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
	495299	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/27/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REH	**3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060**

(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 single story building with a below ground level basement and a construction type of II(111) Sprinkler status: Fully Sprinklered An unannounced Life Safety Code survey was conducted on 27 June 2019, 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 in 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	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
K 211 SS=E	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 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: This Standard is not met as evidenced by: Based upon observations and interviews there are items that obstructs the required clear egress width in corridors. Findings include:	K 211	K211 1. Debris in the egress path at the A-Wing rear EXIT door to the right of the First Short Hall was removed on June 28, 2019. 2. No other egress paths were identified. 3. Maintenance staff were re-educated by the Administrator/ Designee on means of egress to be continuously maintained free of all obstructions to full use in case of emergency.	7/26/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] LNHA
TITLE: Executive Director
(X6) DATE: 8/2/19

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 On 27 June 2019 at approximatly 1140 hrs, it was observed that there is debris in the egress path at the A-Wing rear EXIT door to the right side of the First Short Hall. These observations were witnessed by the facility's Director of Maintenance.	K 211	4. Audits will be conducted by the Maintenance Director/Designee to ensure means of egress of aisles, passageways, corridors, exit discharge, and exit locations are free of obstructions weekly times four weeks then monthly for three months. Results of audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 7/26/19	
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING 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	K 222	K222 1. The second floor elevator lobby stairwell door will be equipped with a 15-second emergency delayed release by 8/16/19 once supplies are received by outside vendor. 2. No other doors were identified. 3. Maintenance staff were re-educated by the Administrator on egress doors and having a 15-second emergency delayed release. 4. Audits of egress doors will be conducted by the Maintenance Director/Designee to ensure egress doors have a 15-second emergency	7/26/19

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K 222	Continued From page 2 doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: This Standard is not met as evidenced by: Based upon observations and interviews there are items that are installed on the doors that restricts the full operation of the door and impead the occupants egress to an EXIT. Findings include: On 27 June 2019 at approximatly 1245 hr. it was observed that there is no 15 second emergency delayed release on the second floor elevator	K 222	delayed release weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: 7/26/19	

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K 222	Continued From page 3 lobby stairwell door. These observations were witnessed by the facility's Director of Maintenance.	K 222	K353	
K 353 SS=E	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: This Standard is not met as evidenced by: Based upon observations there are areas where the sprinkler system is not properly maintained. Findings include: On 27 June 2019 at approximatly 1200 hrs. it was observed that there are missing ceiling tile in the B-Wing Soil Utility room. The ceiling tiles are an integral component of the sprinkler system. This condition was promptly CORRECTED during the	K 353	1. The missing ceiling tiles in the B-Wing Soil Utility room, male and female basement bathrooms, basement housekeeping storage room were replaced on 7/20/19.The sprinkler heads in the laundry room were cleaned on 7/20/19. 2. No other ceiling tiles were missing or sprinkler heads identified. 3. Maintenance staff were re-educated by the Administrator/ Designee on ensuring no missing ceiling tiles in the ceiling and sprinkler heads are clean. 4. Audits will be conducted by Maintenance Director/designee to ensure no ceiling tiles are missing in the ceiling and sprinkler heads are clean weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/26/19	7/26/19

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K 353	Continued From page 4 course of the survey. On 27 June 2019 at approximatly 1515 hrs. it was observed that there are missing ceiling tile in both the Male and Female basement bathrooms. On 27 June 2019 at approximatly 1525 hrs. it was observed that there are missing ceiling tile in the basement Housekeeping Storage room. On 27 June 2019 at approximatly 1530 hrs. it was observed that the sprinkler heads in the laundry room are coated. These observations were witnessed by the facility's Director of Maintenance.	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open	K 363	K363 1. Corridor doors A-22, A-23, A-25, A-27, A-30, B-26 and C-11 will be repaired so they properly seal when closed by August 30, 2019 once supplies are received by outside vendor. 2. An audit was conducted of corridor doors to ensure they are properly sealed when closed. 3. Maintenance staff were re-educated by the Administrator/ Designee on ensuring corridor doors properly seal when closed.	7/26/19

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K 363	Continued From page 5 devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: This Standard is not met as evidenced by: Based on observation and inspections, corridors doors do not provide corridors with protection from smoke or heat. On 27 June 2019 at approximatly 1120 hrs it was observed that the following corridors doors do not properly sealed when closed and the doors have more than a .5 inch gap in the door frame. A-22 A-23 A-25 A-27 A-30 B-26 C-11 Inspect all room doors on C- Wing. These observations were witnessed by the facility's Director of Maintenance.	K 363	4. Audits will be conducted by the Maintenance Director/Designee to ensure corridors doors properly seal when closed weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/26/19	
K 372	Subdivision of Building Spaces - Smoke Barrie	K 372		

