STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495386	A. BUILDING 01 - BUILDING 0101 B. WING _____	02/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT BOTETOURT COMM	290 COMMONS PARKWAY DALEVILLE, VA 24083

(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: 21761 Description of Structure: The structure is a 1-story protected wood frame building on a slab. The attic space is separated from the living area by a 2-hour rated horizontal assembly. The building is separated into three smoke zones. Construction Type: III(211) Sprinkler Status: The facility is protected by NFPA 13 wet and dry pipe systems. The systems are supplied by municipal water. An unannounced LSC standard recertification survey was conducted on 02/06/18 through 02/07/18 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, 483.70(a) et seq (Life Safety from Fire.)	K 000	**This plan of correction constitutes our Credible Allegation of Compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the vision of federal and state laws.** Inspection of all fire rated door assemblies was completed.	
K 211 SS=F	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	K 211	Maintenance Director or designee will test all fire rated door assemblies annually and complete a report on findings. Annual inspections of fire rated door assemblies to ensure they work properly to be completed.	

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

Mitchell P [illegible] — Executive Director — 2/28/18

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 211	Continued From page 1 by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to test rated doors. This has the potential to affect all residents and staff throughout the facility, evidenced as follows; Findings include: On 02/06/18 at approximately 3:35 P.M., it was observed that documentation could not be provided for rated door periodic testing and inspection. The Director of Maintenance witnessed this evidence by observation and interview.	K 211	Report of fire rated door assemblies will be reviewed by the QA committee. The QA committee will determine the need and duration of future audits.	3/19/2018
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	K 222	New locking device was installed. A subsequent random check of all doors was completed to insure proper operation. Bi-weekly inspections of all doors will be done monthly for three (3) months, then randomly thereafter. Reports on the facilities door inspections will be reviewed by the QA committee. The QA committee will determine need and duration of future audits.	2/8/2018

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K 222	Continued From page 2 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 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: 21761 Based on observation and interview, it was revealed the facility failed to maintain delayed	K 222		

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K 222	Continued From page 3 egress exits. This violation potentially affects 1 of 3 smoke compartments, evidenced as follows; Findings include: On 02/06/18 at approximately 4:25 P.M., it was observed during inspection that the egress door to the outside near room 611 delayed locking device was not initiating the count down or releasing after 15 seconds as marked when the door crash bar was pressed. The Director of Maintenance witnessed this evidence by observation and interview.	K 222		
K 293 SS=F	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: 21761 Based on observation and interview made on 02/06/18, it was revealed the facility failed to provide proper exit signage. This violation potentially affects 2 of 3 smoke compartments, evidenced as follows; Findings include: On 02/06/18 at approximately 4:00 PM, it was observed during inspection the doors leading from the enclosed courtyards back into the	K 293	Courtyard doors were locked and access to courtyard will be limited to supervised usage until exit signage inside courtyard is in place. A subsequent random check of all exit doors was completed to insure proper exit signage is in use. Monthly inspections of all exit doors will be done monthly for three (3) months, then randomly thereafter. Reports on the facilities exit door inspections will be reviewed by the QA committee. The QA committee will determine need and duration of future audits.	3/19/2018

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K 293	Continued From page 4 building are not marked by exit signage inside the courtyards. The Maintenance Director witnessed this evidence through observation and interview.	K 293		
K 321 SS=F	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 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: Surveyor: 21761	K 321	Nurses station door at mechanical room will be replaced by outside vendor. A subsequent random check of all fire rated doors was completed to insure all labels are legible. Monthly inspections of all fire rated doors will be done monthly for three (3) months, then randomly thereafter. Reports on the facilities fire rated door inspections will be reviewed by the QA committee. The QA committee will determine need and duration of future audits. (Reference time waiver request dated 2/14/2018.)	5/18/2018

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K 321	Continued From page 5 Based on observation and interview made on 02/06/18, it was revealed the facility failed to maintain Hazardous area doors. This violation potentially affects 1 of 3 smoke compartments, evidenced as follows; Findings include: On 02/06/18 at approximately 4:07 P.M., it was observed during inspection that the rated door to the Blue Ridge Nurses station mechanical room has an illegible rating label. The Maintenance Director witnessed this evidence through observation and interview.	K 321		
K 353 SS=F	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: Surveyor: 21761	K 353	Item was removed and placed lower than the allowable 18 inches to the sprinkler deflector in the Occupational Therapy storage closet. A subsequent random check of all storage closets was completed in the facility. Monthly inspections of all storage closets will be done monthly for three (3) months, then randomly thereafter. Reports on the facilities storage closet inspections will be reviewed by the QA committee. The QA committee will determine need and duration of future audits.	2/7/2018

