W-6760-001

Printed: 06/18/2019 FORM APPROVED OMB NO. 0938-0391

STATEM	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE	D/OLIA	(X2) MU	TIPLE CONSTRUCTION	OMB NO	O. 0938-0391
AND PL	AN OF CORRECTION	IDENTIFICATION NU	:H/CLIA MBER:	A. BUILD	LTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X3) DATE S	SURVEY
•		405450			MAIN DOILDING OF	COMPL	ETED
MALIE		495156		B. WING		05/6	02/2019
CURIS	F PROVIDER OR SUPPLIER		STREET ADD	PRESS, CITY	Y, STATE, ZIP CODE	03/0	72/2019
Contract	AT ROANOKE TRAN	SITIONAL CARE &	324 KII	NG GEOF	RGE AVE SW		
(X4) ID	0111414		HOAN	OKE, VA	24016		
PREFIX	CENTRE DEFICIENCY MUST	TEMENT OF DEFICIENCIES	S SECULATORY	1D	PROVIDER'S PLAN OF CORRECT	ION	/X5)
TAG	OR LSC IDE	NTIFYING INFORMATION)	LEGOLATORT	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	II P DC	COMPLETION DATE
Koo	0 INITIAL COMMENT	0			DEFICIENCY)	PHIAIE	
	O MATTIAL GOIVINENT	5		K 000			
	Surveyor: 21761		1				
	Construction Type: I	II (200)					
	Description of structi	ure: The facility is a	single				
	story building with a walls and unprotecte	d non- combustible	erior				
	construction. The dir	ing area has wood t	russes				1
	and sneathing which	classifies the building	10 20				
	type III (200) constru- contains support sen	ction. A partial baser	nent		1		
	equipment and stora	ge rooms. The hase	ment is			1	
	classified as one larg	e storage area.					
	Sprinkler status: The	facility in fully				1	1
	with an NFPA #13 sys	stem. The system is	Supplied				
1	by city water and the	Dressure is sunnlam	ented				
	by an electric fire pun	np.				1	
1	An unannounced star	idard recertification I	ifo			- 1	
	Safety Code survey w	as conducted 05/02	/10 in	1		1	
	accordance with 42 C	ode of Federal Regu	dation	1			
	Part 483: Requirement Facilities. The facility	its for Long Term Ca	ire				
	compliance using the	LSC 2012 Existing	ļ				
	regulations. The facili	ty was not in complia	ance		•	1	1
	with the Requirements and Medicaid.	for Participation Me	dicare			- 1	
	and Modicald,			1			
	The findings that follow	v demonstrate					
	non-compliance with T	itle 42 Code of					
	Regulations, 483.70(a) Fire.)	et seq (Life Safety)	from	1		1	- 1
VK 211	Means of Egress - Ger	noral					
SS=F	CFR(s): NFPA 101	lerai		K 211			
				1			
	Means of Egress - Ger	neral					
	Aisles, passageways, of exit locations, and acce	corndors, exit discha	rges,	1			
	with Chapter 7, and the	means of earess is	rice				
LABORATOR	Y DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTA	TIVE'S SIGNATI	IDE			
1	1 0 00		G SIGNAT	ME	TITLE	(X6)	DATE

6-20-2019 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 allowing 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 program participation.

