STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/15/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	**542 ALLRED MILL ROAD** **MOUNT AIRY, NC 27030**

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted utilizing the 2012 edition of the National Fire Protection Association (NFPA) 101 - Life Safety Code (LSC) and 2012 edition of the NFPA 99 - Health Care Facilities Code (HCFC) and its referenced publications. The facility plan/construction approval occurred prior to July 5, 2016. The facility is utilizing special locking systems. In the exit conference all LSC deficiencies noted were discussed and acknowledged with Administration. Stories: One Construction Type: V(111) Constructed: 5/1/1981 Fully Sprinkled YES At time of survey the Licensed bed capacity = 120 Total Certified Bed Count = 120 Census = 109	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and/or documentation on 11/15/2017 at 12:00 PM through 3:30 PM the following deficiencies were noted: The standard is non-compliant, specific findings include:	K 211	K211 The dumpster blocking the concrete egress walkway, located near the dumpster pad and 2 large above ground gas tanks, was moved to clear/create the	12/30/17

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

Electronically Signed | 12/01/2017

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K 211	Continued From page 1 1. The facility had an outside large metal dumpster sitting on and blocking the required concrete egess walkway to the public way; the walkway was next to the dumpster pad and 4 main metal outside garbage dumpsters and the 2 large outside above ground gas tanks. This deficiency affected 1 of 7 smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death due to smoke and or fire.	K 211	required access. Concrete barrier strips have been installed to prevent the dumpsters from impeding on the required concrete egress walkway. A 100% audit was conducted, no other concrete egress walkways were found to be blocked or otherwise out of compliance. Monitoring/audits of all egress walkways will be conducted by the Maintenance Director monthly for 3 months. Any infractions will be corrected immediately. Results of the audits will be reviewed by the Administrator or Designee monthly to ensure continued compliance until next annual Life Safety Survey. Results of the audits/monitoring tools will be documented, discussed and reviewed monthly at the Quality Assurance meetings or until no further concerns are noted.	
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		12/30/17

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K 222	Continued From page 2 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		

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K 222	Continued From page 3 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 observations, staff interview, and/or documentation on 11/15/2017 at 12:30 PM through 3:30 PM the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. The facilities freezer inside door handle was not a type that can be seen in low light levels and the shelf was pushed against the emergency screw off black handle so tight and the handle was frozen such that the screw off release handle would not function as designed. The refrigerator inside handle was also a type that cannot be seen in low light levels. 2012 NFPA 101, 19.2.2.2.5, 19.2.2.2.6 This deficiency affected 1 of 7 smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death due to exposure to freezing temperatures.	K 222	K222 Inside freezer handle in kitchen area repaired □ door handle was replaced by the Maintenance Director with a type that is visible in low light levels; shelf pushed against the handle was also repositioned to allow the current handle to operate correctly. Maintenance Director conducted 100% audit of all other walk in freezer and refrigerator doors, no other doors were found to be affected by the alleged deficient practice. All kitchen staff will be educated by the Maintenance Director or Designee, so they understand the importance of not blocking door handles with shelves or other items in the walk in freezers and refrigerators. Maintenance director will audit/monitor all freezer and refrigerator doors monthly for 3 months, remedy any further adverse findings immediately and report any findings monthly to the Administrator or Designee. Results of the audits will be documented, discussed and reviewed at the monthly QA meetings until no further issues are noted or the next annual Life Safety Survey.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		12/30/17

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K 321	Continued From page 4 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 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: Based on observations, staff interview, and/or documentation on 11/15/2017 at 12:30 PM through 3:30 PM the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. The facilities corridor laundry room door had a	K 321	K321 Corridor laundry room was adjusted immediately to ensure the self closing mechanism latched and self closed completely; wood wedge was removed immediately to allow the self closing mechanist to release the door and self	

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K 321	Continued From page 5 wood wedge holding the doors open and these doors when tested for self closing and latching would not self close and latch. 2012 NFPA 101, 19.3.2.1, 8.7, 8.4 This deficiency affected 1 of 7 smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death due to smoke and or fire.	K 321	close. Maintenance Director conducted 100% audit of all other doors in the facility with self closures and found no other doors affected by the deficient practice. All laundry and housekeeping staff will be educated, by the Maintenance Director or Designee, to ensure they do not use wood wedges to block doors from closing and latching. Maintenance director will audit/monitor all doors equipped with self closing mechanisms, monthly for 3 months, remedy any further adverse findings immediately and report any findings monthly to the Administrator or Designee. Results of the audits will be documented, discussed and reviewed at the monthly QA meetings until no further issues are noted or the next annual Life Safety Survey.	
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 day intervals, and exercised once every 36	K 918		12/30/17

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K 918	Continued From page 6 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 observations, staff interview, and/or documentation on 11/15/2017 at 12:00 PM through 3:30 PM the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. The remote generator annunciator, located at the nurses station, did not provide a signal for loss of generator battery charger AC failure when checked by turning off the breaker to the generator battery charger. Reference 2012 NFPA 99: 6.4.1.1.16.2 (Table item O) Reference 2010 NFPA 99: 6.4.1.17, A remote annunciator that is storage battery powered shall	K 918	K918 The remote generator annunciator located at the nurses station was repaired - facility vendor repaired to ensure signal the loss of power from the battery charger, when the generator breaker is switched to off. Facility panel director was corrected to coorelate with the correct breaker and the panel annunciator light. No other areas of the facility were found to be affected by this same deficient practice. Maintenance director will conduct testing monthly for 3 months, by removing power from the generator breaker, and checking to ensure annunciator panel is signaling the loss of power to the batters; remedy	

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K 918	Continued From page 7 be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall be hard wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate the following: a. When the emergency or auxiliary power source is operating to supply power to load b. When the battery charger is malfunctioning (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: a. Low lubricating oil pressure b. Low water temperature (below those required in 6.4.1.1.11) c. Excessive water temperature d. Low fuel when the main fuel storage tank contains less than a 4-hour operating supply e. Overcrank (failed to start) f. Overspeed A remote, common audible alarm shall be provided as specified in 6.4.1.1.17.4 that is powered by the storage battery and located outside of the EPS service room at a work site observable by personnel.. [110: 5.6.6] This deficiency affected 1 of 7 smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death due to loss of emergency generator power supply.	K 918	any further adverse findings immediately and report any findings monthly to the Administrator or Designee. Results of the test will be documented, discussed and reviewed at the monthly QA meetings until no further issues are noted or the next annual Life Safety Survey.	