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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495421	A. BUILDING 01 - MAIN BUILDING B. WING _____	12/20/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER -	5647 STARKEY ROAD CAVE SPRING, VA 24018

(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: 34730 Building Description: The facility is a one-story structure built on a concrete slab with a pitched roof. The building was designed with a one hour corridor rating without door closer's on patient room doors. The building has four patient housing wings, Wing 1, 31 beds, Wing 2, 29 beds, Wing 3, 29 beds, Wing 4, 31 beds, Wings 1/2 and 3/4 are connected by a dining/activity room which also serves as the required smoke compartment for the wing. Fire treated wood located in space between drop ceiling and rated ceiling assembly, used to attach electrical and mechanical equipment. The main entrance to the building is through the administrative building, which connects to all patient housing wings and is separated by a two hour fire barrier. All Patient rooms have prepiped oxygen in them. The therapy building is located between wings 2 and 3 and is separated by a two hour fire barrier from the patient housing wings. The kitchen/services building is located to the rear of the facility between wings 2 and 3. This is a separate building connected to the patient housing wings by a roof with a two hour fire barrier. The patient beauty shop is located in this building. Required fire sprinkler and fire alarm systems are interconnected between all wings/buildings and are indicated on the annunciation panels as zones, the facility is surveyed as one building.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandon Evans	Administrator	12/31/2019

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 000	Continued From page 1 Type of Construction: V (III) Sprinkler Status: Fully sprinklered, NFPA 13 Quick Response System. An unannounced recertification Life Safety Code survey was conducted 12/20/2019 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 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 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	K 222	**K 222** **Corrective Action(s):** The lettering on both sets of the egress doors will be corrected using a decal that can be applied initially and reapplied should the sign become not legible again. **Identification of Deficient Practices/Corrective Action(s):** All other egress doors have been checked and have been verified as having the appropriate signage that meets the requirements of K 222. **Systemic Change(s):** The facility's policies and procedures were reviewed and no changes are needed at this time. The facility's maintenance personnel will perform routine checks on all doors no less than monthly to ensure they meet the standards as outlined in K 222. **Monitoring:** The facility's maintenance department will be responsible for monitoring compliance. To assist with compliance monitoring, the maintenance department will conduct monthly audits on all egress doors. The findings from these audits, along with the corrective action will be presented to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	1/24/2020

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K 222	Continued From page 2 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 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:	K 222		

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K 222	Continued From page 3 Surveyor: 34730 Based on observation and inspection the facility failed to maintain the means of egress. This has the ability to affect all occupants of the building. Findings include: On 12-20-19 at approximately 10:20 A.M. it was observed through observation and inspection that the "PUSH TO EXIT" sign on the access control doors device in the 2nd Wing Staff Entrance is not legible. On 12-20-19 at approximately 11:20 P.M. it was observed through observation and inspection that the "PUSH TO EXIT" sign on the access control doors device in the 3rd Wing Staff Entrance is not legible. The Facility Administrator and Maintenance Director witnessed this evidence by observation and interview.	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 arequired 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	K 223	**K 223** **Corrective Action(s):** The door closing device on maintenance shop door will be replaced with the same or compatible hardware that was originally installed. **Identification of Deficient Practices/Corrective Action(s):** All other doors have been checked and have been verified as having the self-closing device where indicated that meets the requirements of K 223. **Systemic Change(s):** The facility's policies and procedures were reviewed and no changes are needed at this time. The facility's maintenance personnel will perform routine checks on all doors no less than monthly to ensure they meet the standards as outlined in K 223. **Monitoring:** The facility's maintenance department will be responsible for monitoring compliance. To assist with compliance monitoring, the maintenance department will conduct monthly audits on all doors. The findings from this audit, along with the corrective action will be presented to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	1/24/2020

