STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495407	A. BUILDING 01 - FALLS RUN NRSG & REHAB CTR B. WING _____	09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS RUN NURSING AND REHAB CENTER	140 BRIMLEY DRIVE FREDERICKSBURG, VA 22406

(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 The Facility is a two story skilled nursing facility. The Facility is Type II (111) construction and is fully sprinklered. An unannounced recertification Life Safety Code survey was conducted on 9/10/19 in accordance with42 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 not be in compliance with the Requirements for Participation for Medicare and Medicaid. The Findings that follow demonstrate non compliance with title 42 Code of Regulations. Part 483.150 and 410 to 480 (Life safety from Fire).	K 000	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 facility has taken or will take the actions set forth in the following plan of correction. The following 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 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of	K 222	K222 1. Corrective action. Adjusted door sensitivity. 2. How facility will identify similar occurrences. Maintenance Director inspected all egress doors with a time delay. 3. Measures/ systemic changes to prevent recurrences. Maintenance Director/ designee will inspect all egress doors with a time delay monthly and adjust sensitivity as appropriate.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

ADMINISTRATOR 9/20/19

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 222	Continued From page 1 locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in	K 222	4. How facility will monitor performance. Review in safety meetings x3. 5. Date of correction. 10/1/19.	

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K 222	Continued From page 2 accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was revealed that the facility failed to maintain normal activation without excessive force of the time delay egress doors. Findings include; On 9-10-19 between 11:30 am and 12:30 pm it was revealed that the time delay egress unlocking sequence was difficult to engage without using excessive force on the doors in Stair 1 and Stair 2, Floors 1 and 2, and the Kitchen exit. This evidence was confirmed by the Mainteance Director.	K 222		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and	K 223	K223 1. Corrective action. Doors identified open with self-closing devices were closed. 2. How facility will identify similar occurrences. This applies to all doors with self-closing devices. 3. Measures/ systemic changes to prevent recurrences. Department heads/ office staff provided an in-service to close doors that have self-closing devices when they leave the office.	

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K 223	Continued From page 3 * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation it was revealed that there were rated fire doors with closers that were propped open. This could effect 90 of 90 patients. Findings include: On 9-10-19 at approximately 12:10 pm it was revealed by observation the fire rated doors to the nurses office on the second floor, the admissions office door on the 1st floor, and maintenance office door were propped open. There findings were confirmed by the Maintenance Director.	K 223	4. How facility will monitor performance. Maintenance Director/ designee will inspect 5x/week for 2 weeks, 3x/week for two weeks and weekly for eight weeks. Review in safety meetings x3. 5. Date of correction. 10/1/19.	
K 345 SS=D	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 on interview and record review, the horns and strobes locations are not being listed on the annual fire alarm test reports. Findings include;	K 345	K 345 1. Corrective action. Maintenance Director identified location of horns and strobes and provided to the fire alarm inspection contractor. 2. How facility will identify similar occurrences. This incorporates all the horns/ strobes for the facility. 3. Measures/ systemic changes to prevent recurrences. Maintenance Director/ designee will ensure annual fire alarm inspection includes location of horns and strobes. 4. How facility will monitor performance. Review annual fire inspection in safety meeting following the inspection. 5. Date of correction. 10/1/19.	

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K 345	Continued From page 4 At approximately 11:05 am on 9-10-19 it was found by record review and that the fire alarm test reports did not include locations of the horns and strobes that are tested annually. These findings were confirmed by the Maintenance Director.	K 345		
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was revealed the facility failed to properly maintain the smoke resistance of the corridor walls in patient sleeping wings and other corridors. 90 of 90 patients are affected.	K 362	K362 1. Corrective action. Maintenance Director will repair identified items NLT 10/1/19. 2. How facility will identify similar occurrences. Maintenance Director/ designee will inspect above ceiling areas for breaches. 3. Measures/ systemic changes to prevent recurrences. Maintenance Director/ designee will inspect above ceiling barrier walls for breaks and repair. Inspect barrier walls after maintenance is performed. 4. How facility will monitor performance. Review in safety meetings x3. 5. Date of correction. 10/1/19.	

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K 362	Continued From page 5 Findings include: On 9-10-19 during the hours of 11:00 am and 1:00 pm unsealed penetrations were revealed above the drop ceilings thoughout the facility. Examples include 1) Above the stair 1 door second floor are 3 one inch penetrations. 2) Above the Medical Records hall Mirror is a 4 inch penetration. 3) There is a 6 inch hole at wall corner near room 212. 4) There is a 1/2 inch hole by room 215 (red wire). 5) Above the stair 2 door, there is a 1 inch penetration with fire caulk missing. 6) Above the water fountain by the Physical Therapy room is a 1 inch penetration. 7) Near rooms 115 to 117, there is fire caulk missing around a 3 inch pipe. The Mainteance Director confirmed these findings.	K 362		
K 531 SS=D	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency	K 531	K531 1. Corrective action. Maintenance Director conducted appropriate tests. 2. How facility will identify similar occurrences. This applies to the two facility elevators. 3. Measures/ systemic changes to prevent recurrences. Maintenance Director/ designee will conduct and document monthly tests.	

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K 531	Continued From page 6 personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on interview with the Maintenance Director, it was revealed the facility failed to conduct and document a monthly test of the elevators. Findings include; On 9-10-19 at 10:55 am it was determined by interview with the Maintenance Director that the elevators are not being tested monthly and a written record maintained. The Director of Maintenance confirmed these findings.	K 531	4. How facility will monitor performance. Review in safety meetings x3. 5. Date of correction. 10/1/19.	