STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495360	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WOODLANDS HEALTH AND REHAB CEN	1000 FAIRVIEW HEIGHTS CLIFTON FORGE, VA 24422

(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: 34730 Construction Type: V(111) Number of stories: One Story Building description: The facility is a one-story building of wood construction on a concrete slab with pitched roof attics protected by sprinklers. Sprinkler Status: The building is fully sprinklered and protected by NFPA #13 wet and dry pipe systems with quick response sprinklers in patient rooms. Systems are supplied by municipal water. An unannounced standard recertification Life Safety Code survey was conducted on 04/03/2018 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 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	**Plan of Correction** **This plan of correction represents Our allegation of compliance and Our on-going pledge to adhere to all regulatory requirements.**	05/15/18
K 222 SS=F	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	K 222	**K Tag 222** **Corrective Action:** **The delayed egress lock on the Courtyard Fence was repaired on 4/3/18.** **Identifying other residents/situations:** **This affected 1 egress exit. All egress doors were inspected to assure they were fully operational on 04/03/18.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela Baldwin | TITLE: Administrator | (X6) DATE: 4-13-18

ıy 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 222	Continued From page 1 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 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	K 222	**Systemic Changes:** **Maintenance staff was educated on monitoring the working conditions of all egress doors on 04/05/18.** **Monitoring:** **Safety Officers will complete safety rounds monthly which includes assuring egress doors are functioning properly in accordance to LSC 2012 regulations.** **Date Completed:** **The facility is in and will maintain Compliance with the requirement As of 04/6/18**	04/06/18

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K 222	Continued From page 2 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 REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based on observation and inspection the facility failed to maintain delayed egress locking arrangements. This has the ability to affect all occupants of the building. Findings include: On 4-3-18 at approximately 10:25 am it was observed through observation and inspection that the delayed egress lock on the Courtyard Fence did not release when operated. The Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 222		
K 372 SS=F	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	K 372	**K Tag 372** **Corrective Action:** **The penetrations to the Smoke Barrier Wall were repaired on 4/4/18.** **Identifying other residents/situations:** **All smoke barrier walls were inspected for penetrations.**	

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K 372	Continued From page 3 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: Surveyor: 34730 Based on observation and inspection the facility failed to maintain smoke barriers. This has the ability to affect all occupants of the building. Findings include: On 4-3-18 at approximately 10:47 am it was observed through observation and inspection that the smoke barrier walls in the attic space are not being maintained to resist the passage of smoke. Several unprotected through penetrations were observed in the smoke barrier walls. The Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 372	**Systemic Changes:** **Maintenance staff was educated on maintaining smoke barrier walls on 04/05/18.** **Monitoring:** **Safety Officers will complete safety rounds monthly which includes assuring smoke barrier wall are maintained in accordance to LSC 2012 regulations.** **Date Completed:** **The facility is in and will maintain Compliance with the requirement As of 04/6/18**	04/06/18
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by:	K 712	**K Tag 712** **Corrective Action:** **The weather data has been documented from December 2017 to current for all fire drills. This is a required field in the documentation program started in 2017.** **Identifying other residents/situations:** **All Fire drills in the past 12 months were reviewed for weather related data.**	

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K 712	Continued From page 4 Surveyor: 34730 Based on observation and inspection the facility failed to maintain fire drills. This has the ability to affect all occupants of the building. Findings include: On 4-3-18 at approximately 10:00 am it was observed through observation and inspection during the record review that the fire drill documentation from November 2017 and back did not contain the required weather data. The Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 712	**Systemic Changes:** **Maintenance staff was educated on including the weather data conditions for all fire drills on 04/05/18.** **Monitoring:** **Safety Officers will review fire drill reports monthly to assure weather data is documented in accordance to LSC 2012 regulations.** **Date Completed:** **The facility is in and will maintain Compliance with the requirement As of 04/6/18**	04/06/18
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder	K 918	**K Tag 918** **Corrective Action:** **The Generator will be tested on 30% load for 30 mins on 4/16/18 and scheduled monthly thereafter.** **Cummins Atlantic was scheduled to complete a 4 hr. load test during the week of 04/09/18.** **Electric Power solutions was contacted to complete the main and circuit breaker inspection.** **Identifying other residents/situations:** **The main and circuit breaker is scheduled for inspection the week of 05/07/18.** **Systemic Changes:** **Maintenance staff was educated on the generator testing requirements on 04/05/18.**	

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K 918	Continued From page 5 circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based on observation and inspection the facility failed to maintain the generator system. This has the ability to affect all occupants of the building. Findings include: On 4-3-18 at approximately 10:15 am it was observed through observation and inspection during the record review that documentation could not be provided to show that generator set is exercised under load 30 minutes 12 times a year in 20-40 day intervals. On 4-3-18 at approximately 10:17 am it was observed through observation and inspection during the record review that documentation could not be provided to show that generator set is exercised once every 36 months for 4 continuous hours. On 4-3-18 at approximately 10:20 am it was observed through observation and inspection during the record review that documentation could not be provided to show that the main and	K 918	**Monitoring:** **Safety Officers will review generator logs monthly to assure appropriate testing in accordance to** **LSC 2012 regulations.** **Date Completed:** **The facility is in and will maintain Compliance with the requirement** **As of 05/15/18**	05/15/18

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K 918	Continued From page 6 feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. The Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 918		
K 923 SS=F	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."	K 923	**K Tag 923** **Corrective Action:** **The oxygen cylinder in the physical therapy area was remove on 4/3/18 and placed in the designated secured area.** **Identifying other residents/situations:** **Environmental rounds were completed on 04/03/18 to assure oxygen cylinders were stored appropriately.** **Systemic Changes:** **Therapy staff was educated on the proper storage of empty oxygen cylinders on 04/05/18.** **Monitoring:** **Safety Officers will complete safety rounds monthly to assure proper storage of full and empty oxygen cylinders in accordance to LSC 2012 regulations.**	

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K 923	Continued From page 7 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: 34730 Based on observation and inspection the facility failed to maintain oxygen cylinders. This has the ability to affect all occupants of the building. Findings include: On 4-3-18 at approximately 10:20 am it was observed through observation and inspection that a oxygen cylinder in the Physical Therapy area is not secured to prevent falling caused by contact, vibration or seismic activity. The Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 923	**Date Completed:** **The facility is in and will maintain Compliance with the requirement As of 04/6/18**	04/06/18