STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495156	A. BUILDING 01 - MAIN BUILDING 01 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 TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 21761 Construction Type: III (200) Description of structure: The facility is a single story building with a basement. Brick exterior walls and unprotected non- combustible construction. The dining area has wood trusses and sheathing which classifies the building as type III (200) construction. A partial basement contains support services, laundry, mechanical equipment and storage rooms. The basement is classified as one large storage area. Sprinkler status: The facility is fully sprinklered with an NFPA #13 system. The system is supplied by city water and the pressure is supplemented by an electric fire pump. An unannounced standard recertification Life Safety Code survey was conducted 05/02/19 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is	K 211		

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

Jennifer R. Chadwick LNHA 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 following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 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. 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.	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.	
K 221 SS=F	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 room doors, evidenced as follows;	K 221		

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K 221	Continued From page 2 Findings include: 1. On 05/02/19, at approximately 4:48 PM, it was observed during inspection the door to resident room 56 is not completely closing. 2. On 05/02/19, at approximately 4:55 PM, it was observed during inspection the door to resident room 63 is not completely closing. 3. On 05/02/19, at approximately 5:17 PM, it was observed during inspection the door to resident room 19 is not completely closing. The Maintenance Director witnessed this evidence through observation and interview.	K 221	**K221 Patient Sleeping Room Doors** 1.Patient room doors not closing correctly in room #56, #63,#19 2. Patient room doors were adjusted in each room so that the doors would close appropriately. 3.Maintenance Director will audit and inspect all patient room doors weekly x 4 weeks, and then monthly x3 months to ensure proper closure. 4.Maintenance Director will complete an audit and report findings at the QA meeting for the next 3 months. This correction will be accomplished by 6- 21, 2019.	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview made on 05/02/19, it was revealed the facility failed to provide proper exit signage, evidenced as follows; Findings include: 1. On 05/02/19, at approximately 4:05 PM, it was observed during inspection the Activities room	K 293	**K293 Exit Signage** Signage leading to the enclosed courtyard at the adon office, beauty shop and activities room marked has been corrected and now reads "No Exit" 2.Maintenance Director will monitor all exits and ensure that no additional signage will be added with NO EXIT on the sign.	

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K 293	Continued From page 3 door leading from the building into the enclosed courtyard is not marked as "No Exit". 2. On 05/02/19, at approximately 5:00 PM, it was observed during inspection the Old ADON office door leading from the building into the enclosed courtyard is not marked as "No Exit". 3. On 05/02/19, at approximately 5:20 PM, it was observed during inspection the Beauty Shop door leading from the building into the enclosed courtyard is not marked as "No Exit". The Maintenance Director witnessed this evidence through observation and interview.	K 293	3.Maintenance Director will perform an audit of all exits and will continue to report the results during the QA meeting for 3 months. 4.Signage was corrected on May 23rd, 2019.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 21761	K 353	**K353 Sprinkler System- Maintenance and Testing** 1.The facility will maintain the integrity of the sprinkler system. 2.Facility employed a Sprinkler Contractor to replace rusted sprinklers in the kitchen. 3.Escutcheon trim ring was replaced in the Biohazard room in Station II. 3. Dust laden sprinklers have been cleaned behind the dryers. 4. Ceiling tile has been replaced behind the dryers. K 353 All corrected and completed on May 29, 2019	

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K 353	Continued From page 4 Based on observation and interview, it was revealed the facility failed to maintain the sprinkler systems. This violation potentially affects one of three smoke compartments, evidenced as follows; Findings include: 1. On 05/02/19, at approximately 2:07 PM, it was observed during inspection six sprinklers in the kitchen are corroded. 2. On 05/02/19, at approximately 4:15 PM, it was observed during inspection there are two dust laden sprinklers behind the dryers. 3. On 05/02/19, at approximately 4:35 PM, it was observed during inspection there is a sprinkler missing the escutcheon trim ring in the Biohazard room in Station II. 4. On 05/02/19, at approximately 4:19 PM, it was observed during inspection there is a ceiling tile missing behind the dryers that may affect heat collection at the sprinklers. The Maintenance Director witnessed this evidence through observation and interview.	K 353		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 21761	K 355	**K355 Portable Fire Extinguishers** 1.The laundry room fire extinguisher was not signed for April's monthly inspection. 2.The maintenance director inspected the fire extinguisher in Laundry room and updated the inspection date, and checked all others to ensure each are inspected and are signed monthly.	

