STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/20/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD FREDERICKSBURG, VA 22407**

(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 one story with a construction type of V (000). Sprinkler status: The facility is a fully sprinklered building. An unannounced Life Safety Code recertification survey was conducted 11-20-19 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the 2012 Life Safety Code 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 222 SS=D	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 locks; keying of all locks or keys carried by staff at	K 222		

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

[signature] — Administrator — 12/1/19

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 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 accordance with 7.2.1.6.3 shall be permitted on	K 222	K222 Address the corrective action taken for the identified problem; - Pull handles will be placed on the fire doors adjacent to room #3. - New signs will be posted at exit doors that have letters at or above one inch. - The double-delayed egress doors adjacent to West 2 have been remedied and are operating properly. - The exit doors adjacent to West 2 will be inspected by a repair service to inspect/troubleshoot the magnets and doors. ----	

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K 222	Continued From page 2 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, it was revealed the egress doors are not being maintained. Findings include: 1) On 11-20-19 at approximately 11:45 am it was revealed that the cross corridor smoke doors by room #3 Admissions swing only one way and when closed only can be pushed open going North to South, but neither door could be pushed open in the opposite direction, going South to North. 2) On 11-20-19 at 11:30 am it was revealed that the lettering on the signs for the time delay egress doors was too small - less than one inch in height. 3) On 11-20-19 at 1:00 pm it was revealed that the double delayed egress exit doors by West 2 do not open fully and immediately. The magnetic lock portion was corrected at the time of the survey. One leaf is still hard to open and does not open fully. The Director of Maintenance Services confirmed these findings.	K 222	--- Address how facility will identify other residents potentially affected by deficient practice; - Residents in the facility may be affected. --- Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; - The facility will conduct a complete survey of exterior and fire/smoke doors to ensure proper operation. - This exterior door inspection will be documented and reviewed during the Morning Meeting Process weekly; identifying signage, handle placement on smoke doors, and egress compliance. --- Indicate how the facility will monitor it's performance to make sure that solutions are sustained; - Results of weekly inspections will be reported in the facility's monthly Quality Assurance Performance Improvement (QAPI) meetings. --- Date of Compliance; December 19, 2019	
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices	K 223	K223 Address the corrective action taken for the identified problem; - The facility will repair the identified doors and install door knobs and latches for the identified doors. ---	

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K 223	Continued From page 3 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 * 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, doors in the corridor of the facility were not being properly maintained. On 11-20-19 approximately from 12:30 to 3:00 pm corridor doors were found to not close and latch to hazardous areas and other areas open to the corridor, including the Laundry room, Kitchen, and Director of Maintenance Services office/electrical room. The Director of Maintenance Services confirmed these findings.	K 223	Address how facility will identify other residents potentially affected by deficient practice; - The facility will conduct a complete survey of doors requiring latches and knobs to ensure proper installation and operation. --- Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; - The facility will conduct a weekly door and door closure device inspection to ensure compliance and document the results. --- Indicate how the facility will monitor it's performance to make sure that solutions are sustained; - Results of weekly inspections will be reported in the facility's monthly Quality Assurance Performance Improvement (QAPI) meetings. --- Date of Compliance; December 19, 2019	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, it was revealed that	K 291	K291 Address the corrective action taken for the identified problem; - The facility will replace dead batteries in the identified emergency light. --- Address how facility will identify other residents potentially affected by deficient practice; - The facility will conduct a complete survey of emergency lighting.	

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K 291	Continued From page 4 emergency lighting was not being maintained. On 11-20-19 at 2:20 pm it was revealed that the emergency light in the West Utility Room #3 was not working. This finding was confirmed by the Director of Maintenance.	K 291	Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; - The facility will conduct weekly inspections and document the results. ----	
K 331 SS=D	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was revealed that the Director of Maintenance Services office walls were not being properly maintained. Findings include: On 11-20-19 at 11:00 am it was revealed that combustible wood paneling was installed on the walls in the Director of Maintenance Services office. The Director of Maintenance Services confirmed	K 331	Indicate how the facility will monitor it's performance to make sure that solutions are sustained; - Results of weekly inspections will be reported in the facility's monthly Quality Assurance Performance Improvement (QAPI) meetings. --- Date of Compliance; December 19, 2019 _____ K331 Address the corrective action taken for the identified problem; - The facility will install sheet rock in the identified office. ---- Address how facility will identify other residents potentially affected by deficient practice; - The facility will conduct a complete survey of other offices to identify any other non-compliant wall coverings. ---- Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; - The facility will conduct weekly inspections and document the results. ----	

