STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E050	A. BUILDING **04 - MAIN BUILDING** B. WING _____	02/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW NURSING HOME	**1776 ELLY ROAD ARODA, VA 22709**

(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: 35701 The facility is a single story skilled nursing facility. The facility is Type V (111) construction and is fully sprinklered. An unannounced Life Safety Code recertification survey was conducted on 02/28/2018 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 to be not in compliance with the Requirements for Participation for Medicare and Medicaid. The Findings that follow demonstrate noncompliance with title 42 Code of Regulations. Part 483.150 and 410 to 480 (Life safety from Fire).	K 000		
K 200 SS=E	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress 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. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on interview, the facility failed to conduct annual testing and maintain records of the fire door inspections. This has the potential to affect all residents and staff.	K 200		

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

Administrator 3-22-18

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 200	Continued From page 1 The Findings include: An interview with the maintenance supervisor on 02/28/2018 at 12:30 PM revealed the inspection and testing of the fire doors was not conducted and records for the inspection was not available for review. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6 7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. 7.2.1.15.3 The inspection and testing interval for fire-rated and nonrated door assemblies shall be permitted to exceed 12 months under a written performance-based	K 200	K200 Criterion 1: A fire inspection will be scheduled Criterion 2: All residents and staff were potentially impacted Criterion 3: Facility will schedule routine inspections per LSC Criterion 4: Maintenance Supervisor or Designee will make sure annual inspections are completed and report any variances to the Administrator and/ or QAPI. Crieterion 4: April 14, 2018	

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K 200	Continued From page 2 program in accordance with 5.2.2 of NFPA 80, Standard for Fire Doors and Other Opening Protectives 7.2.1.15.4 A written record of the inspections and testing shall be signed and kept for inspection by the authority having jurisdiction. 7.2.1.15.5 Functional testing of door assemblies shall be performed by individuals who can demonstrate knowledge and understanding of the operating components of the type of door being subjected to testing. 7.2.1.15.6 Door assemblies shall be visually inspected from both sides of the opening to assess the overall condition of the assembly. 7.2.1.15.7 As a minimum, the following items shall be verified: (1) Floor space on both sides of the openings is clear of obstructions, and door leaves open fully and close freely. (2) Forces required to set door leaves in motion and move to the fully open position do not exceed the requirements in 7.2.1.4.5. (3) Latching and locking devices comply with 7.2.1.5. (4) Releasing hardware devices are installed in accordance with 7.2.1.5.10.1. (5) Door leaves of paired openings are installed in accordance with 7.2.1.5.11.	K 200		

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K 200	Continued From page 3 (6) Door closers are adjusted properly to control the closing speed of door leaves in accordance with accessibility requirements. (7) Projection of door leaves into the path of egress does not exceed the encroachment permitted by 7.2.1.4.3. (8) Powered door openings operate in accordance with 7.2.1.9. (9) Signage required by 7.2.1.4.1(3), 7.2.1.5.5, 7.2.1.6, and 7.2.1.9 is intact and legible. (10) Door openings with special locking arrangements function in accordance with 7.2.1.6 (11) Security devices that impede egress are not installed on openings, as required by 7.2.1.5.12. 7.2.1.15.8 Door openings not in proper operating condition shall be repaired or replaced without delay.	K 200		
K 211 SS=D	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: 35701 Based on observation, the facility failed to maintain the means of egress. This has the potential to affect one smoke compartment.	K 211	K211 Criterion 1: Trashcan was removed from in front of the door during the LSC survey. Criterion 2: All fire exits will be checked for obstructions such as trashcans Criterion 3: Staff will be educated concerning blocking exits. Criterion 4: Maintenance supervisor or Designee will be responsible to maintain clear passageways and shall report any variances or concerns to the administrator and/or QAPI Criterion 5: April 14, 2018	

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K 211	Continued From page 4 The Findings include: It was observed on 02/28/2018 at 1:21 PM, the exit from the dining hall to the courtyard was obstructed by a stored trash can.	K 211	K271 Criterion 1: Boxes have been cleared from the walkway Criterion 2: All egress ramps and exits will be checked for and cleared of blockages. Criterion 3: Staff will be educated on keeping exits clear of hazards Criterion 4: The Maintenance Supervisor or his designee will monitor exits for blockages and report any problems to the Administrator and/or the QAPI committee Criterion 5: April 14, 2018	
K 271 SS=D	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: 35701 Based on observation, the facility failed to maintain the exit discharge. This has the potential to affect one smoke compartment. The Findings include: It was observed on 02/28/2018 at 12:42 PM, the exit discharge from the receiving area was obstructed by stored boxes.	K 271		
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	K 324		

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K 324	Continued From page 5 * 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: 35701 Based on record review, the facility failed to maintain the commercial cooking hood system. This has the potential to affect all staff in the kitchen. The Findings include: A review of records on 02/28/2018 at approximately 12:20 PM revealed the inspection reports for the commercial cooking hood was not available for review.	K 324	K324 Criterion 1: The hood will be maintained and inspected up to LSC standards Criterion 2: All kitchen staff were potentially impacted Criterion 3: A routine maintenance plan will be developed for the hood. Criterion 4: the Maintenance Supervisor or his designee will ensure all required inspections occur and recommendations are followed. Any problems will be reported to the Administrator and/or QAPI Criterion 5: April 14, 2018	
K 353 SS=D	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,	K 353		

