STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 with a construction of Type V (111). Sprinkler Status: Fully sprinklered - NFPA 13 An unannounced Standard Recertification Life Safety Code Survey was conducted on 5/16/17 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		
K 100 SS=D	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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 Standard is not met as evidenced by: Based upon observations the dryer room and vents are not maintained clear of combustible material. Findings include Around 4:10 PM on 5/16/17, it is observed that the is lint buildup in the dryer vents. Referenced by Virginia Statewide Fire Prevention Code 110.4	K 100	K100 1) Maintenance staff will clean and dust all dryer vents 2) Maintenance staff will do weekly inspections to ensure similar occurrences do not recur 3) To ensure component 2 is met Maintenance Director will create new Preventive Maintenance (PM) form 22 documenting findings to ensure deficient practice will not recur 4) Using PM 22 as weekly documentation to monitor our performance	6/29/17

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

Administrator 6/7/17

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 222 K 222 SS=D	Continued From page 1 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 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	K 222 K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 222	Continued From page 2 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: Based upon observations there is a door that require excessive force to unlock the door that could affect the egress from spaces or the facility to the public way. Findings include Around 3:30 PM on 5/16/17, it is observed that the exit door required excessive force to start the irreversible count down to unlock the time delay lock in Autumn near room 310.	K 222	K222 1) Maintenance staff will change mag lock and tighten hinges to allow normal force in door opening process and natural door closure process 2) Maintenance staff will inspect and correct all remaining doors to meet life safety code regulations 3) To ensure component 2 is met maintenance staff will inspect, correct, and document any and all fire door violations during all monthly fire drill reports 4) To ensure performance is being upheld for component 2 and 3 the Maintenance Director will inspect all fire drill reports upon completion for accuracy	6/29/17
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	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 321	Continued From page 3 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. Solled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) 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: Based upon observations hazardous areas are not maintained to provide required separation and or fire resistant ratings for the hazardous areas. There are doors that are not self closing and latching, doors that do not have the required listing for the door and hardware that could allow smoke and hot gasses to pass through the doors. Findings include Around 3:46 PM on 5/16/17, it is observed that the fire rated door is not self closing and latching to central storage. Around 4:06 PM on 5/16/17, it is observed that	K 321	K321 1) Maintenance staff will replace striker plate for door and install door closure 2) maintenance staff will inspect all hazardous areas to ensure door closures are intact and door is properly latching 3) Will educate staff on importance of door closures and latches to ensure future problems are reported 4) Maintenance Director will audit 5 times per week for 4 weeks then randomly for 8 weeks. Any discrepancies will be reported to the facility Administrator immediately. Audits will be reviewed and revised by the QAPI monthly for 3 months	6/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 321	Continued From page 4 the fire rated door to the east laundry room door is not self closing and latching. Between 4:34 PM and 4:44 PM on 5/16/17, it is observed that the soiled utility rooms doors are not labeled doors Spring and Winter wings.	K 321	K321 1) Maintenance staff will order and install fire rated doors for both soiled utility rooms on Spring and Winter 2) Maintenance Director and Fire Marshall will inspect other two soiled utility rooms to ensure correct door is attached 3) Will educate staff on importance of labeled doors and not allow doors to be removed or replaced 4) Will inspect with Fire Marshall during revisit to confirm all doors that need to be labeled or fire rated are correct	6/29/17
K 324 SS=D	NFPA 101 Cooking Facilities 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 19.3.2.5.5, 9.2.3, TIA 12-2 This Standard is not met as evidenced by: Based upon observation the kitchen equipment is not located in the correct position to provide proper coverage of the suppression system, to capture grease laden vapors and to maintain the equipment in the correct position under the hood.	K 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 324	Continued From page 5 Findings include Around 3:43 PM on 5/16/17, it is observed that there is a stove in physical therapy that is not on a timer that will shut off the stove. Around 3:51 PM on 5/16/17, it is observed that there is a damaged device that that maintains the fryer in the correct position under suppression nozzles and the stove is not located in the device that maintains the stove in the correct position under the suppression nozzles.	K 324	K324 1) Will order and install key activated timing device that connects to stove 2) Will in-service therapy and kitchen staff on importance of cutting off equipment when not in use 3) Therapy will turn off and lock out stove when not in use 4) Maintenance Director will audit 5 times per week for 4 weeks then randomly for 8 weeks. Any discrepancies will be reported to the facility administrator immediately K324 1) Maintenance staff will replace broken device under fryer and move stove to correct position 2) Maintenance Director will inspect other devices and placement of equipment to make sure similar occurrences do not recur 3) Maintenance Director will in-service entire kitchen staff on importance of devices and placement of equipment 4) Maintenance Director will audit 5 times per week for 4	6/29/17
