STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495249	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMVILLE REHABILITATION & HEALTH CAR	**1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901**

(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 (1) story building with partial storage basement with a construction type of II (000). Sprinkler Status: Fully sprinklered - NFPA 13 An unannounced Standard Recertification Life Safety Code Survey was conducted on 03-01-2018 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not 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	Preparation and submission of this plan of correction by **Farmville Rehabilitation and Health Care Center, LLC,** does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under the state and federal laws.	
K 222 SS=E	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.	K 222	**K222** 1. The egress latch identified on the North wing will be inspected and repaired as needed by 4-13-2018. 2. All other exit doors having a 15 second release will be inspected and adjusted as needed by 4-13-2018. 3. During the monthly door checks conducted by the maintenance director an audit will be performed to identify if any doors are out of compliance.	

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

N HA — ADMINISTRATOR — 4-11-18

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 projection 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.

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

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K 222	Continued From page 1 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 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.	K 222	4. The results of the monthly audit wil be reported to the interdisciplinary QA team for further follow-up and continued compliance. 5. Date of completion: 4-13-2018	

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K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based upon observation and interview, the facility failed to maintain the delayed-egress locking arrangements. This has the ability to affect all occupants in the effected compartment of the building. Findings include On 03-01-2018 at 11:00 am, it is observed that the irreversible process to release the delayed egress lock for the exit door at the North nurse's station is not being maintained. The Facility Maintenance Director witnessed this evidence by interview and observation on 03-01-2018 at approximately 2:00 pm during the exit interview.	K 222	**K223** 1. The doors that were identified during the survey will be adjusted by 4-13-2018 and now close properly.	
K 223 SS=E	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: Based upon observation and interview, the facility	K 223	2. All self-closing doors will be inspected by 4-13-2018 by an approved vendor. 3. During the monthly door check audit the maintenance director will inspect the self-closing doors for proper operation. 4. The maintenance director will report the results of his audit to the interdisciplinary QA team for further follow-up and continued compliance. 5. Date of completion: 4-13-2018	

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K 223	Continued From page 3 failed to maintain doors with self-closing devices. This has the ability to affect all occupants in the effected compartment of the building. Findings include On 03/01/2018 at 10:57 am, it was observed that the cross corridor hallway door at room 231 did not self-close. On 03/01/2018 at 11:36 am, it was observed that the door at Fine Dining did not self-close and latch. The facility maintenance director witnessed this evidence through inspection and observation on 03-1-2018 at approximately 2:00 PM during the exit interview.	K 223	**K324** 1. The kitchen equipment will be realigned by 4-13-2018 to meet the requirements of the regulation. 2. During the bi-annual inspection of hood suppression system the equipment placement will be inspected to ensure continued compliance.	
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 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	K 324	3. The maintenance director will audit the placement of the kitchen equipment monthly for the next three months and quarterly thereafter. The dietary manager will in-service kitchen staff on the proper placement of equipment after cleaning has occurred by 4-13-2018. 4. The results of the kitchen equipment audit will be reported the interdisciplinary QA team for further follow-up and to ensure continued compliance. 5. Date of completion: 4-13-2018	

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K 324	Continued From page 4 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain Cooking Equipment. This potentially affects all occupants of the building. Findings include: On 03-01-2018 at 12:19 pm, it was observed that the cooking equipment was not aligned beneath the kitchen hood and hood suppression system. The Facility Maintenance Director witnessed this evidence by interview and observation on 03-01-2018 at approximately 2:00 pm during the exit interview.	K 324	**K353** 1. Corroded sprinkler heads identified during the inspection will be replaced by 4-13-2018. 2. Other sprinkler heads throughout the facility will be inspected and replaced as needed.	
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	K 353	3. The maintenance director will randomly inspect sprinkler heads on a monthly basis for the next three months and quarterly thereafter to ensure continued compliance. 4. The results of the sprinkler head audit will be reviewed by the interdisciplinary QA team for the next three months and quarterly thereafter to ensure continued compliance. 5. Completion date: 4-13-2018	

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K 353	Continued From page 5 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the sprinkler system maintenance and testing. This has the potential to affect all occupants of the building. Findings include On 03-01-2018 at 11:38 am it is observed by inspection that sprinkler heads beneath the canopy of the smoking patio appear to be corroded. On 03-01-2018 at 1:15 pm, it is observed during documentation review that the sprinkler system inspection report dated for 02-23-2018 noted discrepancies listed with no documentation of correction. On 03-01-2018 at approximately10:30 am, it is observed by inspection that a sprinkler head above the ceiling in the attic space of the oxygen room near the West Nurse Station appeared to be loaded. a) Date sprinkler system last checked 02-23-2018 b) Who provided system test Capital City Fire Protection LLC c) Water system supply source Municipal The Facility Maintenance Director witnessed this evidence by interview and observation on 03-01-2018 at approximately 2:00 pm during the exit interview.	K 353	**K363** 1. Doors identified during the inspection (103, 112, 116, 131, 209 and 214) will be adjusted or repaired by 4-13-2018 by the maintenance director or outside vendor. 2. All other resident doors will be inspected by the maintenance director by 4-13-2018. 3. The maintenance director will conduct a random audit of resident room doors on a monthly basis for the next three months and quarterly thereafter to ensure continued compliance. 4. The results of the random audits will be discussed with the interdisciplinary QA team for further follow-up and continued compliance. 5. Completion date: 4-13-2018	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than	K 363		