AN HULL

Printed: 06/18/2019 FORM APPROVED MB NO. 0938-0391

K 211 Continued From page 1 continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.1 through 18/19.2.1.1 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain the egress doors, evidenced as follows; Findings include: On 05/02/19, at approximately 4:04 PM, it was observed during inspection the Activities room door to the corridor has two deadbolts installed with thumb latches. The Maintenance Director witnessed this evidence through observation and interview. Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 K 211 K211 Means of Egress-General 1.The activities room door leading to the corridor had two dead bolted thumb locks, the activity room door locks were removed on 6-3-2019 from the inside of the door. 2.The maintenance Director will inspect the facility to ensure that no Other deadbolt locks are installed. 3.Maintenance Director will complete an audit on all doors in the facility and then weekly x 4 weeks, then monthly x 3 months and present the findings at the QA meeting for the next 3 months. This correction was completed prior to 6/15/19. 5. Surveyor: 21761 K 221 SS=F		TO FOR WEDICARE	& MEDICAID SERV	/ICES				APPHOV
NAME OF PROVIDER OR SUPPLIER CURIS AT ROANOKE TRANSITIONAL CARE & SUMMARY STATEMENT OF DEFICIENCIES PREFER TAGGE AVE SW ROANOKE, VA 24016 SUMMARY STATEMENT OF DEFICIENCIES PREFER TAGGE AVE SW ROANOKE, VA 24016 K 211 Continued From page 1 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 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain the egress doors, evidenced as follows: Findings include: On 05/02/19, at approximately 4:04 PM, it was observed during inspection the Activities room door to the corridor has two deadbolts installed with thumb latches. The Maintenance Director witnessed this evidence through observation and interview. Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the porridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain the egress doors, evidenced as follows: Findings include: On 05/02/19, at approximately 4:04 PM, it was observed during inspection the Activities room door to the corridor has two deadbolts installed with thumb latches. The Maintenance Director witnessed this evidence through observation and interview. Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2.19.2.2.2.174.12.4 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the	STATEME AND PLAN	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA MBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DATE SI	URVEY
CURIS AT ROANOKE TRANSITIONAL CARE & ROANOKE, VA 24016 (A4) ID PRIETRY EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG PROVIDERS PLAN OF CORRECTION PRETRY EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG PROVIDERS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE 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: 21761 Based on observation and interview, it was revealed the facility falled to maintain the egress doors, evidenced as follows; Findings include: On 05/02/19, at approximately 4:04 PM, it was observed during inspection the Activities room door to the corridor has two deadbolts installed with thumb latches. The Maintenance Director witnessed this evidence through observation and interview. K 221 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5 18.2.2.2, 19.2.2.2.7 IA 12-4 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain natient province of the corridor of the corridor of the ordinal province of the corridor of the corridor had two dead bolted thumb locks, the activity room door locks were removed on 6-3-2019 from the inside of the door. 2.The maintenance Director will Inspect the facility to ensure that no Other deadbolt locks are installed. 3.Maintenance Director will complete an audit on all doors in the facility and then weekly x 4 weeks, then monthly x 3 months and present restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2 in			495156	i	B. WING_		05/0	0/0040
CAU DEPARTMENT CARREST CANNOKE TRANSITIONAL CARE & S24 KING GEORGE AVE SW ROANOKE, VA 24016	NAME OF	PROVIDER OR SUPPLIER		STREET ADD	RESS CITY	STATE ZIR CODE	05/0	2/2019
PREFIX TAG K 211 Continued From page 1 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 Based on observation and interview, it was observed during inspection the Activities room door to the corridor has two deadbolts installed with thumb latches. The Maintenance Director witnessed this evidence bring Patient Sleeping Room Doors K 221 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the cordior does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain the egress doors, evidenced as follows: K 221 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the cordior does not restrict egress from the patient com, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. Signature of the patient com, or the locking arrangement is permitted unless the key-locking device that restricts access from the cordior does not restrict egress from the patient com, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. Signature of the patient com, or the locking arrangement is permitted unless the key-locking device that restricts access from the cordior does not restrict egress from the cordior does not restrict egres from the patient community of the patient clinical, security or safety needs in accordance with 18.2.2.2, 19.2.2.2, 114.2.4				324 KIN ROANO	IG GEOR	GE AVE SW		
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: 21761 Based on observation and interview, it was revealed the facility failed to maintain the egress doors, evidenced as follows: Findings include: On 05/02/19, at approximately 4:04 PM, it was observed during inspection the Activities room door to the corridor has two deadbolts installed with thumb latches. The Maintenance Director witnessed this evidence through observation and interview. Patient Sleeping Room Doors CFR(s): NFPA 101 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient from, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2, 19.2.2.2.15 1.The activities room door leading to the corridor had two dead bolted thumb locks, the activity room door locks were removed on 6-3-2019 from the inside of the door. 2.The maintenance Director will lnspect the facility to ensure that no Other deadbolt locks are installed. 3.Maintenance Director will complete an audit on all doors in the facility and then weekly x 4 weeks, then monthly x 3 months and present the findings at the QA meeting for the next 3 months. This correction was completed prior to 6/15/19.	PRÉFIX TAG	OR LSC IDE	BE PRECEDED BY FULL F NTIFYING INFORMATION)	ES REGULATORY	PREFIX	CROSS-REFERENCED TO THE APPL	חווו ח פכ	(XS) COMPLETIO DATE
Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain the egress doors, evidenced as follows; Findings include: On 05/02/19, at approximately 4:04 PM, it was observed during inspection the Activities room door to the corridor has two deadbolts installed with thumb latches. The Maintenance Director witnessed this evidence through observation and interview. Patient Sleeping Room Doors CFR(s): NFPA 101 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2. 19.2.2.2.7 IA 12-4 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain patient	N 211	continuously mainta full use in case of er 18/19.2.2 through 18 18.2.1, 19.2.1, 7.1.1	ined free of all obstra nergency, unless mo 3/19.2.11. 0.1	odified by	K 211	1.The activities room door		
Findings include: On 05/02/19, at approximately 4:04 PM, it was observed during inspection the Activities room door to the corridor has two deadbolts installed with thumb latches. The Maintenance Director witnessed this evidence through observation and interview. Patient Sleeping Room Doors CFR(s): NFPA 101 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2.19.2.2.2. TIA 12-4 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain natient		Surveyor: 21761 Based on observation revealed the facility f	n and interview, it was alled to maintain the	ae		corridor had two dead bo	oor locks we	
On 05/02/19, at approximately 4:04 PM, it was observed during inspection the Activities room door to the corridor has two deadbolts installed with thumb latches. The Maintenance Director witnessed this evidence through observation and interview. Patient Sleeping Room Doors CFR(s): NFPA 101 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.1 ha 12-4 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain patient			follows;		; 		n the inside	
evidence through observation and interview. K 221 SS=F GFR(s): NFPA 101 Patient Sleeping Room Doors CFR(s): NFPA 101 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2. 19.2.2.2, TIA 12-4 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain patient		door to the corridor h	ection the Activities	room		2.The maintenance Directo		
SS=F CFR(s): NFPA 101 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain patient	K 804	evidence through obs	servation and interview	ew.				
Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain patient	SS=F	Patient Sleeping Roo CFR(s): NFPA 101	m Doors	İ	K 221			
restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain patient	i	Locks on patient sleer	oing room doors are	re not				
arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain patient	1	restricts access from	the corridor does not	restrict				
18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain patient	10	arrangement is permit	ted for patient clinica	al l	Ì			
Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain nations	1,	18.2.2.2.5 or 19.2.2.2. 18.2.2.2, 19.2.2.2, TIA This REQUIREMENT	5. .12-4	1	İ			
room doors, evidenced as follows;	E	Surveyor: 21761 Based on observation revealed the facility fai	n and interview, it was				<u> </u> 	