K 345 SS=D	NFPA 101 Fire Alarm System - Testing and Maintenance 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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based upon review of documentation and observations of the fire alarm system testing and inspection reports that there documentation does not contain all the required information according to NFPA 72. Findings include Between 1:00 PM and 3:15 PM on 5/16/17, during review of fire alarm inspection and testing reports it is observed that there was no	K 345		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 345	Continued From page 6 documentation noting that the sensitivity test of the smoke detectors has been done within the last 2 years at time of survey. Between 1:00 PM and 3:15 PM on 5/16/17, during review of fire alarm inspection and testing reports the documentation does not list each audible/visual notification devices noting if they pass or fail.	K 345	Continued from page 6 weeks then randomly for 8 weeks. Any discrepancies will be reported to the facility administrator immediately. Audits will be reviewed and revised by QAPI committee for three months.	6/29/17
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing 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 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This Standard is not met as evidenced by: Based upon observations of the sprinkler system that the required maintenance of the system is not being maintained. Findings include Around 3:40 PM on 5/16/17, it is observed that top of storage is above the clear distance of 18	K 353	K345 1) Maintenance staff will perform this years A/V inspection and document findings 2) Maintenance Director will review contracts to ensure proper inspections are being signed for 3) Facility's fire alarm company (BFPE) will be adding A/V inspections to their contract of yearly reports 4) Having BFPE add this to their report will be contracted monitoring on performance	6/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 353	Continued From page 7 inches below the sprinkler head deflector in the physical therapy storage room. Around 3:46 PM on 5/16/17, it is observed that top of storage is above the clear distance of 18 inches below the sprinkler head deflector in central storage. Around 3:55 PM on 5/16/17, it is observed that top of storage is above the clear distance of 18 inches below the sprinkler head deflector in in dry storage in kitchen.	K 353	K353 1) Maintenance staff will remove all items from tops of shelving to clear 18 inches from sprinkler head deflector 2) Maintenance Director inspect other storage areas to ensure there are no other issues 3) Maintenance Director in-service central supply, therapy, and dietary departments 4) Maintenance Director will audit 5 times per week for 4 weeks then randomly for 8 weeks. Any discrepancies will be reported to the facility administrator immediately. Audits will be reviewed and revised by the QAPI committee monthly for 3 months.	6/29/17
K 374 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This Standard is not met as evidenced by: Based upon observations the smoke barrier fire rated doors have gaps between the door and the astragal, there are doors that are not fully closing and doors that are not self closing and latching that could allow smoke to pass through the doors. Findings include Around 3:23 PM on 5/16/17, it is observed that	K 374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 374	Continued From page 8 the fire rated smoke barrier door is not self closing between Winter and Autumn. Around 4:12 PM on 5/16/17, it is observed that the fire rated door in fire wall in back hall at the Summer side is not self closing and latching. Around 4:14 PM on 5/16/17, it is observed that the fire rated smoke barrier door by sprinkler room is not fully closing in Summer. Around 4:25 PM on 5/16/17, it is observed that the fire rated smoke barrier doors between Summer and Spring have a gap that is greater than 1/8". Around 4:44 PM on 5/16/17, it is observed that fire rated door in the fire wall near the conference room is not self closing and latching.	K 374	K374 1) Maintenance staff will fix swing and latch mechanism on door closer (3:23). Replace hinges, tighten door closer, and replace broken latch (4:12). Tighten swing and latch on closer (4:14). Tighten swing and latch on closer to fix 1/8 inch gap (4:25). Replace hinges and magnet, tighten swing and latch mechanism on door closer, replace broken latch (4:44). 2) Maintenance Director will audit 5 times per week for 4 weeks then randomly for 8 weeks. Any discrepancies will be reported to the facility administrator immediately. 3) Maintenance staff will inspect, correct, and document any and all fire door violations during all monthly fire drill reports 4) Maintenance Director will inspect all monthly fire drill reports for accuracy before being filed away.	6/29/17