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K 372 SS=E	Continued From page 6 CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: This Standard is not met as evidenced by: Based upon observations and interviews the facility's rated construction is not properly maintained. Findings include: On 27 June 2019 at approximatly 1550 hrs. it was observed that there are penetrations in the rated walls above the ceiling tile in both the Kitchen Dietary Storage room and the The Paper Product Storage room. These observations were witnessed by the facility's Director of Maintenance.	K 372	K372 1. The penetration in the rated walls above the ceiling tile in both the Kitchen Dietary Storage room and the Paper Product Storage rooms was repaired on 7/20/19. 2. No other penetration was identified. 3. Maintenance staff were re-educated by the Administrator on ensuring rated walls are free of penetration. 4. Audits will be conducted by the Maintenance Director/Designee to ensure rated walls are free of penetration weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/26/19	7/26/19
K 522 SS=E	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible	K 522	K522 1. The lint and dust was removed from behind the dryers in the laundry room on 7/20/19.	7/26/19

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K 522	Continued From page 7 materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: This Standard is not met as evidenced by: Based on observations and interviews the facility's heating devices are not properly maintained. Findings include: On 27 June 2019 at approximatly 1545 hr. it was observed that there is a significant amount of combustible lint and dust behind the dryers in the laundry room. These observations were witnessed by the facility's Director of Maintenance.	K 522	2. No other concerns identified. 3. Maintenance staff were re-educated by the Administrator/ Designee on keeping behind the dryers free of lint and dust. 4. Audits will be conducted by the Maintenance Director/Designee to ensure dryers are free of lint and dust weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/26/19	
K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the	K 531	K531 1. The elevator emergency call phone is now active. 2. No other concerns identified. 3. Maintenance Staff were re-educated by the Administrator/ Designee on ensuring the elevator emergency call phone is active.	7/26/19

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K 531	Continued From page 8 level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: This Standard is not met as evidenced by: Based upon observations and interviews the elevator car does not meet the required standards.. Findings include: On 27 June 2019 at approximatly 1500 hr. the elevator emergency call phone was inactive at the time of the survey. These observations were witnessed by the facility's Director of Maintenance.	K 531	4. Audits will be conducted by the Maintenance Director/Designee to ensure the elevator emergency call phone is active weekly for four weeks then monthly for three months. Results of the visits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/26/19	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language	K 741	K741 1. Cigarette butts were removed from the ground on C-Wing Long Hall on 6/28/19. 2. No other concerns identified. 3. Facility staff were educated on not throwing cigarette butts on facility grounds. Facility to purchase a noncombustible self-closing container for the disposal of cigarette butts.	7/26/19

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K 741	Continued From page 9 that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: This Standard is not met as evidenced by: Based upon observations and interviews, the proper smoking environment has not been established at the end of C-Wing Long Hall outside EXIT. Metal or non combustible containers with self-closing lid into which ashtrays and other smoking materials can be emptied shall be readily available in all areas where smoking is permitted. Findings include: On 27 June 2017 at approximatly 1440 hrs, it was observed that there are cigarette butts on the ground at C-Wing Long Hall outside EXIT . There is no noncombustible self-closing container for the disposal of of cigarette butts in the area and no scheduled requirements for policing the area. These observations were witnessed by the facility's Director of Maintenance.	K 741	4. Audits will be conducted by the Maintenance Director/ Designee to ensure cigarette butts are disposed of properly and not on the facility grounds weekly times four weeks then monthly times three months to sustain compliance. Compliance Date: 7/26/19	

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K 911 K 911 SS=E	Continued From page 10 Electrical Systems - Other CFR(s): NFPA 101 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 REQUIREMENT is not met as evidenced by: This Standard is not met as evidenced by: Based upon observations and interviews there are areas where the facilities electrical system is not being properly maintained. Findings include: On 27 June 2019 at approximatly 1230 hrs. it was observed that there is exposed electrical wiring at both electrical wall clocks in the In Service room. These observations were witnessed by the facility's Director of Maintenance.	K 911 K 911	K911 1. The exposed electrical wiring at both electrical wall clocks are no longer exposed. 2. An audit was conducted of electrical wall clocks to ensure no electrical wires were exposed. 3. Maintenance staff were re-educated by the Administrator/ Designee on ensuring electrical wiring is not exposed. 4. Audits will be conducted by the Maintenance Director/Designee to ensure electrical wiring is not exposed weekly for four weeks then monthly for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. Compliance Date: 7/26/19	7/26/19

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
	495299	A. BUILDING **02 - MEDICATION ROO** B. WING _____	**06/27/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REH	**3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060**

(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 single story building with a below ground level basement and a construction type of II(111) Sprinkler status: Fully Sprinklered An unannounced Life Safety Code survey was conducted on 27 June 2019, 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 in compliance with the Requirements for Participation in Medicare and Medicaid.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Steve Shine LNHA
TITLE: Executive Director
(X6) DATE: 8/2/19

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.