STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495413	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**07/31/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF MECHANICSVILLE	**7600 AUTUMN PARKWAY MECHANICSVILLE, VA 23116**

(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: 1 Story V (111) Sprinkler status: Fully Sprinklered An unannounced Life Safety Code survey was conducted 07/31/18 to verify compliance 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 222 SS=D	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	K 222		

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

ADM 8/10/18

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 222	Continued From page 1 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 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:	K 222	K 222 1. Adjustments were made to exits doors to the 300 and 500 halls by a qualified vendor. After the adjustments were made the doors met the requirement that it took no more than normal effort to engage the delayed egress locking system to start the 15 second time delay to open the door. 2. After all Exit doors have been checked to assure no more than normal effort is required to engage the 15 second time delay to open the door. 3. 25% of the exit doors will be audited weekly times 12 weeks to assure that the doors remain in compliance. 4. Any variances will be reported to the monthly QAPI meeting and the Administrator. 5. The date of compliance will be 8/21/18	

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K 222	Continued From page 2 Based upon observations the exit doors to the 300 and 500 halls with the 15 second delay sequence took a took more than normal effort to engage the time delay. Findings include: Around 1:00 pm on 7/31/18 it was observed by the Environmental Services Director and Facilities Maintenance Director that the door at the end of corridor 300 took more than normal effort to engage the delayed egress locking system to start the 15 second time delay to open the door. Around 1:15 pm on 7/31/18 it was observed by the Environmental Services Director and Facilities Maintenance Director that the door at the end of corridor 500 took more than usual effort to engage the delayed egress locking system to start the 15 second time delay to open the door. The above observations were witnessed and confirmed by the Facilities maintenance Director and Envionmental Services Director.	K 222		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based upon observations and interviews the fire alarm system smoke detectors have not had the	K 345	K-345 1. Sensitivity Testing was done on 8/9/18 by our approved Fire and Safety Vendor 2. No additional test will need to be done at this time. 3. We have scheduled the next smoke detector sensitivity test for next year with our approved Fire and Safety Vendor 4. Any variance from the required testing will be reported to the Administrator and QAPI meeting 5. The date of compliance will be 8/21/18	

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K 345	Continued From page 3 required every two year smoke detector sensitivity tests. Findings include that at approximately 10:30 am on 7/31/18 accompanied by the Facilities Maintenance Director and Envonmental Services Director the tests had not been done. This above obsevation was witnessed and confirmed by the Facilities Maintenance Director and Environmental Services Director.	K 345		
K 363 SS=D	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 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	K 363	K-363 1. Adjustments were made to the kitchen dry storage door and the chemical closet door to close and latch independently. 2. All similar doors were checked and all independently closed and latched. 3. 25 % of all fire rated door will be audited weekly for compliance times 12 weeks 4. Any variances will be report in the Administrator and QAPI meeting. 5. The date of compliance will be 8/21/18	

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K 363	Continued From page 4 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: Based on observations, interviews, and discussions there was a door found that did not close properly. Findings include that between 11:00 am and 11:45 am on 7/31/18 accompanied by the Facilities Maintenance Director and Environmental Services Director it was observed that the fire rated door to the Kitchen Dry Storage room would not independently close and latch. Around 11:45 am on 7/31/18 accompanied by the Facilities Maintenance Director and Environmental Services Director it was observed that the fire reated door to the Chemical Closet in the Kitchen area would not independently close and latch. The Facilities Maintenance Director and Environmental Services Director witnessed and confirmed these findings	K 363		
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors	K 374		

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K 374	Continued From page 5 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: Based on observations and discussions the cross corridor smoke doors to the "Winter" section were not closing completely. Findings include that around 11:30 am on 7/31/18 accompanied by the Facilities Maintenance Director and the Environmental Services Director it was obseved that the cross corridor smoke doors to the Winter section of the building were not closing completely. Around 11:55 am on 7/31/18 accompanied by the Facilities Maintenace Director and the Environmental Services Director it was observd that the cross corridor smoke doors to the Autumn section of the bulding were not closing completely. The above observations were witnessed and confirmed by the Facilities Maintenance Director and the Environmental Services Director.	K 374	K-374 1. Cross corridor smoke doors on Winter and Autumn sections will close completely. 2. All cross corridor smoke doors have been checked and properly close completely. 3. 25% of all cross corridor smoke will be audited weekly times 12 weeks for compliance. 4. Any variances will be reported to the QAPI meeting and Administrator. 5. The date of compliance will be 8/21/18	
K 500 SS=E	Building Services - Other CFR(s): NFPA 101 Building Services - Other	K 500		

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K 500	Continued From page 6 List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services 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. This REQUIREMENT is not met as evidenced by: Based upon observations the duct fire dampers have not been tested every four years per NFPA 80. Findings include that around 1:00 pm on 7/31/18 there were no records for testing the fire dampers in the duct system. This was witnessed and confirmed by the Environmental Services Director and Facilities Maintenance Director.	K 500	K-500 1. Dampers Test will be done on 8/13/18. 2. No additional test will be done at this time. 3. We have scheduled the next damper test for every 4 years with our approved vendor. 4. Any variances from the required testing will be reported to the Administrator and QAPI meeting. 5. The date of compliance will be 8/21/18.	
K 711 SS=D	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3	K 711	K-711 1. Evacuation plans have been updated to meet compliance. 2. Additional training and education has been given to staff on evacuation plan. 3. Evacuation Maps have been updated with exit routes and where fire wall protection is located which is Spring and Winter with a 1hr fire wall. 4. All staff has been educated with updated evacuation plan that is located in the red fire manual located on all units and throughout the building. 5. The date of compliance will be 8/21/18	

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K 711	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations and discussions the Fire and Evacation Plans needed additional evacuation details. Findings include that at arournd 10:45 am on 7/31/18 accompanied by the Envionmental Services Director and Facilities Maintenance Director the Fire and Evacuation plans needed additional details. The above observations were witnessed and confirmed by the Environmental Services Director and Facilities Maintenance Director.	K 711		