resident room doors that are at or exceed the half inch gap limitation on the door frames. These observations were witnessed by the facility's Director of Maintenance.	K 363	**3. Identify measures/systemic Occurrences of the problem** **The Executive Director in-serviced the Maintenance Director to ensure that Resident room doors latch securely, as well as resident room doors that exceeded the half inch gap limitation on the door frames.** **4. How the facility will monitor Performance.** **The Director of Maintenance will audit all Resident room doors weekly to ensure that they close securely. Any corrective measures deemed appropriate will be initiated. Findings will be reported monthly to the QAPI committee for additional oversight and review.** **1. Address the corrective action taken for the identified problem** **On 3-27 -17, a contracted Laundry service provider installed new parts and repaired the exposed wiring, which is now covered securely.**	**4-28-17**
K 511 SS=D	NFPA 101 Utilities - Gas and Electric 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.	K 511		

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K 511	Continued From page 5 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This Standard is not met as evidenced by: This Standard is not met as evidenced by: Based on observation and inspections there is exposed electrical wiring on the washer in the Laundry room. On 6 March 2017 at approximatly 12:40 it was observed that there is exposed electrical wiring on the washer in the Laundry room. These observations were witnessed by the facility's Director of Maintenance.	K 511	2. Address how the facility will identify similar occurrences of the problem. The Maintenance Director on 3-15-17 inspected all mechanical equipment and found no similar occurrences. 3. Identify measures/systemic Occurrences of the problem The Executive Director in-serviced the Maintenance Director on the need to routinely check electrical equipment to ensure that there is no wiring exposed. How the facility will monitor Performance. The Director of Maintenance will audit all mechanical equipment weekly to ensure that no electrical wiring is exposed. Any corrective measures deemed appropriate will be initiated. Findings will be reported monthly to the QAPI committee for additional oversight and review.	