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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LNJO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: VAICFMR58

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **49G050**
2. STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **CRI SNOWFLAKE DRIVE**
(L4) **4541 SNOWFLAKE DRIVE**
(L5) **RICHMOND, VA** (L6) **23237**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/06/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **11** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)

11. LTC PERIOD OF CERTIFICATION
From (a):
To (b):

12. Total Facility Beds **6** (L18)
13. Total Certified Beds **6** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
				6
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
health 07/05/2018 - 07/06/2018
lsc 07/20/2018

17. SURVEYOR SIGNATURE
Paul Ware for R Trollinger
Date: 09/26/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL
Paul Ware
Date: 09/26/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/11/2010
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/26/2018
(L33)

DETERMINATION APPROVAL

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

FORM APPROVED
OMB NO. 0938-0062

INTERMEDIATE CARE FACILITY FOR PERSONS WITH MENTAL RETARDATION
SURVEY REPORT

1. Name of Facility	2. Street Address	3. City and/or County	4. State	5. ZIP Code
Snowflake	4541 Snowflake Dr.	Richmond	VA	23237

6. Medicaid Provider No.	7. Name of CEO	8. Telephone No.
496-050	Authur Ginsberg	804-271-2755 W1

9. State/Region code	10. State/County code	11. Dates of Survey (Begin) Month / Day / Year W4	(End) Month / Day / Year W5
W2	W3	7-5-18	7-6-18

12. Type of Ownership or Control (enter number in box below) W6
[1] 1. Private (non-profit) 2. Private (proprietary) 3. State 4. City/Town 5. County 6. City/County 7. Other (specify) _____

13. Is this ICF/MR a distinct part of a Hospital, SNF or NF? W7
☐ Yes ☑ No

14. If "Yes" to block 13, indicate either W8
A. Hospital Provider No. .....
B. SNF Provider No. .....
C. NF Provider No. .....

15. Survey Team Composition

Column 1: Indicate the number of disciplines represented on the Survey team.

Column 2: Of the number in column 1 represented on the Survey team, indicate the number who also qualify as a QMRP. Indicate Name(s) and Title(s) on last page of this form.

	W9	W10
A. Administrator		
B. Nurse	3	0
C. Dietitian		
D. Pharmacist		
E. Records Administrator		
F. Social Worker		
G. LSC Specialist		
H. Laboratorian		
I. Sanitarian		
J. Therapist		
K. Physician		
L. Psychologist		
M. Other (specify) _____		
N. Total number of Surveyors onsite	W11	3
O. Total number of QMRP Surveyors onsite	W12	0

16. Facility Data:

A. Is this ICF/MR a residential unit within a larger organization or agency in the State that provides residential services to persons with mental retardation? *(check one)* ☑ Yes ☐ No W13
If "No", proceed to item C.

B. If "Yes," indicate name and address of larger organization.
Name: Community Residences Inc.
Address: 14160 Newbrook Drive
City: Chantilly State: VA ZIP Code: 20151
Name of CEO: Authur Ginsberg

Total Number of Beds	W14	120
Total Number of Clients *(including ICF/MR clients directly served)*	W15	110
C. Total Number of ICF/MR Clients	W16	06
D. Is this ICF/MR community-based? *(check one)* ☑ Yes ☐ No	W17	
E. Total number of ICF/MR beds under this Provider No.	W18	01
F. Total number of discrete living units under this Provider No.	W19	01
G. Age range of clients served from 36 to 62	W20 / W21	
H. Total number of off-campus day program sites used by ICF/MR clients	W22	04

17. Staffing: List the full time equivalents who function in this capacity:

A. Direct Care Personnel (483.430(d)(3))	W23	12.28
B. Registered Nurse (483.480(d)(3))	W24	1.00
C. Licensed Voc./Practical Nurse (483.480(d)(2))	W25	1.00
D. Total Personnel (W26) *(List the Full Time Equivalent for all employees)*		14.28

18. Off-Campus Day Programs:

A. How many clients in the sample attend off-campus day programs?	W27	5
B. In how many off-campus day program sites was an observation done by the Surveyor?	W28	2

20. Individual Characteristics *(Note: The total number in Items B-L (Col.(a)) may exceed the facility's population because some clients have multiple disabilities)*

A.

