STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495399	A. BUILDING **01 - CHATHAM HLTH & REHAB** B. WING _____	**08/21/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM HEALTH & REHABILITATION CENT	**100 RORER STREET CHATHAM, VA 24531**

(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 Surveyor: 21761 Construction Type: V(111) Number of stories: One Story Building description: The facility is a one-story building of wood frame construction with concrete floors, and is separated from the Kitchen by a 3-hour rated barrier wall. Sprinkler Status: The building is fully sprinklered and protected by NFPA #13 systems supplied by municipal water. An unannounced standard recertification Life Safety Code survey was conducted 08/21/18 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 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting	K 321		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Todd W. Barnes — TITLE: Administrator — (X6) DATE: 9/7/18

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 321	Continued From page 1 partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to protect hazardous areas. This violation potentially affects one of three smoke compartments, evidenced as follows; Findings include: On 08/21/18 at approximately 11:50 AM, it was observed during inspection the 200 hall Med Prep Room door does not remain closed. The Maintenance Director witnessed this evidence through observation and interview.	K 321	**K 321** 1. 200 Hall Med Prep Room door repaired to ensure complete closure. 2. 100% audit of Med Prep Room doors completed during maintenance rounds to identify and ensure complete closure. 3. Maintenance staff educated on maintaining doors with self-closing devices. 4. The Administrator, Maintenance Director or Designee will audit doors with self-closing doors five times a week for two weeks, three times a week for two weeks, and then twice a week for four weeks. 5. Data collected will be brought to the QAPI committee for review and recommendation for the duration of the monitoring period.	9/4/18
K 351	Sprinkler System - Installation	K 351		

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K 351 SS=F	Continued From page 2 CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide complete sprinkler protection. This violation potentially affects one of three smoke compartments, evidenced as follows; Findings include: On 08/21/18 at approximately 12:00 PM, it was observed during inspection the 200 wing exit exterior canopy has a combustible trash can stored beneath it without sprinkler protection. The Maintenance Director witnessed this evidence through observation and interview.	K 351	**K 351** 1. Trashcan was removed from area. 2. 100% audit completed of combustible Items placed in area without sprinkler protection. 3. Staff educated on placement of combustible items throughout facility. 4. The Administrator, Maintenance Director or Designee will audit areas five times a week for two weeks, three times a week for two weeks, and then twice a week for four weeks. 5. Data collected will be brought to the QAPI committee for review and recommendation for the duration of the monitoring period.	9/4/18
K 353	Sprinkler System - Maintenance and Testing	K 353		

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K 353 SS=F	Continued From page 3 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: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to maintain the sprinkler systems. This violation potentially affects one of three smoke compartments, evidenced as follows; Findings include: 1. On 08/21/18 at approximately 11:12 AM, it was observed during inspection the sprinklers behind the clothes dryers in the Laundry room are dust laden. 2. On 08/21/18 at approximately 11:32 AM, it was observed during inspection the sprinkler under	K 353	**K 353** 1. Sprinklers behind clothes dryers were cleaned to remove all dust. Mud dauber's nest was removed From sprinkler under the exterior Canopy for the 400 wing. Sprinkler was thoroughly cleaned and cleared of all debris. 2. A 100% inspection was completed on all sprinkler heads in the facility to identify any other issues. 3. Maintenance staff educated on recognizing, reporting and repairing issues relating to sprinkler heads. 4. Weekly inspection of facility sprinkler heads by the Administrator, Maintenance Director or Designee for the next month and then monthly thereafter. 5. Findings will be reported to QA committee monthly for review and revisions as appropriate.	9/4/18

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K 353	Continued From page 4 the exterior canopy for the 400 wing has a mud dauber's nest on it. The Maintenance Director witnessed this evidence through observation and interview.	K 353		
K 372 SS=F	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. 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: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to protect smoke barrier walls. This violation potentially affects two of three smoke compartments, evidenced as follows; Findings include: On 08/21/18 at approximately 11:41 AM, it was observed during inspection the cross-corridor smoke barrier wall at the Beauty Shop has an unprotected penetration by a data cable, approximately 12 inches above the ceiling. The Maintenance Director witnessed this	K 372	**K 372** 1. The unprotected penetration in the cross-corridor smoke barrier in the wall in the Beauty Shop has been repaired. 2. 100% audit of cross corridor smoke Barrier walls completed during maintenance rounds to identify and ensure complete closure. 3. Maintenance staff educated on maintaining smoke barrier walls. 4. The Administrator, Maintenance Director or Designee will audit Facility walls five times a week for two weeks, three times a week for two weeks, and then twice a week for four weeks. 5. Data collected will be brought to the QAPI committee for review and recommendation for the duration of the monitoring period.	9/4/18

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K 372	Continued From page 5 evidence through observation and interview.	K 372		
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to prevent the introduction of combustible decorations. This violation potentially affects one of three smoke compartments, evidenced as follows; Findings include: On 08/21/18 at approximately 11:55 AM, it was observed during inspection resident room 217 has combustible decorations on the door. The Maintenance Director witnessed this evidence through observation and interview.	K 753	**K 753** 1. Combustible decorations on resident's door was immediately removed. 2. 100% audit of all facility doors Was completed to identify and ensure no other combustible decorations were present. 3. Facility staff educated on combustible decorations. 4. The Administrator, Maintenance Director or Designee will audit facility for combustible decorations five times a week for two weeks, three times a week for two weeks, and then twice a week for four weeks. 5. Data collected will be brought to the QAPI committee for review and recommendation for the duration of the monitoring period.	9/4/18
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		

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K 920	Continued From page 6 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to properly use electrical equipment. This violation potentially affects two of three smoke compartments, evidenced as follows; Findings include: 1. On 08/21/18 at approximately 11:05 AM, it was observed during inspection there is a portable power tap device powering another portable	K 920	**K 920** 1. Portable power tap device was removed from IT room. Multi-outlet extension cord was removed from resident room 217. 2. 100% audit of all facility rooms was completed to identify and ensure no other portable power tap devices were in use. 3. Maintenance Director educated on portable tap devices. 4. The Administrator, Maintenance Director or Designee will audit facility for portable tap devices five times a week for two weeks, three times a week for two weeks, and then twice a week for four weeks. 5. Data collected will be brought to the QAPI committee for review and recommendation for the duration of the monitoring period.	9/4/18

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K 920	Continued From page 7 power tap device in the IT room. 2. On 08/21/18 at approximately 11:51 AM, it was observed during inspection resident room 217 has a multi-outlet extension cord being used as permanent wiring. The Maintenance Director witnessed this evidence through observation and interview.	K 920		