STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING 01 B. WING _____	08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WARWICK FOREST	1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602

(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: 36033 Description of structure: 1 Story II (000) Building Sprinkler status: Fully Sprinklered An unannounced Life Safety Code standard survey was conducted on 08-14-18 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. 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 300 SS=C	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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. This REQUIREMENT is not met as evidenced by: Surveyor: 36033 Based upon observations & discussions there are open penetrations above the Fire Doors in the Corridors which will allow the passage of smoke & flames from one smoke compartment to another.	K 300	K300 – 1.On August 15, the facility maintenance manager corrected the ceiling in the beauty shop` and the ceiling tile around the sprinkler head in the linen room. On August 20, the Director of Facilities selected and engaged a certified contractor to begin identifying and properly correcting the open penetrations in the fire walls/rated ceilings on North Exit from Piedmont to Chesapeake, near room 520 on Chesapeake Unit, the fire wall above the electrical panels off of Chesapeake dining room, the fire wall near beauty shop, the fire wall near room 219, and the improper penetration of the fire wall in the main electrical room. 2.The facility's selected certified contractor will inspect fire walls above the corridor ceilings throughout the building to identify and correct other improper penetrations not noted in Form CMS-2567. The Director of Facility Services or designee will conduct a building-wide visual inspection of ceiling tiles and escutcheon rings surrounding sprinkler heads. Any variances will be addressed and reported to the QAPI Committee. 3.An above ceiling permit program will be developed by the Director of Facility Services and implemented for projects involving work above the drop ceiling that may entail fire wall penetration. The program will include inspection of said work to ensure that the integrity of the fire walls is maintained. All team members will be in-serviced on the process and requirement to report any person observed in the ceiling without a permit attached to the ladder. 4.The Director of Facility Services or designee will complete observations weekly for four weeks then monthly for 3 months of contractors working in the ceiling to ensure a permit has been issued. Any variances will be addressed and reported to the QAPI Committee.	8/15/18 9/26/18 9/26/18 9/26/18 Start 9/26/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Meg Mercer, LNHA	Asst Admin	8/24/18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING 01 B. WING _____	08/14/2018

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K 300	Continued From page 1 Findings include on 08/14/18 accompanied by the Director of Facilities, the following item was noted: Observed open penetrations in the fire walls/ rated ceilings in the following locations: North Exit from Piedmont to Chesapeake Near Room 520 on Chesapeake Unit Fire Wall above electrical panels off of Chesapeake Dining Room Fire Wall near Beauty Shop Ceiling in the Beauth Shop TV mount hanging down Fire Wall room 219 Ceiling tile Broken in linen room around sprinkler head Main Electrical room penetrations to the fire wall. The Director of Facilities and Administrator confirmed these findings.	K 300		
K 324 SS=B	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as	K 324	K324 – 1.The damaged smooth glass cooktop in the kitchen of the Monticello Unit was immediately disabled by the Maintenance Manager at the circuit breaker panel and all combustible material was immediately removed on August 14 during the inspection. The cooktop was uninstalled on August 16 by the Maintenance Manager. The nozzles to the fire suppression system within the commercial hood in the kitchen to the Chesapeake Unit were reinstalled in their correct locations on August 16 by the facility's selected fire protection systems contractor. 2.The Food Services Director or designee will conduct a visual inspection of remaining cooktops, nozzles to suppression system, ovens and fryers building-wide to assess their fitness and integrity. Any variances will be addressed and reported to the QAPI Committee. 3.Food Services Director or designee will ensure that the facility's kitchen inspection schedule, assignments and forms include monthly inspection of all cooking appliances beginning September 1. All Food Services Department personnel will be trained by the Food Services shift supervisors on the procedure for reporting damaged equipment. The Food Services Director or designee will conduct risk assessments prior to replacing or relocating equipment that have fire suppression systems. A notebook will be developed that includes routine testing and maintenance records and will be kept current by Director of Facility Services or designee. 4.Food Services Director or designee will complete observations weekly for four (4) weeks then monthly of a combination of five (5) cooktops and nozzles to suppression systems. Any variances will be addressed and reported to the QAPI Committee.	8/14/18 8/16/18 8/16/18 9/1/18 9/1/18 9/21/18 Start 8/14/18 Start 9/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495071	A. BUILDING **01** B. WING _____	**08/14/2018**

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THE GARDENS AT WARWICK FOREST	**1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA 23602**