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K 355	Continued From page 5 Based on observation and interview, it was revealed the facility failed to maintain the fire extinguishers, evidenced as follows; Findings include: On 05/02/19, at approximately 4:17 PM, it was observed during inspection the Laundry room fire extinguisher is missing the April monthly inspection. The Maintenance Director witnessed this evidence through observation and interview.	K 355	3.Maintenance Director will monitor and sign each extinguisher on a monthly basis. 4.Maintenance Director will audit the completion of monthly inspection and signatures. 5.Audits will be presented and discussed during the next 3 QA meetings. All inspections up to date as of 6-3- 2019.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 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 REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain the corridor doors, evidenced as follows; Findings include:	K 374	**K374 Subdivision of Building Spaces-Smoke Barrier Doors** 1.The Smoke barrier doors by the bio waste room, nurse station 2 door, and nurse station 3 and 4 not closing due to the failure of the coordinator. 2.All smoke barrier cross corridor doors have been audited and repaired so that they close correctly.	

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K 374	Continued From page 6 1. On 05/02/19, at approximately 4:35 PM, it was observed during inspection the Station II smoke barrier cross corridor doors by the Bio-waste room have one leaf not closing due to the failure of the coordinator. 2. On 05/02/19, at approximately 4:45 PM, it was observed during inspection the Station 4 smoke barrier cross corridor doors have one leaf not closing due to the failure of the coordinator. 3. On 05/02/19, at approximately 5:12 PM, it was observed during inspection the Station 3 smoke barrier cross corridor doors near Respiratory have one leaf not closing due to the failure of the coordinator. The Maintenance Director witnessed this evidence through observation and interview.	K 374	3.The Maintenance Director will continue to audit and adjust doors weekly x 4 weeks and monthly x 3 months to ensure so they operate correctly. 4.The Maintenance Director will submit his monthly audit of doors to the QA committee for 3 months. 5.Doors in compliance on May 23rd, 2019.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to conduct fire drills,	K 712	**K712 Fire Drills** 1.Fire drills were not recorder for 2018 by previous maintenance director 2.Facility Fire drills will be conducted and recorded monthly for all three shifts and to also include weekends. 3.The Maintenance Director will perform fire safety drills with staff to include all new hires on all shifts and will do so monthly.	

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K 712	Continued From page 7 evidenced as follows; Findings include: On 05/02/19, at approximately 3:30 PM, it was observed during records review and inspection there are several months without fire drill records recorded for 2018. The Maintenance Director witnessed this evidence through observation and interview.	K 712	4.The Maintenance Director and Administrator will audit the fire drill log to ensure monthly occurrence. 5.The Maintenance Director will report the results of the monthly fire drills during the QA/Safety meetings for 3 months. Monthly Fire Drills have been done since 6-3-19.	
K 753 SS=F	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to prevent the introduction of combustible decorations, evidenced as follows; Findings include:	K 753	**K753 Combustible Decorations** 1.Resident room # 42 was found to have decorations on the door that were considered combustible 2.The decorations were removed from Room#42, and all other doors were audited by the maintenance director. 3.Maintenance Director will monitor the placemen t of any objects on the doors throughout the facility. 4.Maintenance Director will audit the doors weekly x 4 weeks to ensure nothing is placed on the doors 5.Maintenance Director will present this audit to the QA committee for 3 months. Door violation corrected on May 2nd, 2019.	

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K 753	Continued From page 8 On 05/02/19, at approximately 4:41 P.M., it was observed during inspection there is a combustible decoration on the door of room 42. The Director of Maintenance witnessed this evidence by observation and interview.	K 753		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide periodic testing of electrical equipment. This has the potential to affect all residents and staff throughout the facility, evidenced as follows	K 914	**K914 Electrical Systems-** **Maintenance and Testing** 1.The facility did not maintain inspection records for testing and inspection of electrical outlets throughout the facility 2.The maintenance director performed Testing and inspection of electrical receptacles throughout the facility including patient care areas. 3.Maintenance Director repaired any outlets that were not in working condition and replaced any faceplates with chips or cracks. 4.Maintenance Director will audit on all outlets weekly x 4 weeks and monthly x 3 months. 5.Maintenance Director will present this audit to the QA committee monthly x3 months and annually. Inspections completed 6/20/2019.	

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K 914	Continued From page 9 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.	K 914		