(1) Age

under 22(a)		W29
22-45 (b)	1	W30
46-65 (c)	5	W31
66+ (d)		W32
[redacted] Total	6	W33

(2) SEX

Male	5	W34
Female	1	W35
[redacted] Total	6	W36

B. DISABILITIES

(1) Mental Retardation

Mild	3	W37
Moderate	1	W38
Severe	0	W39
Profound	2	W40
[redacted] Total	6	W41

(2) Autism	1	W42
(3) Cerebral Palsy	2	W43
(4) Epilepsy	[redacted]	
Controlled	1	W44
Uncontrolled		W45
[redacted] Total	1	W46

C. OTHER DISABILITIES

(1) Non-ambulatory

Mobile	4	W47
Non-Mobile	2	W48
[redacted] Total	6	W49

(2) Speech/Language Impairment	3	W50
(3) Hearing Impairment		
Hard of Hearing	2	W51
Deaf	1	W52
[redacted] Total		W53

(4) Visual Impairment

Impaired	3	W54
Blind	0	W55
[redacted] Total	3	W56

D. MEDICAL CARE PLAN	0	W57
E. DRUGS TO CONTROL BEHAVIOR	1	W58
F. PHYSICAL RESTRAINTS	0	W59
G. TIME-OUT ROOMS	0	W60
H. APPLICATION OF PAINFUL OR NOXIOUS STIMULI	0	W61
I. NUMBER ATTENDING OFF-CAMPUS DAY PROGRAMS	6	W62
J. NUMBER OF COURT ORDERED ADMISSIONS	0	W63
K. NUMBER OF CLIENTS OVER AGE 18 WITH A LEGAL GUARDIAN ASSIGNED BY THE COURT	0	W64

L. OTHER *(specify)*

(1)		W65
(2)		W66
(3)		W67

M. ALLEGATIONS OF ABUSE AND NEGLECT

no. of allegations of abuse investigated (a)	0	W68
no. of allegations of neglect investigated (b)	1	W69
[redacted] Total	1	W70

N. NUMBER OF DEATHS

no. of deaths related to unusual incidents (a)	0	W71
no. of deaths related to restraints (b)	0	W72
no. of deaths for any reason (c)	0	W73
[redacted] Total	0	W74

GPO U.S. GOVERNMENT PRINTING OFFICE: 2007— 339-313/20255

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G050	A. BUILDING _____ B. WING _____	07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI SNOWFLAKE DRIVE	4541 SNOWFLAKE DRIVE RICHMOND, VA 23237

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7-5-18 through 7-6-18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
W 000	INITIAL COMMENTS An unannounced 55 Fundamental Medicaid Certification survey was conducted 7-5-18 through 7-6-18. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities. The Life Safety Code survey/report will follow. There were no complaints. The census in this 6 certified bed facility was 5 at the time of the survey. The survey sample consisted of 3 Individual reviews (Individuals #1 through #3).	W 000		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure fire drills were held quarterly for each shift for the 7-3- shift. The findings included: Review of the facility's fire drills revealed the following:	W 440	1. Program Manager will review and update the fire drill schedule to make sure it captures the day shift, evening shift and overnight shifts for all quarters. 2. Program Manager will post updated fire drill schedule in the Program. 3. Program Manager will conduct an in service with staff to review the importance of conducting fire drills during the day shift, evening shift and overnight shifts every quarter. 4. Program Manager will review fire drill documentation monthly to make sure the drill was completed during the appropriate shift. 5. Clinical Director will oversee the quality of all services in the program to include fire drills and address areas of concern with Program Manager during supervision.	08/10/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Valerie Tansinda
TITLE: Clinical Director
(X6) DATE: 07/23/2018