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K 353	Continued From page 6 Based on observation and interview, it was revealed the facility failed to maintain the sprinkler system, evidenced as follows; Findings include: On 02/06/18, at approximately 4:35 P.M., it was observed during inspection there is combustible storage closer than the allowable 18 inches to the sprinkler deflector in the Occupational Therapy storage closet. The Director of Maintenance witnessed this evidence by observation and interview.	K 353		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363	Occupational Therapy door will be replaced by outside vendor. A subsequent random check of all fire rated doors was completed to insure proper closure. Monthly inspections of all fire rated doors will be done monthly for three (3) months, then randomly thereafter. Reports on the facilities fire rated door inspections will be reviewed by the QA committee. The QA committee will determine need and duration of future audits. (Reference time waiver request dated 2/14/2018.)	5/18/2018

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K 363	Continued From page 7 of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview made on 02/06/18, it was revealed the facility failed to maintain corridor doors. This violation potentially affects 1 of 3 smoke compartments, evidenced as follows; Findings include: On 02/06/18 at approximately 4:38 P.M., it was observed during inspection that the Occupational Therapy double doors to the corridor do not properly close due to a faulty coordinator, which prevents proper sequencing, and prevents the closing of the doors against the passage of smoke. These doors also appear to be damaged. The Maintenance Director witnessed this evidence through observation and interview.	K 363		
K 712 SS=F	Fire Drills CFR(s): NFPA 101	K 712		

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K 712	Continued From page 8 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to properly document fire drills. This has the potential to affect residents and staff throughout the facility, evidenced as follows; Findings include: On 02/06/18, at approximately 3:15 P.M., it was observed during review of the fire drill records that fire drill documentation is incomplete. The Director of Maintenance witnessed this evidence by observation and interview.	K 712	Fire Drill documentation revised to reflect more accurate timeline. Maintenance staff and department heads in-serviced on proper documentation requirements. Monthly inspections of all fire drill documentation be done monthly for three (3) months, then randomly thereafter. Reports on the facilities fire drill documentation will be reviewed by the QA committee. The QA committee will determine need and duration of future audits.	2/14/2018
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 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	K 918	New recording document for the generator to show all the required information was developed. Removed books obstructing the emergency generator annunciator panel view and access at the nurses station.	

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K 918	Continued From page 9 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: 21761 Based on observation and interview, it was revealed the facility failed to maintain the emergency power system. This has the potential to affect residents and staff throughout the facility, evidenced as follows; Findings include: 1. On 02/06/18, at approximately 3:22 P.M., it was observed during review of the generator	K 918	Maintenance staff was in-serviced on proper procedures to test generators and properly record the required information. Facility staff in-serviced on importance of having clear access to the panel. Inspection of generator testing log will be done monthly for three (3) months, then randomly thereafter. Inspection of panel will be done daily for 3 months, then randomly thereafter. Reports on the facilities generator testing log documentation and panel checks will be reviewed by the QA committee. The QA committee will determine need and duration of future audits.	2/8/2018

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K 918	Continued From page 10 records the documentation does not indicate the generator batteries electrolyte levels are being checked. Reference: NFPA 110, 2012 Edition, Section 9.1.3.1. 2. On 02/06/18, at approximately 4:11 P.M., it was observed during inspection there were books obstructing the emergency generator annunciator panel view and access at the Nurses station. The Director of Maintenance witnessed this evidence by observation and interview.	K 918		
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced	K 920	Power adapter and power tap devices were removed. A subsequent random check for any power adapters and power tap devices was completed throughout the facility. Monthly inspections for power adapters and power tap devices will be done monthly for three (3) months, then randomly thereafter. Reports on the facilities power adapter inspections and power tap devices will be reviewed by the QA committee. The QA committee will determine need and duration of future audits.	2/7/2018

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K 920	Continued From page 11 by: Surveyor: 21761 Based on observation and interview, it was revealed the facility failed to prevent improper power device use. This violation potentially affects one of three smoke compartments, evidenced as follows; Findings include: 1. On 02/06/18, at approximately 4:45 P.M., it was observed during inspection a non-approved power adapter was in use for the IT equipment in the Medical Records' Office. 2. On 02/06/18, at approximately 4:47 P.M., it was observed during inspection a portable power tap device was powered by another portable power tap device for the IT equipment in the Medical Records' Office. The Director of Maintenance witnessed this evidence by observation and interview.	K 920		