DEPARTMENT OF HEALTH AND HUMAN SERVICES Printed: 06/18/2019 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 495156 B. WING 05/02/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **CURIS AT ROANOKE TRANSITIONAL CARE &** 324 KING GEORGE AVE SW ROANOKE, VA 24016 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (X5) MPLETION DATE PREFIX EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 221 Continued From page 2 K 221 Findings include: **K221 Patient Sleeping Room Doors** 1. On 05/02/19, at approximately 4:48 PM, it was 1. Patient room doors not closing correctly in observed during inspection the door to resident room 56 is not completely closing. room #56, #63, #19 2. On 05/02/19, at approximately 4:55 PM, it was 2. Patient room doors were adjusted in each observed during inspection the door to resident room 63 is not completely closing. room so that the doors would close 3. On 05/02/19, at approximately 5:17 PM, it was appropriately. observed during inspection the door to resident room 19 is not completely closing. 3. Maintenance Director will audit and inspect all The Maintenance Director witnessed this patient room doors weekly x 4 weeks, and then evidence through observation and interview. K 293 Exit Signage monthly x3 months to ensure proper closure. K 293 SS=F CFR(s): NFPA 101 4. Maintenance Director will complete an audit Exit Signage 2012 EXISTING and report findings at the QA meeting for the Exit and directional signs are displayed in accordance with 7.10 with continuous illumination next 3 months. This correction will be also served by the emergency lighting system. 19.2.10.1 accomplished by 6-21, 2019. (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit K293 Exit Signage travel is obvious.) This REQUIREMENT is not met as evidenced Signage leading to the enclosed courtyard bv: Surveyor: 21761 at the adon office, beauty shop and activities Based on observation and interview made on room marked has been corrected and now 05/02/19, it was revealed the facility failed to provide proper exit signage, evidenced as reads "No Exit" follows:

On 05/02/19, at approximately 4:05 PM, it was

observed during inspection the Activities room

Findings include:

2. Maintenance Director will monitor all exits

and ensure that no additional signage will

be added with NO EXIT on the sign.