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
	49G050	A. BUILDING _____ B. WING _____	07/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI SNOWFLAKE DRIVE	4541 SNOWFLAKE DRIVE RICHMOND, VA 23237

(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
W 440	Continued From page 1 The 11-7 shift conducted fire drills for the following dates: 5-26-18 2-28-18 1-31-18 11-22-17 8-29-17 5-13-17 The 3-11 shift conducted fire drills for the following dates: 6-9-18 3-18-18 12-17-17 9-30-17 6-14-17 The 7-3 shift conducted fire drills for the following dates: 1-31-18 On 7-5-18 at approximately 3:30 PM, an interview with the Program Manager was conducted. He stated, "I didn't know." The Program Manager was notified of the oversight. The Program Manager stated he had no further documentation to present.	W 440		

COMMONWEALTH of VIRGINIA

Virginia Department of Fire Programs

Michael T. Reilly
EXECUTIVE DIRECTOR

Brian M. McGraw, P.E.
STATE FIRE MARSHAL

State Fire Marshal's Office
Division 1
1005 Technology Park Drive
Glen Allen, VA 23059-4500
Phone: 804/ 371-0220
Fax: 804/ 371-3367

Kathaleen Creegan-Tedeschi, Director
Office of Licensure/Certification
Division of Long Term Care
Virginia Department of Health
9960 Mayland Drive
Perimeter Center Suite 401
Henrico, VA 23233

RE: Cri Snowflake Drive
4541 Snowflake Drive
Richmond, VA. 23237
File Number: C-1353-001
CMS Certification Number: **49G050**
Event ID Number: **LNJO21**

The attached report is forwarded to you with the following comments:

I. SURVEY [X]

[X] Recommend certification based on compliance with Life Safety Code.
[ ] Recommend certification based on acceptable POC.
[ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
[ ] Recommend certification based on compliance with LSC by requested continuous waiver.
[ ] Recommend certification based on compliance with LSC by requested Time Limited waiver.
[ ] Recommend certification based on satisfactory results from application of the FSES.
[ ] Do not recommend certification.

II. POST SURVEY [ ]

[ ] All deficiencies corrected:

[ ] All deficiencies not corrected:

- [ ] Recommend certification based on acceptable POC
- [ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
- [ ] Recommend certification based on approved or requested continuous waiver.
- [ ] Recommend certification based on approved or requested Time Limited waiver.
- [ ] Do not recommend certification.

If you have any questions or if we may be of further assistance, please contact me at 804-371-0220

Sincerely,

John J Cullinane

John Cullinane
Life Safety Code Coordinator

Survey Date: 07/20/2018 SOD Sent: 09/18/2018 POC Rec 'd: NA POC to HQ: 09/24/2018
Highest Scope/Severity: NA

PART VI - FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS 2786 FORMS)

C-1353-001

Provider Number	Facility Name	Survey Date
49G050	CRI Snowflake ICF	20 July 2018
K1		*K4

K6 DATE OF PLAN APPROVAL: 12/4/2009

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS: 1

NUMBER OF THIS BUILDING: 01

[A]
A. BUILDING
B. WING
C. FLOOR
D. APARTMENT UNIT

LSC FORM INDICATOR

HEALTH CARE FORM		
12	2786R	2012 EXISTING
13	2786R	2012 NEW

AHCO FORM		
14	2786U	2012 EXISTING
15	2786U	2012 NEW

ICF/IID FORM		
16	2786V, W, X	2012 EXISTING
17	2786V, W, X	2012 NEW

*K7 [16] SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

SMALL (16 BEDS OR LESS)

K8 [1]
1. PROMPT
2. SLOW
3. IMPRACTICAL

LARGE

K8 [ ]
4. PROMPT
5. SLOW
6. IMPRACTICAL

APARTMENT HOUSE

K8 [ ]
7. PROMPT
8. SLOW
9. IMPRACTICAL

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, and Y.)

