STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495034	A. BUILDING **02 - MAIN BUILDING 2** B. WING _____	**03/22/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDAL AT LEXINGTON	**160 KENDAL DRIVE LEXINGTON, VA 24450**

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K 000	INITIAL COMMENTS Surveyor: 34730 Construction Type: V(III) Description of structure:The facility is a single story wood framed structure on a concrete slab. The partial basement area which residents do not enter houses utilities only. Sprinkler status: The facility is fully sprinkled with an NFPA # 13 wet and dry pipe systems supplied by municipal water. An unannounced recertification Life Safety Code survey was conducted 03/22/2018 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 2018 (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 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and	K 161	1. Regarding Identified Problem: Maintenance staff adjusted door alignment to ensure center gap met code. 2. Regarding Other Potential occurrences: Director of Operations/designee will assess all fire doors to ensure the center gap is not in excess of the allowable limited as per NFPA 80. 3. Systematic Changes: Director of Operations/designee will obtain a door gap measuring tool to aid in assessment of gaps in fire doors.	3/23/18 4/6/18 4/13/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administratn — (X6) DATE: 4/2/18

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.

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K 161	Continued From page 1 sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based on observation and inspection the facility failed to maintain building construction. This has the ability to affect all occupants of the building. Findings include: On 3-22-18 at approximately 10:40 AM it was observed through observation and inspection that the center gap in the corridor double fire doors is	K 161	Director of Operations/designee will ensure ongoing assessments of fire doors. 4/13/18 4. Monitoring: Director of Operations/ designee will ensure that door assessments continue to be completed as per regulation. Any issues will be addressed and reported to the Safety Committee. 4/13/18 5. All components of this plan will be completed by 4/13/18 and ongoing monitoring will be done to ensure compliance. Results of monitoring will be reported to Safety Committee.	

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K 161	Continued From page 2 in excess of the allowable limit as required by NFPA 80. The facility Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 161	1. Regarding identified problem: Director of Operations/designee adjusted switch so delayed egress door opens in 15 seconds as per signage. 2. Regarding other potential occurrences: Director of Operations/designee tested all delayed egress doors to ensure doors released after 15 seconds as noted on signage.	3/22/18 4/2/18
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 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.	K 222	3. Systematic Change: New process initiated by Director of Operations for daily assessment of delay egress doors. Staff will now use a timer to ensure the doors release within 15 seconds Director of Operations/designee educated staff on new process. 4. Monitoring: Staff will continue to check doors daily but will now utilize a timer to ensure doors release as required. Any identified issues will be corrected and reported to Safety Committee. 5. All components of this plan will be completed by 4/13/18 and ongoing monitoring will be done to ensure compliance. Results will be reported to Safety Committee.	4/2/18 4/2/18 4/13/18

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K 222	Continued From page 3 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: Surveyor: 34730 Based on observation and inspection the facility failed to maintain delayed egress locking arrangements. This has the ability to affect all occupants of the building. Findings include: On 3-22-18 at approximately 11:18 AM it was observed through observation and inspection that the sign on the exit door at the end of the main hall reads the door will release after 15 seconds	K 222		

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K 222	Continued From page 4 but the actual release time is 30 seconds. The facility Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 222		
K 372 SS=D	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. 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 of the smoke compartment. Findings include: On 3-22-18 at approximately 11:02 AM it was observed through observation and inspection that there are unprotected penetrations to the smoke barrier wall in the Medication Room. On 3-22-18 at approximately 11:31 AM it was observed through observation and inspection that there are unprotected penetrations to the smoke	K 372	1. Regarding Identified Problem: Director of Operations/designee repaired the unprotected penetrations to smoke barrier walls in the pool mechanical room and the medication room. 2. Regarding other Potential Occurrences: Director of Operations/designee completed walking rounds of Borden Center to identify other possible penetrations to smoke barriers. Any identified issues will be corrected and reported to Safety Committee. 3. Systematic Change: Director of Operations/designee re-educated maintenance staff that any-time a smoke barrier wall is penetrated corrective action must be taken. Safety checklists utilized for walking rounds will be updated to include a line item to check for possible penetration of smoke barriers. Safety Committee members educated. 4. Monitoring: Quarterly safety rounds will include checking for penetration to the smoke barriers.	3/23/18 4/6/18 4/2/18 4/13/18 4/13/18

