STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495241	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/19/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE AND REH	**4142 BONNEY ROAD VIRGINIA BEACH, VA 23452**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 1 Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected 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: Based upon observations the facility delayed	K 222		

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CONCORDIA TRANSITIONAL CARE AND REH	**4142 BONNEY ROAD VIRGINIA BEACH, VA 23452**

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K 222	Continued From page 2 egress doors are not properly labeled Findings include On 09/19/19 between 9:00 AM and 12:00 PM, it is observed that there are delayed egress doors in the facility that are not label with a readily visible durable sign with directions to push until alarm sounds with door can be opened in approved seconds. The above deficiency was observed by the Director of Maintenance	K 222	K-223 1. Identified doors were tested. 2. All residents have the potential to be affected. 3. Executive Director or designee will in-service Maintenance Director about testing doors with self-closing devices. 4. Maintenance Director or designee will perform audits daily audit X2 weeks, weekly x8, and biweekly x4. 5. 10/21/2019.	
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based upon review of doors with self closing devices are not being tested. Findings include On 09/19/19 between 9:00 AM and 12:00 PM, it was observed that the facility does not have documentation for testing doors with self closing	K 223		

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K 223	Continued From page 3 devices. The above deficiency was observed by the Director of Maintenance.	K 223	K-347	
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based upon review of smoke detection system sensitivity results are not documented. Findings include On 09/19/19 between 9:00 AM and 12:00 PM, it was observed that the facility does not have documentation for smoke detection sensitivity testing. The above deficiency was observed by the Director of Maintenance.	K 347	1. Sensitivity results were obtained Related to facility's Smoke Detection System and documented 10/21/2019. 2. All residents have the potential to be affected. 3. Maintenance Director will work with the local Fire alarm vendor to ensure sensitivity results are obtained and documented every 2 years and Maintenance Director will be in-serviced by Executive Director about this as well. 4. Maintenance Director or designee will completely daily audits on facility smoke detectors x2 weeks, weekly x8, and biweekly x 4. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been maintained for 60 days. 5. 10/21/2019.	
K 353 SS=D	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	K 353		

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K 353	Continued From page 4 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: Based upon observations of the sprinkler system that the required maintenance of the system is not being maintained. Findings include On 09/19/19 between 9:00 AM and 12:00 PM , it was observed a missing escutcheon ring in the kitchen walk-in freezer. The above deficiencies were observed by the Director of Maintenance.	K 353	K-355 1. The fire extinguishers that were identified as past due for annual inspections were inspected by 9/30/2019. 2. All residents have the potential to be affected. 3. Executive Director or designee will in-service Maintenance Director abut the importance of timely fire extinguisher inspections for the safety of residents, staff and visitors. 4. Maintenance Director or designee will audit 5 fire extinguishers daily for 2 weeks to ensure the inspection dates for fire extinguishers don't become past due, audit will continue as weekly x 8 and biweekly x4. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been maintained for 60 days. 5. 10/21/2019.	
K 355 SS=E	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: Based upon observations, there is evidence that the fire extinguishers are not being maintained properly. Findings include On 09/19/19 between 9:00 AM and 12:00 PM, it was observed several ABC Fire Extinguisher throughout the facility were past due annual inspection. The above deficiency was observed by the Director of Maintenance.	K 355		
K 521	HVAC	K 521		

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K 521 SS=E	Continued From page 5 CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based upon interviews the facility does not have documentation that the fire dampers have been inspected and tested within the last four years. Findings include On 09/19/19 between 9:00 AM and 12:00 PM, it was observed that the facility does not have documentation that the fire dampers have been inspected and tested within the last four years. The above deficiency was observed by the Director of Maintenance.	K 521	K-521 1. Facility has scheduled for fire dampers to be inspected and tested by 10/21/2019. 2. All residents have the potential to be affected. 3. Maintenance Director will be in-serviced by Executive Director about fire dampers requirements and semi-annual visual inspection or most recent NFPA 101. 4. Maintenance Director or designee will audit 5 areas of facility with fire dampers to ensure areas meet the life safety code, audits will be daily for 2 weeks, weekly x 8, and biweekly x 4. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been maintained for 60 days. 5. 10/21/2019.	
K 741 SS=D	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	K 741		

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K 741	Continued From page 6 prohibited and signs are prominently placed at all major entrances, secondary signs with language 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: Based upon observations a self closing metal container was not readily available. Findings include. On 09/19/19 between 9:00 AM and 12:00 PM. It was observed at the main entrance of the facility a visitor and resident smoking. An ashtrays of noncombustible material of safe design was not provided in the smoking area with metal container of self closing cover device into which ashtrays can be emptied. The above deficiency was observed by the Director of Maintenance	K 741	K-741 1. Ashtrays of noncombustible material of safe design were placed in the smoking areas of the facility. Self-closing metal containers to empty ashtrays were placed in smoking areas of facility grounds 10/21/2019. 2. All residents have the potential to be affected. 3. Executive Director designee will in-service Maintenance Director about the requirements for healthcare facilities that allow patient smoking. 4. Maintenance Director or designee will audit ashtrays and self-closures to empty ashtrays into daily x 2 weeks, weekly x 8, and biweekly x 4. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been maintained for 60 days. 5. 10/21/2019.	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918		

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

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K 918	Continued From page 7 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based upon review of documentation that there is not complete documentation of the testing and inspection of the emergency generator according NFPA 110. Findings include On 09/19/19 between 9:00 AM and 12:00 PM during review of emergency generator reports it is observed that all of the required information	K 918	K-918 1. Generator testing and inspection documentation completed by 10/21/2019. 2. All residents have the potential to be affected. 3. Executive Director or designee will in-service Maintenance Director about appropriate and complete documentation of the testing and inspections of the emergency generator according to NFPA 110. 4. Executive Director or designee will audit Generator documentation to ensure testing and inspection information meets NFPA 100. The audits will be daily x 2 weeks, weekly x 8, and biweekly x 4. The results of the audit will be presented to the QAPI committee monthly until 100% compliance has been maintained for 60 days. 5. 10/21/2019.	

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K 918	Continued From page 8 required by NFPA 110 is not in the reports. The above deficiencies were observed by the Director of Maintenance.	K 918		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored	K 923	K-923 1. Cylinder storage decrease to less than 300 cubic feet of full E-tanks. Empty E-tanks and Full E-tanks were separated and labeled either Full or Empty. Oxygen Precautionary sign displayed on Oxygen compartment storage room. 2. All residents have the potential to be affected. 3. SDC or designee will in-service Maintenance on proper storage of E-tanks per NFPA 99. 4. SDC or designee will audit Oxygen compartment daily X2 weeks, weekly x 8, and biweekly x4. The results of the audits will be presented to the QAPI committee monthly until 100% compliance has been maintained for 60 days. 5. 10/21/2019.	

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K 923	Continued From page 9 in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based upon observations improper cylinder storage Findings include On 09/19/19 between 9:00 AM and 12:00 PM, it was observed that more then 300 cubic feet of full and empty size E oxyen tanks in storage. Oxygen precautionary sign not displayed on oxygen compartment storage room, Oxygen tanks not properly labeled Full or Empty. The above deficiencies were observed by the Director of Maintenance.	K 923		