K321: [ ] K351: [ ]

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

ENTER E – SCORE

K5: [ ] e.g. 2.5

*K9 FACILITY MEETS LSC BASED ON *(Check all that Apply)*

A1. [✓]	A2. [ ]	A3. [ ]	A4. [ ]	A5. [ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. [ ]

K0180

A. [✓]	B. [ ]	C. [ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G050	A. BUILDING **01 - CRI SNOWFLAKE** B. WING _____	**07/20/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRI SNOWFLAKE DRIVE	**4541 SNOWFLAKE DRIVE RICHMOND, VA 23237**

(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: One story construction type of V (000) Sprinkler status: The facility is not sprinklered. An unannounced Life Safety Code re-certification survey was conducted on 20 July 2018, in accordance with 42 Code of Federal Regulation, Part 483.150 and 410 to 480: Requirements for Intermediate Care Facilities for Persons with Intellectual Deficiencies. The facility was surveyed for compliance using the LSC 2012 ICF/ID Existing regulations. The facility was in compliance with the Requirements for Participation in Medicare and Medicaid.	K 000		

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

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.

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

C-1353-001

2012 LIFE SAFETY CODE
Form approved OMB Exempt

FIRE SAFETY SURVEY REPORT – 2012 LIFE SAFETY CODE
Intermediate Care Facilities for Individuals with Intellectual Disabilities
SMALL FACILITIES

1. (A) PROVIDER NO.	1. (A) MEDICAID I.D. NO.
49G050 K1	K2

PART I – Instructions for Completing the Form (CMS-2786V)
PART II – Existing Resident Board & Care Occupancies Requirements (NFPA 101, Chapter 33)
PART III – New Residential Board & Care Occupancies Requirements (NFPA 101, Chapter 32)
PART IV – Building Services (New and Existing Facilities)
PART V – Operating Features (New and Existing Facilities)
PART VI – Crucial Data Extract
Optional – Fire Safety Evaluation System for Board and Care Occupancies (CMS-2786Y, NFPA 101A, Chapter 7)

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACULTY (STREET, CITY, STATE, ZIP CODE)	
CRI Snowflake ICF	A. BUILDING 01 B. WING C. FLOOR K3	4541 Snowflake Dr. North Chesterfield Va. 23237	A. ☐ Fully Sprinklered (All required areas are sprinklered) B. ☐ Partially Sprinklered (Not all required areas are sprinklered) C. ☑ None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER:
☐ MEDICARE ☐ MEDICAID	20 July 2018 K4	12/4/2009 K6	5. ☑ 2012 EXISITING 6. ☐ 2012 NEW K7

E-SCORE: 1.32
K5

USE FOR EXISTING FACILITIES ONLY	
E-Score	Level of Evacuation Difficulty
≤ 1.5	Prompt
> 1.5 ≤ 5.0	Slow
> 5.0	Impractical

5. SURVEY FOR CERTIFICATION OF: SMALL FACILITY - LEVEL OF EVACUATON DIFFICULTY (*Check one*)
USE FOR EXISTING FACILITIES ONLY
1. ☑ Prompt 2. ☐ Slow 3. ☐ Impractical
K8

6. BED COMPOSITION	e. NUMBER OF ICF/IID BEDS CERTIFIED FOR MEDICAID
a. TOTAL NO. OF BEDS IN THE FACILITY 6	6

6. A. ☐ THE FACILITY MEETS, BASED UPON *(check all appropriate boxes)*:
1. ☐ COMPLIANCE WITH ALL PROVISIONS 2. ☐ ACCEPTANCE OF A PLAN OF CORRECTION 4. ☐ FSES 5. ☐ PERFORMANCE BASED DESIGN
B. ☐ THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR *(Signature)*	TITLE	OFFICE	DATE
Darnell Weatherington SURVEYOR ID 14953 K10	Deputy State Fire Marshal	Virginia State Fire Marshal's Office14953	9/24/18
FIRE AUTHORITY OFFICIAL *(Signature)* Calvin Dee Madsen	CDSFM	SFMO Division 1	9/24/18

CMS FORMS SHALL BE COMPLETED AND RETAINED AS PART OF THE SURVEY RECORD.