Printed: 06/18/2019 FORM APPROVED MB NO. 0938-0391

CTATCHENT OF STATE		I SELLAND	720			OMB NO. 0938-039	
STATEMENT OF DEFIC AND PLAN OF CORRE	CTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER	CLIA BER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		495156		B. WING_		05/02/2019	
NAME OF PROVIDER O			STREET ADD	DRESS, CITY,	STATE, ZIP CODE		
CURIS AT ROAN	OKE TRAN	SITIONAL CARE &			GE AVE SW		
v				OKE, VA 2			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	!				
TAG (EACH DEF	OR LSC IDE	BE PRECEDED BY FULL RE NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D RF COMPLETION	
K 293 Continu	ed From pa	ge 3	!	K 293	3.Maintenance Director will pe	rform an audit	
door lea	ding from th	e building into the end	losed		5. Mantenance Director will be	riorm an audit	
courtyar	d is not mar	ked as "No Exit".	i		of all exits and will continue to	rapart tha	
		*			or all exits and will continue to	report the	
observed	d during ins	approximately 5:00 PM pection the Old ADON	office		results during the QA meeting t	for 3 months.	
courtyard	ding from the	e building into the end ked as "No Exit".	losed		4. Signage was corrected on Ma	y 23 rd , 2019.	
3 On 05	5/02/10 at a	maravia ataly 5 00 Dt		1		ļ.	
ohserver	during ince	pproximately 5:20 PM pection the Beauty Sho	, it was				
leading f	rom the huil	ding into the enclosed	op aoor				
courtvard	is not mari	ked as "No Exit".					
1	- 10 Hot man	TO AS THO EXIL.					
The Mair	tenance Di	rector witnessed this	1	į			
evidence	through ob	servation and interview	٧ :	1		1	
		laintenance and Testir					
SS=F, CFR(s):	VEDA 101	iamenance and Testir	ig	K 353	K353 Sprinkler System- Mainte	nance	
00=1 01 11(0). 1	4.17(101				The state of the s	inance	
Sprinkler	System - M	aintenance and Testin	a	Į.	and Testing		
Automatic	sprinkler a	nd standpipe systems	are	i	_		
; inspected	i, tested, an	d maintained in accord	dance :	į	1.The facility will maintain the i	ntegrity	
with NFP	A 25, Stand	ard for the Inspection	i			inceginty	
lesting, a	ınd Maintair	ing of Water-based Fi	re	ļ	of the sprinkler system.		
Protection	n Systems.	Records of system des	sign,	i			
maintena	nce, inspec	ion and testing are	1		2.Facility employed a Sprinkler (Contractor to	
maintaine	d in a secui	e location and readily					
available.					replace rusted sprinklers in the	kitchen.	
a) Date s	sprinkler sys	stem last checked				t t	
b) Who r	provided sys		1	•	3. Escutcheon trim ring was repla	aced in the	
0) 44110	Jiovided Sys	stem test	ļ.	ì			
c) Water	system sup	univ course	1		Biohazard room in Station II.		
o) water	System Sup	iply source		1	2 Dest le le		
Provide in	REMARKS	information on covera	100	Į.	3. Dust laden sprinklers have bee	en cleaned	
for any no	n-required o	or partial automatic spr	inklor	i	hohind the days		
system.	quil ou (- Partial automatic spi	IIIVIEI		behind the dryers.		
	7, 9.7.8, and	NFPA 25	į.		1 Coiling tile bus		
This REQ	JIREMENT	is not met as evidence	ed		Ceiling tile has been replaced !	pehind the	
; by:			1		dryers.		
Surveyor:	21761				,		
				K 353 A	ll corrected and completed on I	May 29, 2019	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 06/20/2019

