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 _____	**12/12/2019**

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 12/12/19 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 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		January 18, 2019
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 | TITLE | (X6) DATE

Administrator 12/23/19

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 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 maintain hazardous area opening protectives. This has the potential to affect all residents and staff in three of three smoke compartments, evidenced as follows; Findings include: On 12/12/19, at approximately 2:06 P.M., it was discovered during inspection, observation, and interview, the Laundry area rated door was found chocked open. The Maintenance Director witnessed this evidence by observation and interview.	K 321	Corrective Action: K321 Maintenance director closed door that was propped open and educated staff member who was in laundry that it was dangerous to patients and staff to have a hazardous area open without self closing doors performing its duties. Facility will perform 100% audit of all hazardous area enclosures (A-G) to identify any other door closure failures. The maintenance and housekeeping director will in-service all staff who work in laundry or come to laundry for drop off to ensure proficient knowledge of hazardous area enclosures. Facility Administrator will review monthly in safety meeting that hazardous areas are properly maintained.	January 18, 2019
K 711	Evacuation and Relocation Plan	K 711		

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K 711 SS=D	Continued From page 2 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 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide updates to emergency procedures. This has the potential to affect all residents and staff in one of three smoke compartments, evidenced as follows; Findings include: On 12/12/19, at approximately 2:48 P.M., it was discovered during inspection, interview, and observation the Emergency Evacuation & Disaster Plan at the 400 wing Nurses' station has not had the most recent revisions as the rest of the facility. The Maintenance Director witnessed this evidence by observation and interview.	K 711	Corrective Action: K711 Emergency Evacuation & Disaster Plan was updated December 17, 2019 from February 2019 review and placed back on the unit. Plan will be reviewed quarterly at our QAPI meetings and changes will be logged in the master and on the units for review. Staff will be in-serviced on all changes as they occur. A 100% in-service of updates will occur for all staff who have access to 400 unit. Facility will audit units and review plan at QAPI meetings. All logs will match master. Administrator will audit after every QAPI meeting to ensure compliance.	January 18, 2019
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 918		

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K 918	Continued From page 3 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 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: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to document periodic testing of emergency electrical equipment. This has the potential to affect all residents and staff in	K 918	Corrective Action: K918 Facility to perform a generator check on full load for 30 minutes to comply with the monthly standard. This will include documentation of emergency battery electrolyte levels & specific gravity of the generator battory. Facility will perform weekly checks to ensure sets are inspected weekly. Building will maintain a weekly check sign off and a monthly test log to monitor compliance of testing that will be due completed to the Administrator by the 29th of every month for audit. Building will perform a 4 hour continuous test annually to ensure generator is working proficiently in addition to our weekly and monthly checks. A review of the generator manual and working process with administrator and maintenance director will occur annually. Administrator will audit weekly and monthly audits by the 5th of every month to ensure timely accuracy on audits. Any issues will be discussed in safety with a end goal for it to be fixed.	January 18, 2019

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K 918	Continued From page 4 three of three smoke compartments, evidenced as follows; Findings include: On 12/12/19, at approximately 1:41 P.M., it was observed during review of facility documentation there are no records of testing of the emergency generator battery electrolyte levels, or specific gravity. The Maintenance Director witnessed this evidence by observation and interview.	K 918		
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in	K 921		

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K 921	Continued From page 5 accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to provide periodic testing of Personal Care Related Electrical Equipment (PCREE). This has the potential to affect all residents and staff in all smoke compartments, evidenced as follows; Findings include: On 12/12/19, at approximately 1:57 P.M., it was observed during review of facility documentation there are no current records of inspection and testing for Personal Care Related Electrical Equipment (PCREE) in patient care areas. The Maintenance Director witnessed this evidence by observation and interview.	K 921	Corrective Action: K 921 Facility performed initial inventory of all PCREE equipment and distinguish working order of equipment. Facility will inspect and test all equipment based on manufacturer's guidelines moving forward. Logs for each distinguished category of PCREE are kept and audited at monthly safety meetings. The maintenance director will report broken, out of order, and fixed equipment weekly and develop deadlines and solutions for equipment needed. Audit of all PCREE annually and logging equipment with dates of products out of service and when it was repaired to be put back in use.	January 18, 2019