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K 331	Continued From page 5 these findings.	K 331	--- Indicate how the facility will monitor it's performance to make sure that solutions are sustained; - Results of weekly inspections will be reported in the facility's monthly Quality Assurance Performance Improvement (QAPI) meetings. --- Date of Compliance; December 19, 2019	
K 351 SS=D	Sprinkler System - Installation 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: Based on observation, the sprinkler system coverage was not being maintained. Findings include: On 11-20-19 at 1:00 pm it was revealed that there was combustible rubbish stored in a semi confined foyer area by the basement exit way on the Northwest side of the building that was not protected by a sprinkler. On 11-20-19 at 1:45 pm it was revealed that the West #3 Utility room was not protected by a	K 351	K351 Address the corrective action taken for the identified problem; - The facility will have new sprinkler heads installed in the two identified areas. --- Address how facility will identify other residents potentially affected by deficient practice; - The facility will conduct a complete survey of the building to ensure no other areas exist that do not have sprinkler coverage. --- Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; - The facility will have quarterly and annual inspections of the sprinkler system. --- Indicate how the facility will monitor it's performance to make sure that solutions are sustained;	

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K 351	Continued From page 6 sprinkler. These findings were confirmed by the Director of Maintenance Services.	K 351	- Results of quarterly/annual inspections will be reported in the facility's monthly Quality Assurance Performance Improvement (QAPI) meetings. --- Date of Compliance; December 19, 2019	
K 371 SS=F	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Compartments 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on observation, it was revealed that the facility was not maintaining the smoke barrier walls. Findings include: On 10-20-19 at approximately 2:20 pm it was revealed that the penetrations in the smoke barrier walls were not properly maintained. These findings were confirmed by the Director of Maintenance Services.	K 371	K371 Address the corrective action taken for the identified problem; - The facility will fix smoke barrier penetrations using appropriate sealant. --- Address how facility will identify other residents potentially affected by deficient practice; - The facility will conduct a complete survey of the building's smoke barriers. --- Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; - The facility will conduct monthly inspections of the smoke barriers. --- Indicate how the facility will monitor it's performance to make sure that solutions are sustained; - Results of monthly smoke barrier inspections will be reported in the facility's monthly Quality Assurance Performance Improvement (QAPI) meetings. --- Date of Compliance; December 19, 2019	
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall	K 521		

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K 521	Continued From page 7 comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation, the Laundry room ventilation was not being adequately maintained. Findings include: On 11-20-19 at approximately 12:35 pm, it was revealed that there was excessive lint buildup in the dryers, on top of the dryers, and behind the dryers coating the equipment. The Director of Maintenance confirmed these findings.	K 521	K521 Address the corrective action taken for the identified problem; - The facility will insure lint is removed from the identified dryers. --- Address how facility will identify other residents potentially affected by deficient practice; - Inspections will be conducted by management staff. --- Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; - The facility will institute a systematic inspection and cleaning schedule for dryers. Lint screens will be cleaned hourly when units are in use. Rear areas of the dryers will be cleaned daily and interior areas of the dryer will be inspected and cleaned weekly. --- Indicate how the facility will monitor it's performance to make sure that solutions are sustained; - The Director of Maintenance and/or the Housekeeping Manager will inspect and sign-off on the cleaning schedules. --- Date of Compliance; December 19, 2019	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System 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	K 918		

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K 918	Continued From page 8 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: Based on observation, it was revealed that the electrical generator and electricial circuits are not being properly maintained. On 10-20-19 at 1:10 pm it was revealed that the generator had not been exercised under load for 4 continuous hours in the past 36 months. On 10-20-19 at 2:05 pm it was revealed that the labeling of electrical circuits in panels throughout the facility were not complete. Examples include KS Panel in basement, Communications/phone circuit room panels, West Utility #3 room panels. The Director of Maintenance Services confirmed these findings.	K 918	K918 Address the corrective action taken for the identified problem; - The facility will have a continuous four-hour generator load bank test conducted. - The identified electrical panels will be properly labeled. --- Address how facility will identify other residents potentially affected by deficient practice; - Four-hour load bank testing for the generator will be added to the preventative maintenance and testing contract as well as the facility maintenance schedule. - All electrical panels will be inspected, existing labeling will be tested for accuracy and new labeling added where needed. --- Address what MEASURES will be put in place or SYSTEMATIC CHANGES made to ensure the deficient practice will not recur; - The facility will institute a quarterly inspection of all electrical panels. --- Indicate how the facility will monitor it's performance to make sure that solutions are sustained; - The Director of Maintenance will document inspection results. --- Date of Compliance; December 19, 2019 _____	

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