STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/21/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	**112 N CONSTITUTION DR** **YORKTOWN, VA 23692**

(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: 1 Story V (111) masonry Building Sprinkler status: Fully Sprinklered NFPA 13 An unannounced Standard Recertification Life Safety Code Survey was conducted on 2/21/24 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	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilities allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated.	3/21/24
K 100 SS=F	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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: The standard is not met by evidence that the fire alarm is in the triouble mode. Findigs include; On 2/21//24 at 3 PM, it was revealed that the fire alarm panel was in the trouble Mode. The maintenace person stated it had been in this condition for over a week. The Code requires that when the fire alarm detections system is down	K 100	K 100 1. Fire watch was started immediately. The fire panel vendor was contacted and resolved the issue on 2/22/24. 2. Current residents have the potential to be affected. 3. The Maintenance Director or Designee will educate management staff on requirement to notify vendor related to any change in the fire panel trouble mode. 4. The Maintenance Director or Designee will complete random weekly audits for 4 weeks related to fire panel trouble mode monitoring. Any isssues noted during the audits will be addressed immediately and presented to the QAPI committee. Once the QAPI committee determines the problem no longer exists, the review will be completed randomly. 5. Date of Completion 3/21/24.	

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

[signature] LNHA | Administrator | 3/1/2024

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 100	Continued From page 1 for over 4 hours a Fire Watch Must be established. Effected immediatly unit thre Alarm system is repaire a building wide fire watch must be established 24/7. THE FIRE WATCH PERSONS DUTYS CAN ONLY BE FOR THE FIRE WATCH. Per bNFPA 101-9.6.1.6 This was confirmed by the Maintenace Director	K 100		
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 by: The Standard is not met by evidence that the sprinkler system has not had the required maintenance.' Findings include;	K 353	K353 1. Sprinkler vendor was contacted immediately to schedule inspections. 2. Current residents have the potential to be affected. 3. The Maintenance Director or Designee will ensure all sprinkler system inspections and test are up to date. 4. The Maintenance Director or Designee will complete random weekly audits for 4 weeks related to sprinkler system inspections. Any issues noted during the audits will be addressed immediately and presented to the QAPI committee. Once the QAPI committee determines the problem no longer exists, the review will be completed randomly. 5. Date of Completion 3/21/24.	3/21/24

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K 353	Continued From page 2 On 2/21 at 3;30 pm, it was revealed that by documenation review that there was no record of the 5 year test on the sprinkjler gauges. Per NFPA 25- 5.3.2 By documenation review there was no record of the 10 year test to the dry sprinkler heads as required per NFPA 25- 5.3.1.1.1.5	K 353		
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: The standard is not met by evidence of documenation review concering Fire Doors. Findings include; On 2/.21/24 at 3 PM , it was revealed that the facility had no documenation that a fire door inspection had been completed, AS per NFPA 80 5.2.2 , 5.5.9, 5.5.9.2 a inspectionm and documenation is required.	K 761	K 761 1. Fire Door vendor was contacted immediately to schedule inspection. 2. Current residents have the potential to be affected. 3. The Maintenance Director or Designee will ensure all fire door inspections are up to date. 4. The Maintenance Director or Designee will complete random weekly audits for 4 weeks related to fire door inspections. Any issues noted during the audits will be addressed immediately and presented to the QAPI committee. Once the QAPI committee determines the problem no longer exists, the review will be completed randomly. 5. Date of Completion 3/21/24.	3/21/24

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K 761	Continued From page 3 This was confirmed by the Director of Maintenance	K 761		