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K 372	Continued From page 5 barrier drywall ceiling assembly in the Pool Mechanical Room. The facility Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 372	5. All components of this plan will be completed by 4/13/18 and ongoing monitoring will be done to ensure compliance. Results of monitoring will be reported to Safety Committee.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based on observation and inspection the facility failed to maintain the Evacuation and Relocation plan. This has the ability to affect all occupants of the building. Findings include: On 3-22-18 at approximately 9:30 AM it was observed through observation and inspection during the record review that documentation could not be provided to show that employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with	K 711	1. Regarding identified problem: While evacuation and relocation drills and education had been completed in 2017, Administrator was unable to demonstrate that all staff were included in the drills and education. By April 13, Borden Center staff will complete evacuation and relocation education. 2. Regarding other possible Occurrences: As noted above. 3. Systematic Changes: Safety calendar will be updated to include regular evacuation and relocation education for staff. 4. Monitoring: Safety Committee, which meets monthly, will review to ensure education is being provided as appropriate or required. 5. All components of this plan will be completed by 4/13/18 and ongoing monitoring will be done to ensure compliance. Results of monitoring will be reported to Safety Committee.	4/13/18 4/13/18 4/13/18 4/13/18

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K 711	Continued From page 6 security. The facility Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 711		
K 911 SS=D	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 of the the smoke compartment. Findings include: On 3-22-18 at approximately 11:27 AM it was observed through observation and inspection that there is a damaged power cord on the Patient automatic bed in Room 607. The facility Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 911	1. Regarding Identified Problem: Director of Operations ensured a maintenance staff member removed and replaced power cord on bed in room 607. Another bed assessment was completed on bed after repair. 2. Regarding Other Possible Occurrences: Director of Operations/designee completed audit of all beds to ensure power cords were in good repair. 3. Systematic Changes: Staff were reeducated on how to identify bent/ frayed cords and process to follow when an issue is identified. 4. Monitoring: Director of Operations will ensure that ongoing bed assessments are completed as required/indicated. 5. All components of this plan will be completed by 4/13/18 and ongoing monitoring will be done to ensure compliance. Results of monitoring will be reported to Safety Committee.	4/13/18 4/13/18 4/13/18 4/13/18 4/13/18
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918	1. Regarding Identified Problem: Director of Operations scheduled inspection of main and feeder circuit breakers by electrician.	4/13/18

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K 918	Continued From page 7 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 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: Surveyor: 34730 Based on observation and inspection the facility failed to maintain the Generator system. This has the ability to affect all occupants of the building. Findings include:	K 918	Director of Operations scheduled for a 4 hour load test of generator. Director of Operations working with consultant to determine appropriate testing of circuit breakers, based upon manufacturer recommendations. If testing appropriate, will be completed and scheduled to be done annually. If testing is not recommended documentation will be obtained. 2. Regarding other possible occurrances: As noted above. 3. Systematic Changes: 4 hour load test of generator added to the Safety Committee calendar for tracking. Annual inspection of circuit breakers added to the Safety Committee calendar for tracking. Any manufacturer recommendations for exercising the components of the circuit breakers will be added to the Safety Committee calendar for tracking. .	4/13/18 4/13/18 4/13/18 4/13/18 4/13/18

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K 918	Continued From page 8 On 3-22-18 at approximately 10:15 AM it was observed through observation and inspection during the record review that documentation could not be provided to show that the generator set is exercised once every 36 months for 4 continuous hours. On 3-22-18 at approximately 10:17 AM it was observed through observation and inspection during the record review that documentation could not be provided to show that the 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 The facility Administrator and Maintenance Director witnessed this evidence by observation and interview.	K 918	4. Monitoring: Safety Committee, which meets monthly, will monitor calendar to ensure audits, inspections and testing completed as required and/or recommended 5. All components of this plan will be completed by April 13, 2018 and ongoing monitoring will be done to ensure compliance. Results of monitoring will be reported to Safety Committee.	4/13/18