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K 223	Continued From page 4 This REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based on observation and inspection the facility failed to maintain doors to hazardous areas. This has the ability to affect occupants in this area. Findings include: On 12-20-19 at approximately 10:05 A.M. it was observed through observation and inspection that the door closing device has been removed off the Maintenance Shop door. The Facility Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 223	**K 353** **Corrective Action(s):** The missing sprinkler escutcheon in 428A was replaced. The ceiling tile in room 469 had been replaced. The sign identifying the sprinkler room has been located and will be replaced. **Identification of Deficient Practices/Corrective Action(s):** The maintenance department performed a comprehensive review of the entire facility and, aside from the above items, all escutcheon rings, ceiling tiles, and signage to be present and in great condition.	1/24/2020
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 _____ 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	K 353	**Systemic Change(s):** The facility's policies and procedures were reviewed and no changes are needed at this time. The facility's maintenance personnel will perform a comprehensive facility wide audit no less than monthly to ensure compliance with K 353. **Monitoring:** The facility's maintenance department will be responsible for monitoring compliance. To assist with compliance monitoring, the maintenance department will conduct a comprehensive facility wide audit no less than monthly to ensure compliance with K 353. The findings from this audit, along with the corrective action will be presented to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	

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K 353	Continued From page 5 by: Surveyor: 34730 Based on observation and inspection the facility failed to maintain the sprinkler system. This has the ability to affect all occupants of the building. Findings include: On 12-20-19 at approximately 11:15 A.M. it was observed through observation and inspection that a sprinkler escutcheon is missing in Room 428A. On 12-20-19 at approximately 11:17 A.M. it was observed through observation and inspection that a ceiling tiles is missing in Room 469. On 12-20-19 at approximately 11:19 A.M. it was observed through observation and inspection that the sign identifying the sprinkler room is missing. The Facility Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 353	**K 372** **Corrective Action(s):** The facility's maintenance personnel patched the unprotected through penetrations to the corridor wall in the Dietary wing outside of Room 611. **Identification of Deficient Practices/Corrective Action(s):** **Practices/Corrective Action(s):** The maintenance department performed a comprehensive review of the entire facility and aside from the unprotected through penetrations to the corridor wall in the Dietary wing outside of Room 611, all areas of the facility to be compliant with the requirements of K372. **Systemic Change(s):** The facility's policies and procedures were reviewed and no changes are needed at this time. The facility's maintenance personnel will perform routine a comprehensive facility wide audit no less than monthly to ensure compliance with K 372. **Monitoring:** The facility's maintenance department will be responsible for monitoring compliance. To assist with compliance monitoring, the maintenance department will conduct a comprehensive facility wide audit no less than monthly to ensure compliance with K 372. The findings from this audit, along with the corrective action will be presented to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	12/24/2019
K 372 SS=E	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.	K 372		

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K 372	Continued From page 6 This REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based on observation and inspection the facility failed to maintain smoke barriers. This has the ability to affect occupants in 2 smoke compartments. Findings include: On 12-20-19 at approximately 10:17 A.M. it was observed through observation and inspection that there are unprotected through penetrations to the corridor wall in the Dietary wing outside of Room 611. The Facility Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 372	**K 911** **Corrective Action(s):** The items blocking the electrical service panel were immediately removed when pointed out by the Fire Marshal. Additionally, the Director of Dining Services performed staff education regarding proper placement of supplies. **Identification of Deficient Practices/Corrective Action(s):** All other electrical service panels were inspected to ensure there were no items blocking access. **Systemic Change(s):** The facility's policies and procedures were reviewed and no changes are needed at this time. The facility's maintenance personnel will perform routine checks on all electrical service panels no less than monthly to ensure compliance with K 911. The Director of Dining Services, or designee, will continue to provide all staff with education regarding the proper location to store products and the importance of keep access to the panel open at all times. **Monitoring:** The facility's maintenance department will be responsible for monitoring compliance. To assist with compliance monitoring, the maintenance department will conduct monthly audits on all electrical service panels no less than monthly. The findings from these audits, along with the corrective action will be presented to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice, and length in which audits need to be continued.	12/20/2019
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based on observation and inspection the facility failed to maintain the electrical system. This has the ability to affect occupants in this area. Findings include: On 12-20-19 at approximately 10:15 A.M. it was	K 911		

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K 911	Continued From page 7 observed through observation and inspection that the electrical service panel in the Kitchen is obstructed. The Facility Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 911		