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K 324	Continued From page 2 hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Surveyor: 36033 Findings on 08/14/18, accompanied by the Director of Facilities, the following was observed: Upon inspection of the cooking equipment and Hood Suppression equipment throughout the facility, the following deficiencies were noted: Monticello Kitchen: Combustibles stored on cooking equipment] Glass cooking top broken and covered with plastic wrap (plastic wrap, combustibles and stove taken out of service immediately by maintenance prior to my departure) Chesapeake Kitchen: Nozzles to suppression system not aimed properly to adequately cover cooking equipment The Director of Facilities and Administrator confirmed these findings.	K 324		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 495071	DATE SURVEY COMPLETE: 08/14/2018
NAME OF PROVIDER OR SUPPLIER **THE GARDENS AT WARWICK FOREST**	STREET ADDRESS, CITY, STATE, ZIP CODE **1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA. 23602**	

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 223	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 * 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: Surveyor: 36033 Based upon observations, interviews & discussions there are doors that were found that did not have positive latching or requires excessive force to latch the doors Findings include on 08/14/14, accompanied by the Director of Facilities, the following item was noted: The Fire door not closing to Monticello Store room. The Director of Facilities and Administrator confirmed these findings.
K 293	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Surveyor: 36033 Based upon observations exit sign located near room 302 directional arrow is pointed in the wrong direction. The Director of Facilities and Administrator confirmed these findings.
K 911	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.

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The above isolated deficiencies pose no actual harm to the residents

Meg Merritt 8/24/18

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 495071	DATE SURVEY COMPLETE: 08/14/2018
NAME OF PROVIDER OR SUPPLIER **THE GARDENS AT WARWICK FOREST**	STREET ADDRESS, CITY, STATE, ZIP CODE **1000 OLD DENBEIGH BOULEVARD NEWPORT NEWS, VA. 23602**	

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 911	Continued From Page 1 Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 36033 Findings include on 08/14/18 accompanied by the Director of Facilities, found extension cords in use as permanent wiring and also noted combustibles stored in electrical rooms: Extension cord in use in recreation office powering a microwave Combustible storage in the main electrical room The Director of Facilities and Administrator confirmed these findings.

K223 –
1.On August 15, the facility's maintenance technician installed a screw where missing in order to properly secure the striker plate in the door jamb to the storage room on the Monticello Unit allowing the self-closing door to latch properly.
2.A visual inspection of all self-closing doors facility-wide will be conducted by the Director of Facilities or designee to ensure positive latching. Any variances will be addressed and reported to the QA Committee.
3.Inspection of self-closing doors will be added to the facility's monthly preventive maintenance (PM) program. Any variances will be addressed and reported to the Safety Committee.
4.The Facility Services Director or their designee will randomly spot check five (5) self-closing doors weekly for four (4) weeks then three (3) self-closing doors weekly for eight (8) weeks. Any variances will be addressed and reported to the QAPI Committee.
5.All corrective actions will be completed by September 21, 2018.

K293 –
1.The erroneous directional arrow on the exit sign near room 302 on the Rehab 300 unit was covered (blocked out) by the facility's Maintenance Manager to correct the deficient exit sign and bring it into compliance. A replacement exit sign was ordered and will be installed upon arrival.
2.A visual inspection of all exit signs building-wide will be conducted by the Director of Facility Services or designee to ensure the accuracy of their directional arrows and to ensure that they are properly placed and illuminated. Any variances will be addressed and reported to the QA Committee.
3.Inspection of exit signs will be added to the monthly preventive maintenance (PM) program. Exit signage will continue to be observed during monthly safety rounding. Any variances will be addressed and reported to the Safety Committee.
4.The Director of Facility Services or their designee will randomly spot check five (5) exit signs weekly for four (4) weeks then three (3) exit signs weekly for eight (8) weeks. Any variances will be addressed and reported to the QAPI Committee.
5.All corrective actions will be completed by September 21, 2018.

K911 –
1.The microwave in the recreation office was immediately unplugged by the Director of Facility Services and the extension cord removed. Combustible items were removed from the main electrical room by the facility's maintenance technicians on 8/14/18.
2.Room rounds, to include office spaces, will be conducted facility-wide by Director of Facility Services or designee to identify any deficient use of extension cords and to ensure no combustible items are stored in electrical rooms. Any variances will be addressed and reported to the QAPI Committee.
A sign was placed on the door to the main electrical room which reads- Electrical Room- No Storage.

3.Staff will be re-educated by the Director of Facility Services or designee concerning the use of extension cords and prohibition against the storage of combustible items in electrical rooms. Safety Committee rounds will be revised to include inspection for the improper use of extension cords.
4.The Director of Facility Services or their designee will randomly spot check the main electrical room and five (5) office spaces weekly for four (4) weeks then the main electrical room and three (3) offices weekly for eight (8) weeks. Any variances will be addressed and reported to the QAPI Committee.
5.All corrective actions will be completed by September 21, 2018.

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The above isolated deficiencies pose no actual harm to the residents