CENT	ERS FOR MEDICARE	& MEDICAID SERVICE	S				APPROVE
STATEM AND PLA	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	LIA R:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE SL COMPLE	
		495156		B. WING		05/0/	2/2010
	F PROVIDER OR SUPPLIER	ST	TREET ADD	RESS, CITY	, STATE, ZIP CODE	05/02	2/2019
	AT ROANOKE TRAN	SITIONAL CARE &	324 KIN	NG GEOF OKE, VA	RGE AVE SW		
(X4) ID PREFIX TAG	OR LSC IDE	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REG NTIFYING INFORMATION)	ULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	IIIDBE	(X5) COMPLETION DATE
K 35	Based on observation revealed the facility sprinkler systems. affects one of three evidenced as follow. Findings include: 1. On 05/02/19, at a observed during insplacen sprinklers beh 3. On 05/02/19, at a observed during insplacen sprinklers beh 3. On 05/02/19, at a observed during insplacen sprinklers beh	on and interview, it was failed to maintain the This violation potentially smoke compartments, s; approximately 2:07 PM, pection six sprinklers in the peroximately 4:15 PM, is pection there are two dues failed to maintain the pection there are two dues failed to maintain the pection there are two dues failed to maintain the pection there are two dues failed to maintain the pection there are two dues failed to maintain the pection there are two dues failed to maintain the pection there are two dues failed to maintain the pection there are two dues failed to maintain the pection there are two dues failed to maintain the pection the pection there are two dues failed to maintain the pection the pection there are two dues failed to maintain the pection and the pection	it was the it was st	K 353			
K 355 SS=F	4. On 05/02/19, at a observed during insp missing behind the d collection at the sprin. The Maintenance Direvidence through observable Fire Extingu CFR(s): NFPA 101 Portable Fire extinguis inspected, and mainten NFPA 10, Standard for Extinguishers. 18.3.5.12, 19.3.5.12.	pproximately 4:19 PM, it ection there is a ceiling ryers that may affect heaklers. ector witnessed this servation and interview. ishers ishers shers are selected, instatatined in accordance with pr Portable Fire	t was tile at	K 355	K355 Portable Fire Extinguish 1.The laundry room fire exting not signed for April's monthly 2.The maintenance director in fire extinguisher in Laundry roupdated the inspection date, all others to ensure each are in	guisher was inspection. spected the oom and and checked	d

Surveyor: 21761

by:

are signed monthly.

Printed: 06/20/2019 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES		100-111		OMB NO. 0938-0391	
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		495156	B. WING		05/02/2019	
	PROVIDER OR SUPPLIER AT ROANOKE TRAN	SITIONAL CARE & 324	ADDRESS, CITY KING GEOI NOKE, VA	RGE AVE SW 24016	1 200	
(X4) ID PREFIX TAG	OR LSC IDE	NTEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATOR NTIFYING INFORMATION)	T	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ID BE COMPLETION	
	Continued From pa Based on observation revealed the facility extinguishers, evide	on and interview, it was failed to maintain the fire	K 355	3.Maintenance Director will r sign each extinguisher on a m 4.Maintenance Director will a	nonthly basis.	
	Findings include: On 05/02/19, at approbserved during inspectinguisher is missinspection.	roximately 4:17 PM, it was pection the Laundry room fire ng the April monthly		completion of monthly inspe signatures. 5.Audits will be presented an	ection and	
K 374	The Maintenance Di evidence through ob	rector witnessed this servation and interview. ng Spaces - Smoke Barrie	K 374	the next 3 QA meetings. All inspections up to date as o		
	Doors 2012 EXISTING Doors in smoke barri bonded wood-core de resists fire for 20 min plates of unlimited he are permitted to have assemblies per 8.5. I automatic-closing, do are not required to sw egress travel. Door of clear width of 32 inch doors. 19.3.7.6, 19.3.7.8, 19 This REQUIREMENT by: Surveyor: 21761 Based on observation	Doors are self-closing or not require latching, and ving in the direction of pening provides a minimum es for swinging or horizontal 3.7.9 is not met as evidenced and interview, it was iled to maintain the corridor		K374 Subdivision of Building S Smoke Barrier Doors 1. The Smoke barrier doors by to room, nurse station 2 door, and nurse not closing due to the failure of 2. All smoke barrier cross corridor been audited and repaired so the correctly.	the bio waste e station 3 and 4 the coordinator. or doors have	