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K 363	Continued From page 6 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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the doors protecting corridor	K 363	**K372** 1. The wall penetrations around the installed fire dampers will be repaired by 4-13-2018 with the properly approved product. 2. Other fire dampers will be inspected by 4-13-2018 to ascertain if the same issue exists. Noted discrepancies will be rectified as well. 3. The maintenance director will be in-serviced by the regional maintenance director on the identification of wall penetrations and the use of proper materials to rectify discrepancies by 4-13-2018. 4. The maintenance director will report the results of his inspection on other fire damper penetrations during the next regularly scheduled QA team meeting. 5. Completion date: 4-13-2018	

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K 363	Continued From page 7 openings . This has the ability to affect all occupants in the effected smoke compartment of the building. (CMS S&C-07-18) Findings include On 03-01-2018 at approximately 9:37 am, it is observed that the doors to following patient rooms would not resist the passage of smoke: Room 103, 112, 116, 131, 209, and 214. The Maintenance Director witnessed this evidence by interview and observation on 03-01-2018 at approximately 2:00 pm during the exit interview.	K 363		
K 372 SS=E	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: Based on observation and interview, the facility failed to maintain the fire rated smoke barrier walls as required by the Life Safety Code. This has the ability to affect all occupants in the effected smoke compartment of the building.	K 372		

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K 372	Continued From page 8 Findings include On 03-01-2018 at approximately 9:44 AM, it is observed by inspection the areas around the installed fire dampers have penetrations with no opening protection. (LSC 8.3.4.1) The Maintenance Director witnessed this evidence by interview and observation on 03-01-2018 at approximately 2:00 pm during the exit interview.	K 372	**K500** 1. Facility Fire Dampers will be properly labeled by 4-13-2018.	
K 500 SS=E	Building Services - Other CFR(s): NFPA 101 Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services 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: Based on observation and interview, the facility failed to maintain the fire dampers in accordance with the Life Safety Code (9.2.1) and NFPA 90A, 90B, and 80. This has the ability to affect all occupants in the effected compartment of the building. Findings include On 03-01-2018 at approximately 9:44 AM, it is observed that the fire damper access panels do not contain the proper signage of "Fire Damper" in 1" letters. It is observed that documentation is	K 500	The facility fire dampers will be inspected by 4-13-2018. Repairs will be made as indicated. 2. During the fire damper inspection if other dampers are found to be in need of serving they will be scheduled for repair by 4-13-2018. 3. The Regional Maintenance Director will provide in-service education on the inspection and repair process for fire dampers. 4. The maintenance director will report the results of his inspection to the interdisciplinary QA team during the next scheduled review. 5. Completion date: 4-13-2018	

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K 500	Continued From page 9 not available of the latest fire damper inspections for the following locations that were found to have fire dampers: Unit Manager/Electrical Room, M-3 Mechanical Room, and Bathroom of Room 105. The Maintenance Director witnessed this evidence by interview and observation on 03-01-2018 at approximately 2:00 pm during the exit interview.	K 500	**K511** 1. The open wiring identified during the inspection will be repaired by 4-13-2018. The improperly identified breakers will be labeled appropriately on 4-13-2018. 2. The maintenance director will randomly audit for the next three months various components of the facility electrical system noted discrepancies will scheduled for repair. The breaker panels will be monitored for the next three months to ensure continued compliance with proper labeling of the breaker panels. 3. During the maintenance directors monthly preventative maintenance rounds. Various components of the facility electrical system will be inspected and repaired as indicated.	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 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. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based upon observations and interview, the facility failed to ensure that the electrical wiring and equipment complies with NFPA 99 and 70, National Electrical Code. This has the ability to affect all occupants of the building. Findings include On 03-01-2018 at approximately 12:19 pm, it is observed that the water heater found in the Mechanical Room has open wiring. (NFPA 70, 110.27)	K 511		

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K 511	Continued From page 10 At approximately 11:04 am, it is observed that there is open wiring in the ceiling of the Electrical Room. (NFPA 70, 110.27) At approximately 10:42 am, it is observed that the Electrical Panel "C" Breaker 9 & 21 is not properly labeled in the legend/directory. (NFPA 70, 408.4) The Maintenance Director witnessed this evidence by interview and observation on 03-01-2018 at approximately 2:00 pm during the exit interview.	K 511	4. The maintenance director will discuss the results of the facility inspections with the interdisciplinary QA team on a monthly basis for the next three months to ensure continued compliance.	
K 923 SS=D	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	K 923	5. Completion date: 4-13-2018	

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	495249	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARMVILLE REHABILITATION & HEALTH CAR	**1575 SCOTT DRIVE ROUTE 5 FARMVILLE, VA 23901**

(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 923	Continued From page 11 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 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 interview, the facility failed to maintain the oxygen cylinder storage area. This has the potential to affect all occupants in the building. Findings include On 03-01-2018 at 10:23am it is observed by inspection the oxygen storage room door near the West nurse station was not capable of being secured. On 03-01-2018 at 11:06 am it is observed by inspection the oxygen storage room door near the North nurse station was not capable of being secured. The Maintenance Director witnessed this evidence by interview and observation on 03-01-2018 at approximately 2:00 pm during the exit interview.	K 923	**K923** 1. The door securing hardware for the oxygen storage rooms will be replaced by 4-13-2018. 2. There are no other oxygen storage spaces to identify any further issues. 3. The Administrator will audit the door closing mechanisms monthly for the next three months and quarterly thereafter to ensure continued compliance. 4. The results of the administrator audits will be discussed with the interdisciplinary QA team for the next three months and quarterly thereafter. 5. Completion date: 4-13-2018	