Cedars
HEALTHCARE CENTER
Serving with Pride.

August 27, 2019

Mr. Anthony T. Williams
State Fire Marshal's Office
Commonwealth of Virginia
Virginia Department of Fire Programs
124 North South Street
Farmville, VA 23901

RE: Annual Fire Safety Survey CMS 2567 Provider # 485153

Dear Mr. Williams,

Please find attached the completed Statement of Deficiencies and Plan of Corrections for the deficiencies cited on the unannounced survey 08/15/19 at Cedars Healthcare Center.

Your visit enlightened both myself and Mr. Guy Painter, Maintenance Supervisor to serval matters and provided education of which we are both grateful. Your visit, and the education provided will only prove to further the fire safety and wellbeing of the facility.

I trust you to find the PoC acceptable towards corrections and resolutions to the survey findings and that you not hesitate in contacting either myself or Mr. Painter should additional information be required. Again, thank you for your visit and know we look forward to the revisit over the next weeks.

Sincerely,

Stephen Reynolds, Administrator

CC: Hard copy mailed to Mr. Anthony Williams

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495153	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/15/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDARS HEALTHCARE CENTER	**1242 CEDARS CT CHARLOTTESVILLE, VA 22903**

(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 building with mechanical and laundry rooms in basement with a construction type of II (111). Sprinkler Status: Fully sprinklered - NFPA 13 An unannounced Standard Recertification Life Safety Code Survey was conducted on 08-15-2019 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 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	The statement made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State regulations, the facility has taken or will take the action set forth in the plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
K 345 SS=E	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 interviews and observations of the fire alarm system there are components that are not maintained according to NFPA 72. This has the ability to affect all occupants of the building.	K 345	1. Corrected. Johnson Control has completed inspection on all duct smoke detectors in accordance to NFPA 72. A sensitivity test has been completed via the facility Edwards iO 1,000 model fire panel by Johnson Control Vendor that does read the ranges of sensitivity. Reports are available for review. All test passed within range of margin identified by manufacturer specifications. 2. All duct detectors have been tested by Johnson Controls on 8/27/19 and passed. The Sensitivity test measurements on all smoke detectors completed in accordance to NFPA 70 and manufacturer specifications of ranges. Tested also on 8/27/19.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: STEPHEN REYNOLDS — TITLE: ADMINISTRATOR — (X6) DATE: 8-28-19

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 345	Continued From page 1 Findings include On 08-15-2019 at approximately 2:55 pm, it is observed on the Johnson Controls annual inspection report of 2-15-2019 & 07-24-2019 shows only 4 of the 6 duct detectors annually tested. No sensitivity test measurements are found of 10-2018 system acceptance. Maintanance Director and Administrator witnessed this evidence through observation on 08-15-2019 at 4:30 PM during the exit interview.	K 345	3. Facility Maintenance Director and Administrator now have comprehension as to regulation governing the Duct Smoke Detectors and also proper sensitivity testing of detectors. Facility has made clear to contracted vendor what procedures and type of sensitivity testing will be completed annually and every two years. 4. Facility Maintenance Director will present annual inspection results of Duct detectors and sensitivity testing to the Administrator, QAPI and Safety Committee for review and direction upon each testing. 5. Date of compliance: September 9th, 2019	
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	K 363	1. Corrected. Doors to room 111, 424, & 410 no longer have impediment to the closing of the doors and sealing of door prohibiting smoke penetration. 2. Facility maintenance performed audit on other doors to resident rooms finding no impediments to the doors. 3. Education provided to maintenance personnel on proper sealing and closure of doors without impediment. Maintenance will check all resident room doors each quarter for next 12 months to ensure proper closing without impediment. 4. Door audits will be turned in quarterly for next 12 months to QAPI and Safety Committees for review and/or direction to ensure doors are identified and corrected to close without any impediment. 5. Date of Compliance September 9th, 2019	

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K 363	Continued From page 2 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: Based on observation and interview, the facility failed to maintain the doors protecting corridor openings . This has the ability to affect all occupants in the effected smoke compartment of the building. (CMS S&C-07-18) Findings include On 08-15-2019 at approximately 12:15 pm, it is observed that doors at Room 111, 424, & 410 have a impediment to the closing of the door. The Maintenance Director and Administrator witnessed this evidence by interview and observation on 08-15-2019 at approximately 4:30 pm during the exit interview.	K 363	See Page 2 of 6	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie · 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.	K 372	1. Corrected. The penetration identified in the wall above the ceiling near Unit 3 Manager's Office area has been properly sealed/repaired using fire rated caulking to ensure compliance with NFPA 101. The wall is repaired do its designed rating, LCS 8.3.5.1	