K 712 SS=E	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This Standard is not met as evidenced by: Based upon observations and review of documentation that the fire drills were not conducted quarterly.	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 712	Continued From page 9 Findings include Between 1:00 PM and 3:15 PM on 5/16/17, during review of the fire evacuation drills it was observed that the documentation did not contain all of the required information for the fire drills. Some of the documentation for the drills had the sign in sheet and did not have the required information referenced by 2012 Virginia Fire Prevention Code section 405.5 (Record Keeping. Records shall be maintained of required emergency evacuation drills and include the following information: 1. Identity of the person conducting the drill., 2. Date and time of the drill., 3. Notification method used. 4. Employees on duty and participating. 5. Number of occupants evacuated if required. 6. Special conditions simulated. 7., Problems encountered., 8 Weather conditions when occupants were evacuated., 9. Time required to accomplish complete evacuation if required.). There is documentation that did not have the time of drill noted and there is no documentation showing the drills were conducted every quarter for each shift. The report for 7/15/16 for 2nd shift did not have a time noted. There is no drill report between 7-5-16 and 11-1-17 for the 3rd shift. There is no drill report between 11-1-16 to 4-3-17 for the 2nd shift. The report for 4/3/17 had the time noted but no AM or PM was not noted. The report for 7-6-16 for 3rd shift did not have a time noted.	K 712	K712 1) Maintenance Director will in-service all staff throughout all shifts to make up for all fire drills that had been missing 2) Maintenance Director will in-service entire maintenance staff on procedures of proper documentation of once per shift per quarter for all fire drill reports 3) Maintenance Director will create a new fire drill documentation form with all pertinent information needed that will be utilized for all fire drill activation 4) Maintenance Director will supervise all fire drills and will inspect documentation for accuracy and organization upon completion before being filed	6/29/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 911	Continued From page 10	K 911		
K 911 SS=B	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) This Standard is not met as evidenced by: Based upon observations the electrical systems and equipment is not being maintained. Findings include Around 4:04 PM on 5/16/17, it is observed that the electrical system is not labeled noting what panels the emergency transfer switch feeds and location, the emergency panels are not labeled noting what transfer switch feeds the panels and location, the transfer switch is not labeled noting what breaker or disconnect feeds the transfer switch for normal power and emergency power and location, and the breaker on the emergency generator is not labeled noting what equipment that it feeds and location.	K 911	K911 1) Maintenance Director will write up a label to be attached to generator with all information needed 2) Maintenance Director will inspect all breaker boxes and panels to ensure no other information is missing 3) Maintenance Director will attach clear coat sleeve for the label to be inserted into then connecting sleeve to generator to ensure label will not detach from generator or accumulate damage from weather 4) During weekly generator inspections maintenance staff will check to make sure label is still intact	6/29/17
K 923 SS=E	NFPA 101 Gas Equipment - Cylinder and Container Storag 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	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 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." 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 Standard is not met as evidenced by: Based upon observations oxygen cylinders having a quantity of over 300 cubic feet in volume are not stored in a room with construction of at least 1-hour fire resistant rating. Findings include Around 4:34 PM on 5/16/17, it is observed that there are oxygen cylinders that are stored in room in service corridor of Spring and Winter that are over 300 cubic feet in volume and the room is not	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING 01 - MAIN BUILDING B. WING _____	05/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116

(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 12 constructed to provide a 1-hour fire resistance rating. The door and door hardware is not labeled and listed in the Service Corridor of Spring. The door is not labeled and listed and door hardware is missing on the door in the Service Corridor of Winter.	K 923	K923 1) Maintenance staff will remove all oxygen tanks until the required amount per cubic feet is met. Will order and install door hardware 2) Maintenance Director will in-service staff on not storing an excess amount of oxygen cylinders in the storage room along with inspecting rest of storage rooms to ensure all other doors that are required to fire rated are just that and that no other hardware is broken or damaged or in the process of either 3) Maintenance Director will audit 5 times per week for 4 weeks then randomly for 8 weeks. Any discrepancies will be reported to the facility administrator immediately. Audits will be reviewed and revised by the API committee monthly for 3 months. 4) Inspections of all oxygen rooms will be added to hourly administrative rounds that each department head is responsible for to make sure problems do not recur.	6/29/17