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K 353	Continued From page 6 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: Surveyor: 35701 Based on record review and observation, the facilty failed to maintain the sprinkler system. This has the potential to affect all residents and staff. The Findings include: A review of records on 02/28/2018 at 12:14 PM revealed the sprinkler reports did not identify the servicing contractors information and test (annual or quarterly). 4.3 Records. 4.3.1* Records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. 4.3.2 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date.	K 353	K353 Criterion 1:The facility will maintain maintenance records for all Sprinkler inspections that include the name of the Service provider, the Inspection date, and the typer of inspection (i.e. quarterly or annual). Also, Facility will replace the escutcheon plates in rooms 122 and 135. Criterion 2: All residents and staff were potentially affected Criterion 3: Service Provider will be notified of the concerns and facility will monitor reports for all the necessary components. Sprinklers will be checked for missing escutcheon plates. Criterion 4: The Maintenance Supervisor or his designee will ensure that all inspections are up to date and complete. and will be responsible to keep all escutcheon plates on sprinkler heads. Any variances will be reported to the administrator and/or QAPI. April 14, 2018	

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K 353	Continued From page 7 4.3.3* Records shall be maintained by the property owner. It was observed on 02/28/2018 at 12:50 PM, an escutcheon plate was missing from the sprinkler head located in room 135. It was observed on 02/28/2018 at 1:05 PM, an escutcheon plate was missing from the sprinkler head located in the center of room 122.	K 353	K355 Criterion 1: Facility will maintain clear passageway to all fire extinguishers Criterion 2: All other fire extinguishers will be checked for blockages and corrected. Criterion 3: Staff will be educated concerning blocking fire extinguishers Criterion 4: The housekeeping supervisor or her designee will be responsible to make sure that decorative vegetation is not blocking fire extinguishers. Any variations will be corrected. Criterion 5: April 14, 2018	
K 355 SS=D	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: Surveyor: 35701 Based on observation, the facility failed to maintain portable fire extinguishers. This has the potential to affect one smoke compartment. The Findings include: It was observed on 02/28/2018 at 11:55 AM, the portable fire extinguisher located in the main lobby near the exit door was obstructed by decorative vegetation.	K 355		
K 363 SS=D	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		

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K 363	Continued From page 8 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: Surveyor: 35701 Based on observation, the facility failed to maintain corridor doors. This has the potential to affect one smoke compartment.	K 363	K363 Criterion 1: Door latch for room 128/129 will be adjusted Criterion 2: All other smoke compartment doors will be checked for proper latch. Criterion 3: All smoke compartment doors will be monitored for needed adjustments Criterion 4: The maintenance Supervisor or his designee will ensure that all smoke compartment door latches are properly maintained. Criterion 5: April 14, 2018	

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K 363	Continued From page 9 The Findings include: It was observed on 02/28/2018 at 12:52 PM, the suite door to rooms 128/129 was not completely closing.	K 363		
K 511 SS=D	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: Surveyor: 35701 Based on observation, the facility failed to maintain electrical equipment. This has the potential to affect one smoke compartment. The Findings include: It was observed on 02/28/2018 at 12:55 PM, the electrical panels located between rooms 137 and 138 was obstructed by chairs and decorative vegetation.	K 511	K511 Criterion 1: Chairs and decor will be moved from in front of electrical panels Criterion 2: All electrical panels will be observed for blockages Criterion 3: Staff will be educated concerning blocking electrical panels Criterion 4: Maintenance Supervisor or his Designee will be responsible to make sure all electrical panels are clear of blockages. Criterion 5: April 14, 2018	
K 711 SS=D	Evacuation and Relocation Plan CFR(s): NFPA 101 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.	K 711		

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K 711	Continued From page 10 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 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 REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on record review, the facility failed to maintain the fire safety and evacuation plans. This has the potential to affect all residents and staff. The Findings include: A review of records on 02/28/2018 at 2:20 PM revealed the horizontal exiting locations and exterior assembly areas was not identified in the evacuation plans.	K 711	K711 Criterion 1: The written evacuation plan will be updated to identify the horizontal exiting locations and exterior assembly areas. Criterion 2: All residents and staff are potentially impacted Criterion 3: Facility will annually evaluate evacuation plan to ensure that it is up to date. Criterion 4: The Administrator or his designee will be responsible to ensure that the evacuation plan is up to date. Criterion 5: April 14, 2018	
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	K 923		

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K 923	Continued From page 11 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 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: Surveyor: 35701 Based on observation, the facility failed to maintain the storage of oxygen cylinders. This has the potential to affect all residents requiring the use oxygen. The Findings include: It was observed on 02/28/2018 at 1:25 PM, the oxygen cylinders stored in the basement was not segregated from empty cylinders and full cylinders.	K 923	K923 Criterion 1: Oxygen storage will be segregated based on full vs. empty cylinders. Criterion 2: All residents requiring oxygen were potentially affected Criterion 3: A new system of segregating cylinders will be established. Criterion 4: the Maintenance Supervisor or his designee will maintain the segregated area for the oxygen cylinders Criterion 5: April 14, 2018.	