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K 372	Continued From page 3 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: Based on observation and interview, the facility failed to maintain the fire rated smoke barrier as required by the Life Safety Code. This has the ability to affect all occupants in the building. Findings include On 08-15-2019 at approximately 11:45 am, it is observed by inspection that the rated wall above the ceiling near the Unit 3 Manager's Office area is found to be in disrepair and not repaired to its designed rating. (LSC 8.3.5.1) The Administrator and Maintenance Director witnessed this evidence by interview and observation on 08-15-2019 at approximately 4:30 pm during the exit interview.	K 372	2. No other area has been found to be in noncompliance with K 372 LCS 8.3.5.1 for barrier penetration. 3. Maintenance Supervisor will coordinate all work by outside vendors educating on any penetrating of smoke/fire barriers with proper sealing. Maintenance Supervisor will follow up behind all work performed by outside vendors to ensure any penetration of barriers are properly sealed with correct fire caulking or barrier sealer. 4. Facility Maintenance Supervisor will each week for four weeks spot check a section of facility along fire or smoke petitions checking for any penetration. Maintenance Supervisor will check behind all work performed by outside vendors to ensure proper sealing. Maintenance Director will report findings on a monthly basis over next 12 months to the QAPI and Safety committees for review and direction. 5. Date of Compliance September 9th, 2019	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511	1. Corrected. The Diesel fuel tank on the emergency generator does now have proper signage in accordance with NFPA 54. The remote emergency generator stop button for outside generator now has proper signage providing identification to the emergency stop. All breakers in electrical panel "L" breaker 8, 18, 20 are labeled in accordance with NFPA 70 designating proper accuracy of legend.	

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K 511	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based upon observations and interviews the facility failed to ensure that the electrical wiring and fuel equipment complies with NFPA 70, National Electrical Code, NFPA 99 and NFPA 110. This has the ability to affect all occupants in the immediate area. Findings include: On 08-15-2019 at 10:50 am, it is observed that the electrical panel "L" Br. 8, 18, & 20 at the Nurse #2 Hall is not labeled as required by the Life Safety Code. (NFPA 70, 408.4). At 2:45 pm, it is observed that the diesel fuel tank on the generator does not contain emergency signage and content. The remote emergency stop does not have signage. (NFPA 110, 7.9.1.1) The Maintenance Director and Administrator witnessed this evidence by interview and observation on 08-15-2019 at 4:30 pm during the exit interview.	K 511	2. Facility has only the one generator and findings identified have been corrected. All electrical panels have been examined and all breakers are now properly labeled with accuracy of legend. 3. Facility Maintenance Supervisor has been educated to understand breakers require proper labeling, and proper signage on generator. 4. Maintenance Supervisor will check breakers weekly for the next 4 weeks and then monthly for 2 months, followed by quarterly for 9 months to ensure breakers are properly labeled with accurate legend. Audits will be turned into QAPI/Safety Committee for review and direction. 5. Date of compliance September 9th, 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.	K 741	1. Corrected. Refuse container has been replaced with a fire retardant UL rated metal container. Resident designate smoking area around canopy with landscaping mulch has been removed and replaced with stone gravel. 2. No other designated resident smoking area	

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K 741	Continued From page 5 (2) In health care occupancies where smoking is 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 and interview, the facility failed to maintain smoking regulations in the designated patient smoking area. Findings include At 12:55 pm on 08-15-2019, it is observed that an exterior trash can at the courtyard patient smoking area and entry canopy nonsmoking area contained discarded cigarette butts as well as butts found in the pine mulch. The Administrator and Maintenance Director witnessed this evidence by interview and observation on 08-15-2019 at 4:30 pm during the exit interview.	K 741	3. In-service education will be provided to nursing staff involved in Resident smoke breaks and education to Residents that smoke regarding the proper disposal of cigarette butts using the proper smoker's receptacle/ash urn. 4. Maintenance staff will monitor weekly for the compliance of proper use of cigarette butt disposal and empty urns into proper disposal container. Maintenance will report findings for next three months to both Safety and QAPI Committee for review and directions. 5. Date of Compliance September 9th, 2019	