Printed: 06/20/2019 FORM APPROVED OMB NO. 0938-0391

STATEME	NT OF PERIORS INC.		T			OWR NO	<u>. 0938-0391</u>
AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A. BU	ILDI	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
		495156	B. WI	NG_		05/0:	2/2019
NAME OF	PROVIDER OR SUPPLIER	STREE	TADDRESS C	ITY	STATE, ZIP CODE	30/0/	2013
CURIS	AT ROANOKE TRAN	SITIONAL CARE & 32	4 KING GE PANOKE, V	OR	GE AVE SW		
(X4) ID PREFIX TAG	OR LSC IDE	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULAT NTIFYING INFORMATION)	ORY PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	II D RE	(X5) COMPLETION DATE
K 374	Continued From pa	ge 6 .	Кз	74	3.The Maintenance Director w	ill continu	e to audit
	observed during ins	approximately 4:35 PM, it w pection the Station II smoke	as		and adjust doors weekly x 4 we		
	room have one leaf	r doors by the Bio-waste not closing due to the failur	e		months to ensure so they oper	ate correc	ctly.
	of the coordinator.				4.The Maintenance Director wi	il submit h	nis monthly
	observed during insi	approximately 4:45 PM, it was section the Station 4 smoke	as		audit of doors to the QA comm	ittee for 3	months.
	closing due to the fa	r doors have one leaf not ilure of the coordinator.			5.Doors in compliance on May 2	23 rd , 2019.	
	observed during insp barrier cross corrido	approximately 5:12 PM, it was section the Station 3 smoke r doors near Respiratory ssing due to the failure of the					
		rector witnessed this servation and interview.					
K 712 SS=F	Fire Drills CFR(s): NFPA 101		K 71	2	K712 Fire Drills	•	
	Fire Drills				1. Fire drills were not recorder	for 2018	
	signal and simulation	transmission of a fire alarm of emergency fire	1		by previous maintenance direc	tor	
	unexpected times un	are held at expected and der varying conditions, at			2.Facility Fire drills will be cond	lucted and	d
	with procedures and of established routine	ch shift. The staff is familiar is aware that drills are part			recorded monthly for all three	shifts and	
	conducted between 9	:. Where drills are :00 PM and 6:00 AM, a t may be used instead of			to also include weekends.		
- 1	audible alarms. 19.7.1.4 through 19.7				3.The Maintenance Director wi	ll perform	
	This REQUIREMENT by:	is not met as evidenced			fire safety drills with staff to inc	lude all	
	Surveyor: 21761 Based on observation	and interview, it was			new hires on all shifts and will	do so mor	nthly.

Printed: 06/20/2019 FORM APPROVED

OTATEL 4EL	T 05 55555					OWR NO	<u>. 0938-0391</u>
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	A. BUILD	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE SU COMPLE	
NAME OF A		495156		B. WING		05/0	2/2019
	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY	, STATE, ZIP CODE		
CURIS	AT ROANOKE TRAN	SITIONAL CARE &	7.70	NG GEOF OKE, VA	IGE AVE SW 24016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)	S REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
K 712	Continued From pa evidenced as follow	ge 7 s;		K 712	4.The Maintenance Director a	nd Admin	istrator
	Findings include:				will audit the fire drill log to e	nsure mor	nthly
N	observed during rec	roximately 3:30 PM, ords review and insp	ection		occurrence.		
	there are several me recorded for 2018.	onths without fire dril	l records		5.The Maintenance Director w		
	The Maintenance Di evidence through of	irector witnessed this eservation and intervi	S IOW		results of the monthly fire dri QA/Safety meetings for 3 mon		the
	Combustible Decora			K 753	Monthly Fire Drills have been		e 6-3-19.
	Combustible Decora	tions			K753 Combustible Decorations		1
	Combustible decora unless one of the following retardant	tions shall be prohibi lowing is met: or treated with appro			1.Resident room # 42 was foun		
	fire-retardant coating product.	that is listed and lat	peled for		decorations on the door that w	ere consid	dered
,	o Decorations me o Decorations exh	ibit heat release less	than		combustible	16 -	
	o Decorations, suc	00 kilowatts in accordance with NFPA 289. Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 0.7.5.6(4) or 19.7.5.6(4).		2.The decorations were remove and all other doors were audite		oom#42,	
	and non-fire-rated do 18.7.5.6(4) or 19.7.5.			maintenance director.	a by the		
	 The decorations in such limited quant development or spre 	in existing occupand ities that a hazard of	ies are fire		3.Maintenance Director will mo	nitor the	placemen
1	19.7.5.6 This REQUIREMENT		enced		t of any objects on the doors the	roughout	the facility.
	by: Surveyor: 21761				4. Maintenance Director will aud		150
1	Based on observation revealed the facility fa introduction of combu	ailed to prevent the	s		x 4 weeks to ensure nothing is p		
	evidenced as follows	i		1	5.Maintenance Director will pres		udit to
	Findings include:				the QA committee for 3 months		
ORM CMS-2	567(02-99) Previous Versi	ons Obsolete			Door violation corrected on May	2 ^{na} , 2019).

