NLC.

PRINTED: 12/14/2021
FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0016	A. BUILDING: _____ B. WING _____	C 12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT HARRISONBURG	94 SOUTH AVENUE HARRISONBURG, VA 22801

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 12/7/21 through 12/9/21. Corrections were required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 117 bed facility was 68 at the time of the survey. The survey sample consisted of eighteen current resident reviews and two closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12VAC5-371-220 F cross reference to F561 12VAC5-371-75 B. 2 cross reference to F607 12VAC5-371-250 C, F cross reference to F657 12VAC5-371-220 F cross reference to F677 12VAC5-371-220 A, B cross reference to F684, F697, F758 12 VAC5-371-210 B cross reference to F725	F 001	F561 cross reference to 12VAC5-371-220 F F607 cross reference to 12VAC5-371-75 B. F657 cross reference to 12VAC5-371-250 C, F F677 cross reference to 12VAC5-371-220 F F684, F697, F758 cross reference to 12VAC5-371-220 A, B F725 cross reference to 12 VAC5-371-210 B	1/25/22 1/25/22 1/25/22 1/25/22 1/25/22 1/25/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Leah Queen — TITLE: Administrator — (X6) DATE: 12/23/21

STATE FORM 6899 642Q11 If continuation sheet 1 of 2

RECEIVED
DEC 27 2021
VDH/OLC

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F 001	Continued From page 1 12VAC5-371-300 A, B cross reference to F755, F761 12VAC5-371-340 B cross reference to F801 12VAC5-371-340 A cross reference to F812 12VAC5-371-360 A, E cross reference to F849	F 001	F755, F761 cross reference 12VAC5-371-300 A, B . F801 cross reference to 12VAC5-371-340 B F812 cross reference to 12VAC5-371-340 A F849 cross reference to 12VAC5-371-360 A, E	1/25/22 1/25/22 1/25/22 1/25/22

COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

M. Norman Oliver, MD, MA
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120

9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

MEMORANDUM

December 22, 2021

TO: Ruthanne Risser, Interim Director
Division of Long Term Care

FROM: Joyce Walker, Life Safety Coordinator
Division of Life Safety Code

SUBJECT: Choice Healthcare at Harrisonburg in Harrisonburg, Virginia CMS #495146, Event ID #642Q21, Survey Date 12/13/2021, Highest Scope/Severity: D

The attached report forwarded to you with the following comments:

I. SURVEY [X]

[ ] Recommend certification based on compliance with Life Safety Code.
[X] Recommend certification based on acceptable POC.
[ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
[ ] Recommend certification based on compliance with LSC by requested continuous waiver.
[ ] Recommend certification based on compliance with LSC by requested Time Limited waiver.
[ ] Recommend certification based on satisfactory results from application of the FSES.
[ ] Do not recommend certification.

II. POST SURVEY [ ]

[ ] All deficiencies corrected:
[ ] Not all deficiencies corrected:
- [ ] Recommend certification based on acceptable POC
- [ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
- [ ] Recommend certification based on approved or requested continuous waiver.
- [ ] Recommend certification based on approved or requested Time Limited waiver.
- [ ] Do not recommend certification.

If you have any questions or if we may be of further assistance, please contact me at (804) 367-2129.

PART IV - FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS 2786 FORMS)

Provider Number K1	Facility Name	Survey Date *K4
495146	Choice Of Harrisonburg	12.13.21

K6 DATE OF PLAN APPROVAL

11/01/74

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING _____

[A]
A. BUILDING
B. WING
C. FLOOR
D. APARTMENT UNIT

LSC FORM INDICATOR

HEALTH CARE FORM		
12	2786R	2012 EXISTING
13	2786R	2012 NEW

AHCO FORM		
14	2786U	2012 EXISTING
15	2786U	2012 NEW

ICF/IID FORM		
16	2786V, W, X	2012 EXISTING
17	2786V, W, X	2012 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

SMALL (16 BEDS OR LESS)

K8 [ ]
1. PROMPT
2. SLOW
3. IMPRACTICAL

LARGE

K8 [ ]
4. PROMPT
5. SLOW
6. IMPRACTICAL

APARTMENT HOUSE

K8 [ ]
7. PROMPT
8. SLOW
9. IMPRACTICAL

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, and Y.)

K321: [ ] K351: [ ]

COMPLETE IF ICF/IID IS SURVEYED UNDER CHAPTER 33, EXISTING

ENTER E – SCORE

K5: [ ] e.g. 2.5

*K9 FACILITY MEETS LSC BASED ON *(Check all that Apply)*

A1. [ ] (COMP. WITH ALL PROVISIONS)

A2. [X] (ACCEPTABLE POC)

A3. [ ] (WAIVERS)

A4. [ ] (FSES)

A5. [ ] (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. [ ]

K0180

A. [X] FULLY SPRINKLERED (All required areas are sprinklered)

B. [ ] PARTIALLY SPRINKLERED (Not all required areas are sprinklered)

C. [ ] NONE (No sprinkler system)

*MANDATORY

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

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	495146	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/13/2021

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K 000	INITIAL COMMENTS Description of structure: The facility is a 1 story masonry structure Type II (222) Sprinkler status: Fully sprinklered-NFPA 13 An unannounced Standard Recertification Life Safety Code Survey was conducted on 12/13/2021 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 483.90(a) et seq (Life Safety from Fire)	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321	1. The Maintenance Director reviewed the affected area and priced out supplies to fix area. Area was fixed on 12/15/2021. 2. All residents have the potential to be affected by this. 3. Education was provided to Maintenance department regarding the importance of ceiling tiles being properly sealed to active sprinkle/ smoke alarm system. 4. Maintenance Director and/or designee will audit all ceiling tiles weekly for 6 weeks to ensure facility is in compliance. Information will be reported at QA and determined if further monitoring will be needed.	12/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather Queen	Administrator	12/20/21

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 321	Continued From page 1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: It was revealed by observation that smoke tight seperation is not being maintained. Findings include; On 12/13/21 at 3 PM it was revealed that in the laundry area the ceiling tiles had penerations that were not sealed. This condition shall allow smoke and heat to by pass the sprinkler heads delaying activation. This was confirmed by the Director of Maintenance.+	K 321		