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
	495291	A. BUILDING 04 - LOWER LEVEL WING UNIT 4 B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

(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 a two story structure with construction Type II (111). Sprinkler Status: Fully sprinklered - NFPA 13 An unannounced Standard Recertification Life Safety Code Survey was conducted on 3/21/19 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 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=D	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: Based upon observation that the exit discharge door required excessive force to open the door and could affect the egress from spaces or the facility. Findings include	K 211	**K 211** The statements made in 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 will take actions set forth in the following plan of correction. The, following POC constitutes the centers allegation of compliance, such that all alleged deficiencies cited have been or will be corrected by the date indicated. *It is the intended practice of this facility to have appropriate means of egress.* Criteria 1 Maintenance director will have the exit discharge door from the stairway by Penn Park fixed so that it doesn't require excessive force to open. Criteria 2 Residents and staff located in that area have the potential to be affected. Criteria 3 Maintenance Director will have door fixed and functioning properly. Criteria 4 Maintenance director or designee will conduct checks on the door weekly X 4 and monthly X 2 to ensure it doesn't take excessive force to open. These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is April 28, 2019.	

LABORATORY DIRECTOR'S ~~OR PROVIDER/SUPPLIER REPRESENTATIVE'S~~ SIGNATURE | TITLE: Administrator | (X6) DATE: 4-1-19

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 Between 10:30 AM and 3:30 PM on 3/21/19, it is observed that the exit discharge door from the stairway by Pen Park required excessive force to open the door.	K 211	**K 225** The statements made in 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	
K 225 SS=D	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based upon observations the fire rated stairway door is not latching smoke and hot gasses to pass into the stairway. Findings include Between 10:30 AM and 3:30 PM on 3/21/19, it is observed that the stairway fire rated door by room 307 is not latching. The latching hardware is missing.	K 225	Federal and State regulations, the center has taken or will take actions set forth in the following plan of correction. The, following POC constitutes the centers allegation of compliance, such that all alleged deficiencies cited have been or will be corrected by the date indicated. *It is the intended practice of this facility for stairways and smokeproof enclosures to latch properly.* <u>Criteria 1</u> Maintenance Director was informed by fire marshal that the stairway fire-rated door by room 307 wasn't latching because the hardware was missing. Maintenance director corrected the concern upon notification. <u>Criteria 2</u> Everyone in the Home has the potential to be affected. <u>Criteria 3</u> Maintenance director will educate staff on monitoring doors. <u>Criteria 4</u> Maintenance director or designee will audit fire rated doors weekly X 4 and monthly X2. These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. <u>Criteria 5</u> Date of compliance is April 28, 2019.	
K 300 SS=C	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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.	K 300	**K300**	

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K 300	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based upon review of documentation and observations there was no documentation for the annual fire rated door inspections. Findings include Between 10:30 AM and 3:30 PM on 3/21/19, during review of documentation it is observed that the facility did not have the annual fire door inspection and testing. The last fire door inspection and testing was conducted in January 2018.	K 300	*It is the intended practice of this facility to ensure protection requirements are being followed in accordance with the regulation.* Criteria 1 Upon notification from the fire marshal regarding the annual fire rated door inspections not being completed, facility maintenance director arranged for these inspections to be completed. Criteria 2 Everyone in the facility has the potential to be affected. Criteria 3 Maintenance director and staff will be re-educated on ensuring fire-rated door inspections are being done on an annual basis. Criteria 4 Audits will be completed by maintenance director of designee monthly X3 and quarterly thereafter. These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criteria 5 Date of compliance is April 28, 2019.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and 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 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483,	K 363	**K363** *It is the practice of this facility to ensure corridor- doors are functioning in accordance with the regulation.* Criteria 1 Upon notification regarding rooms 315 and 301 corridor doors not latching, the maintenance director scheduled to have doors fixed, and they have been repaired. Criteria 2 Residents in rooms 315 and 301 have the potential to be affected.	

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K 363	Continued From page 3 and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This REQUIREMENT is not met as evidenced by: Between 10:30 AM and 3:30 PM on 3/21/19, it is observed that there are corridor doors that are not positively latch in rooms 315 and 301.	K 363	Criteria 3 Maintenance staff will be re-educated on ensuring that corridor doors are latching properly. Criteria 4 Maintenance director or designee will audit corridor doors weekly X 4 and monthly X 2. These results will be forwarded to the QA committee for review. The committee will determine the need for further audits and/or action. Criteria 5 The date of compliance is April 28, 2019.	
K 521 SS=C	HVAC 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: Between 10:30 AM and 3:30 PM on 3/21/19, during review of documentation it is observed that the facility did not have the report for the inspection and testing of the fire dampers at time of survey.	K 521	**K521** *It is the practice of this facility to ensure HVAC system is functioning in accordance with the regulation.* Criteria 1 Upon notification from fire marshal regarding fire dampers not being inspected, maintenance director scheduled them to be inspected. Criteria 2 Everyone in the nursing home has the potential to be affected. Criteria 3 Maintenance director and staff will be re-educated to ensure that fire damper inspections are completed in accordance with the regulation. Criteria 4 Maintenance director or designee will complete an inspection and do a follow up annually thereafter.	
K 914 SS=C	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	K 914	Criteria 5 Date of compliance is April 28, 2019. **K914**	

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K 914	Continued From page 4 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 one 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: Based observations and inquiry that there are no reports that the receptacles in patient rooms that have not been tested and inspected annually. Findings include Between 10:30 AM and 3:30 PM on 3/21/19, during review of documentation it is observed that the facility did not have the annual inspection for the receptacle testing in the resident rooms at time of survey.	K 914	*It is the intended practice of the facility to conduct maintenance and testing in accordance with the regulation.* Criteria 1 Upon notification from fire marshal regarding the inspections for receptacle testing not being completed the maintenance director scheduled testing to be done. Criteria 2 All residents have the potential to be affected. Criteria 3 Maintenance director and staff will be re-educated on ensuring receptacle testing is being completed in accordance with the regulation. Criteria 4 Maintenance director or designee will ensure that receptacles in resident rooms are tested annually. Audits will be completed monthly and then quarterly thereafter. Criteria 5 Date of compliance is April 28, 2019.	
K 918 SS=C	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	K 918	**K918**	

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K 918	Continued From page 5 criterion is not met during the monthly test, a 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 Between 10:30 AM and 3:30 PM on 3/21/19, during review of documentation it is observed that	K 918	*It is the practice of this facility to ensure electrical systems in in accordance with the regulations.* Criteria 1 Upon notification from fire marshal regarding the emergency generator didn't contain all the information required by the NFPA 110 for the monthly run under load for 30 minutes and that the emergency generator hasn't been run under load for 4 hours in the last 3 years. Facility will update the generator run log to include the items listed above and document a 4 hour load test. Criteria 2 All residents have the potential to be affected. Criteria 3 Maintenance staff will be re-educated on ensuring the emergency generator contains all information required for the monthly run under load for 30 minutes and to be run under load for at least 4 hours every 3 years. Criteria 4 Maintenance director or designee will oversee all emergency generator testing to ensure facility is in compliance with the regulation and initial each test. Criteria 5 Date of compliance is April 28, 2019.	

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K 918	Continued From page 6 the monthly inspection reports for the emergency generator does not contain all the information required by NFPA 110 for the monthly run under load for 30 minutes. Between 10:30 AM and 3:30 PM on 3/21/19, during review of documentation it is observed that the facility did not have the documentation noting that the emergency generator has been run under load for 4 hours in the last 3 years at time of survey.	K 918		