Printed: 06/20/2019 FORM APPROVED OMB NO. 0938-0391

CTATELIES	T 05 05 05 05 05 05 05 05 05 05 05 05 05			Company of the Company		OWR M	<u>J. 0938-0391</u>
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		495156		B. WING		05/0	02/2019
	PROVIDER OR SUPPLIER	STREE	TADDR	ESS, CITY,	STATE, ZIP CODE		
CURIS	AT ROANOKE TRAN	SITIONAL CARE & 32	4 KIN	G GEOR KE, VA	GE AVE SW		
(X4) ID PREFIX TAG	OR LSC IDE	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATION)	ORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	II D RE	(X5) COMPLETION DATE
K 753	Continued From pa	ge 8		K 753			
	On 05/02/19, at app observed during ins decoration on the do	roximately 4:41 P.M., it wa pection there is a combusti por of room 42.	ble				
	evidence by observa						
K 914 SS=F	Electrical Systems - CFR(s): NFPA 101	Maintenance and Testing		K 914	K914 Electrical Systems-		
	Electrical Systems -	Maintenance and Testing			Maintenance and Testing		
	Hospital-grade receil locations and where	otacles at patient bed deep sedation or general			1.The facility did not maintain	i inspectio	on records
	installation, replacen	stered, are tested after initinent or servicing. Additiona	al		for testing and inspection of	electrical	outlets
	documented perform	at intervals defined by nance data. Receptacles no de at these locations are	ot		throughout the facility		
I	tested at intervals no	t exceeding 12 months. Lin M), if installed, are tested a	e		2.The maintenance director p	erformed	Testing
	intervals of less than actuating the LIM tes	or equal to 1 month by t switch per 6.3.2.6.3.6			and inspection of electrical re	ceptacles	
	which activates both LIM circuits with auto	visual and audible alarm. F mated self-testing, this			throughout the facility includ		
12	equal to 12 months. I	med at intervals less than o IM circuits are tested per	r		3.Maintenance Director repair		
1	electric distribution sy	pair or renovation to the vstem. Records are			that were not in working con		d replaced
	repairs or modificatio area tested, and resu	d tests and associated ns, containing date, room o	r		any faceplates with chips or c		
11	6.3.4 (NFPA 99)	is not met as evidenced			4.Maintenance Director will a		
11	by: Surveyor: 21761	is not met as evidenced			weekly x 4 weeks and monthl	y x 3 mon	iths.
1	Based on observation	and interview, it was iled to provide periodic			5.Maintenance Director will p	resent th	is audit
1	esting of electrical ecotential to affect all r	uipment. This has the			to the QA committee monthly	y x3 mont	hs and annua
li	hroughout the facility	evidenced as follows			Inspections completed 6/20/2	2019.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES Printed: 06/20/2019 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 495156 B. WING 05/02/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **CURIS AT ROANOKE TRANSITIONAL CARE &** 324 KING GEORGE AVE SW **ROANOKE, VA 24016** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 914 Continued From page 9 K 914 Findings include: 1. On 05/02/19, at approximately 3:35 PM, it was observed during review of facility documentation there are no records of inspection and testing for electrical receptacles in patient care areas. 2. On 05/02/19, at approximately 4:45 PM, it was observed during inspection there is a broken electrical outlet cover plate in the Medical Supply and Records room. The Maintenance Director witnessed this evidence through observation and interview.