DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURIS AT HARRISONBURG TRANSITIONAL C	94 SOUTH AVENUE HARRISONBURG, VA 22801

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K 000	INITIAL COMMENTS Surveyor: 35701 TYPE OF STRUCTURE: One (1) story, Type II (111) non-combustible construction with four (4) smoke compartments and a complete automatic (wet) sprinkler system. An unannounced Life Safety Code recertification survey was conducted on 03/25/2019 in accordance with 42 Code of Federal Regulations, Part 483.150 and 410 to 480: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing Regulations. The facility was found to be not in compliance with the Requirements for Participation for Medicare and Medicaid. The Findings that follow demonstrate noncompliance with title 42 Code of Regulations. Part 483.150 and 410 to 480 (Life safety from Fire).	K 000		
K 325 SS=D	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in	K 325	**K 325** **Plan of Correction:** 1. Maintenance Director immediately relocated dispenser for required safety code compliance. Housekeeping Supervisor immediately tested dispenser for required safety code compliance and recorded results on sanitizer refill 3/28/2019. 2. Maintenance Director completed 100% center audit on all ABHR dispensers for installation location. Housekeeping Supervisor immediately tested 100% of facility sanitizers for regulatory compliance with documented results 3/28/2019. 3. Executive Director educated Maintenance Director and Housekeeping Supervisor on required dispenser safety code compliance for installation location, testing, and documentation. Executive Director will audit sanitizer refills 1 x per week x 4 weeks, then 1 x per month x 3 months. 4. The Maintenance Director and Executive Director will present findings to the Safety committee with the recommendations made to the Performance Improvement Committee for three months or until resolved.	4/07/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Elsie Carter	Executive Director / Interim Administrator	04/04/201

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 325	Continued From page 1 sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on interview and observation, the facility failed to maintain the Alcohol Based Hand Rub dispensers. This has the potential to affect all residents and staff. The Findings include: It was observed on 03/25/2019 at 11:05 AM, an alcohol based hand rub dispenser was installed within one inch of an ignition source (light switch) located in the dining hall near the exit to the main corridor. An interview with the maintenance supervisor revealed the facility was not testing the alcohol based hand rub dispensers in accordance with the manufacture's care and use instructions each time a new refill was installed.	K 325		
K 353 SS=D	Sprinkler System - Maintenance and Testing 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 ______	K 353	**K 353** **Plan of Correction:** 1. The Maintenance Director immediately installed escutcheon plate on 3/25/2019. 2. The Maintenance Director completed a 100% center audit for maintained sprinkler system escutcheon plates for the sprinkler heads. 3. Executive Director educated Maintenance Director on regulatory requirement of sprinkler system compliance per regulation frequency and as needed. The Executive Director will review and monitor the center's sprinkler system compliance on a quarterly basis. 4. The Maintenance Director and Executive Director will present findings to the Safety committee with the recommendations made to the Performance Improvement Committee for three months or until resolved.	4/07/19

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K 353	Continued From page 2 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: 35701 Based on observation, the facility failed to maintain the sprinkler system. This has the potential to affect one smoke compartment. The Findings include: It was observed on 03/25/2019 at 10:51 AM, the escutcheon plate for the sprinkler head located in the soiled laundry prep area was missing.	K 353		
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	K 363	**K 363** **Plan of Correction:** 1. The Maintenance Director removed the paint on the door, door frame and fire rated tags on 3/28/2019. The Maintenance Director immediately adjusted door sweeping device to ensure complete closure on 03/25/2019. 2. The Maintenance Director completed an audit of all fire rated doors equipped with a door closer throughout facility to remove any paint on the door, door frame and fire rated tags on 03/28/2019. The Maintenance man will do a quarterly audit of the fire rated doors with door closures to monitor for any paint or other items covering the door, door frames and fire tags to prevent the door from closing. 3. The Executive Director educated Maintenance Director on regulatory requirement on corridor doors. The Maintenance man will educate any staff painting not to paint the areas identified on the door, door frame or fire rated tags for future painting. 4. The Maintenance Director and Executive Director will present findings to the Safety committee with the recommendations made to the Performance Improvement Committee for three months or until resolved.	4/07/19

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K 363	Continued From page 3 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 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: Surveyor: 35701 Based on observation, the facility failed to maintain corridor doors. This has the potential to affect one smoke compartment. The Findings include: It was observed on 03/25/2019 at 11:09 AM, the door located at the B Wing entrance was equipped with a door closer and held open with a magnetic hold open device. Observation revealed when the door was released, the door was not completely closing. Observation of the door frame revealed the fire rated tags on the door and door frame was painted. It was observed on 03/25/2019 at 11:54 AM, the	K 363		

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K 363	Continued From page 4 door to the oxygen storage room located in A Wing near room 6 was equipped with an automatic door closer. When operated, the door was not completely closing.	K 363		
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. (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: Surveyor: 35701 Based on record review, the facility failed to properly identify designated smoking areas for staff. This has the potential to affect all staff that	K 741	**K 741** **Plan of Correction:** 1. The Maintenance Director immediately purchased appropriate signage on 03/28/2019. The Maintenance Director will post appropriate signage to designate the facility employee smoking area upon once received. 2. The Maintenance Director will monitor the designated smoking area quarterly to ensure appropriate signage is displayed at the designated smoking area for facility staff. 3. The Executive Director educated Maintenance Director on regulatory requirement on smoking areas for staff. The Staff Development Coordinator will educate all staff on the smoking policy and where the Designated smoking area is for staff. The facility will include the employee smoking policy in all new hire packets. As part of the orientation process staff, will also sign a copy of the smoking policy for their employee file. All staff will be educated on the staff smoking policy during monthly staff meetings for three months or until resolved. 4. The Maintenance Director and Executive Director will present findings to the Safety committee with the recommendations made to the Performance Improvement Committee for three months or until resolved.	4/07/19

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K 741	Continued From page 5 smoke. A record review of the smoking policy on 03/25/2019 at 12:45 PM revealed the designated smoking areas for staff was not identified in the smoking policy.	K 741		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with	K 923	**K 923** **Plan of Correction:** 1. The Maintenance Director immediately installed appropriate oxygen storage room signage on 03/25/2019. The Director of Nursing immediately provided appropriate oxygen in use signage on resident door frame on 03/25/2019. 2. The Maintenance Director and the Director of Nursing will monitor the designated storage room and resident door frame signage on daily rounds for two weeks, weekly for four weeks, and monthly for three months. 3. The Executive Director educated the Maintenance Director and the Director of Nursing on the regulatory requirements for gas equipment cylinder and container storage. 4. The Maintenance Director and Executive Director will present findings to the Safety committee with the recommendations made to the Performance Improvement Committee for three months or until resolved.	4/07/19

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K 923	Continued From page 6 integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to properly identify rooms where oxygen was being stored or used. This has the potential to affect one smoke compartment. The Findings include: It was observed on 03/25/2019 at 11:25 AM, empty E cylinders of oxygen was being stored in a room located in the B Wing near the nurses station and the room was not identified as an oxygen storage area. Observation revealed the room was identified as the supply room. It was observed on 03/25/2019 at 11:34 AM, an oxygen concentrator was observed in use located in B Wing room 8. Observation revealed no sign was placed on the frame of the door to identify oxygen in use.	K 923		