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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495197	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELVOIR WOODS HEALTH CARE CENTER AT	9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060

(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: 29282 Description of structure: The facility occupies one floor of a three story building with a construction type of II(111). Sprinkler status: The facility is a fully sprinklered building. An unannounced recertification Life Safety Code survey was conducted 5/7/2019 in accordance with 42 Code of Federal Regulation, Part 483.70: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the 2012 Life Safety Code. 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		6/2/19
K 293 SS=D	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: 29282 Based on observations it was determined the health care facility failed to maintain an exit sign. This has the possibility to affect 20% of the	K 293	**A. With respect to the specific situation cited:** The exit sign in the center stairwell of the 2nd floor has been labeled correctly to indicate proper direction of exit. This was corrected on 5/7/19 and confirmed by the Director of Engineering. **B. With respect to what systemic measures have been put into place to address the stated concern:** The Director of Engineering and/or designee will inspect the exit signs in the building to confirm the indicator arrows are pointing in the proper direction. Issues that may be identified will be addressed and resolved by the Maintenance/Facilities department.	

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

WHA. Administrator 6/2/19

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 293	Continued From page 1 residents. The Findings Include: On 5/7/2019 at approximately 10:53 AM, it was identified by observation there was a mislabeled exit sign in the center stairwell on the second floor.	K 293	**C. With respect to how the plan of correction will be monitored:** The Director of Engineering and/or designee will conduct monthly inspections for 3 month of exit signs to confirm proper operation and that directional indicators are facing the proper direction. This inspection is entered into our preventative maintenance tracking system to confirm the monthly inspection has been completed. The findings of the monthly inspections will be presented by the Director of Engineering in the Quality Assurance Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. **D. With respect to how the plan will be reported during QAPI and for how long:** The Administrator is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, addressing, and resolving variances that may occur. The Administrator is responsible for confirming the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.	6/2/19
K 353 SS=E	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: 29282 Based on observations it was determined the health care facility failed to maintain the fire suppression system. This has the possibility to affect 40% of the residents. The Findings Include: On 5/7/2019 at approximately 10:55 AM, it was revealed by observation there was a hole in the			

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K 353	Continued From page 2 ceiling in the third floor medication room. On 5/7/2019 at approximately 10:56 AM, it was revealed by observation there was a missing escutcheon ring in the third floor medication room. On 5/7/2019 at approximately 11:15 AM, it was revealed by observation there was a ceiling grid wire attached to sprinkler piping by the west stairwell.(Corrected onsite)	K 353	**A: With respect to the specific resident/situation cited:** The Director of Engineering has confirmed that the following items have been corrected: 1). Hole in the ceiling of the 3rd floor medication room. Installed new drywall, patch and paint. Completed on 5/8/19 2). Escutcheon ring missing in the 3rd floor medication room. Installed new escutcheon ring on sprinkler head on 5/7/19 3). Ceiling grid had a wire attached to the sprinkler piping. The wire was removed from the ceiling grid and sprinkler piping on 5/7/19 **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Director of Engineering and/or designee will conduct observational rounds to confirm the following: 1). No penetrations are found in ceilings 2). Escutcheon rings are intact and properly installed 3). No wires are wrapped around sprinkler pipes or connected to the ceiling grid. **C. With respect to how the plan of correction will be monitored:** The Director of Engineering and/or designee will conduct monthly operational inspections for 3 months to confirm that: 1). No penetrations are found 2). Escutcheon rings are in place 3). Wires are not connecting sprinkler pipes to the ceiling grid Issues identified will be addressed and resolved. The findings of the monthly inspections will be presented by the Director of Engineering in the Quality Assurance Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.	6/2/19
K 363 SS=D	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 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			

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K 363	Continued From page 3 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: 29282 Based on observation the facility failed to maintain correct operation of a resident's room door. This has the possibility to affect 20% of the residents. The Findings Include: On 5/7/2019 at approximately 11:02 AM, it was identified by observation the door to resident room 302 was propped open.(Corrected onsite)	K-363	**D. With respect to how the plan will be reported During QAPI and for how long:** The Administrator is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, addressing, and resolving variances that may occur. The Administrator is responsible for confirming the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required. **A.With respect to the specific resident/situation cited:** The Administrator and The Director of Engineering have confirmed that no objects are blocking the room 302 main door from closing and latching. **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Administrator, Director of Engineering or designee will conduct observational rounds to confirm that the doors are not obstructed and close properly and positively latch.	6/2/19
K 372 SS=E	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			

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K 372	Continued From page 4 in REMARKS. This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to maintain rated walls. This has the possibility to affect 35% of the residents. The Findings Include: On 5/7/2019 at approximately 11:06 AM, it was identified by observation there was an unsealed penetration in the rated wall at the north stairwell. On 5/7/2019 at approximately 11:40 AM, it was identified by observation there was an unsealed penetration in the rated wall at the east stairwell.		**C. With respect to how the plan of correction will be monitored:** The Director of Engineering and/or designee will conduct monthly operational inspections for 3 months to confirm that: Doors are not obstructed and close properly and positively latch. Issues identified will be addressed and resolved. The findings of the monthly inspections will be presented by the Director of Engineering in the Quality Assurance Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.	6/2/19
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to prevent dust accumulation. This has the possibility to affect 20% of the residents. The Findings Include: On 5/7/2019 at approximately 10:47 AM, it was identified by observation there was excessive accumulation of dust on an exhaust vent in the	K-372	**D. With respect to how the plan will be reported during QAPI and for how long:** The Administrator is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, addressing, and resolving variances that may occur. The Administrator is responsible for confirming the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required. **A. With respect to the specific resident/situation cited** The Director of Engineering has confirmed that the penetrations in the rated wall at the north stairwell and the east stairwell have been properly sealed with 3M Fire Barrier. This work was completed on 5/8/19.	

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K 521	Continued From page 5 physical therapy director's office closet.		**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Director of Engineering or designee will conduct observational rounds to confirm penetrations are properly sealed. Issues that may be identified will be addressed and resolved by the Maintenance/Facilities department.	6/2/19
K 920 SS=D	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 by: Surveyor: 29282 Based on observation the facility failed to maintain control of the proper use of electrical components. This has the possibility to affect 20% of the residents. The Findings Include: On 5/7/2019 at approximately 10:45 AM, it was identified by observation there was a power strip in use in the physical therapy director's office		**C. With respect to how the plan of correction will be monitored:** The Director of Engineering and/or designee will conduct monthly observational inspections for 3 months to confirm that: 1). Fire penetrations have been properly sealed with the appro sealant. Issues identified will be addressed and resolved. The findings of the monthly inspections will be presented by the Director of Engineering in the Quality Assurance Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period. **D. With respect to how the plan will be reported during QAPI and for how long:** The Administrator is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, addressing, and resolving variances that may occur. The Administrator is responsible for confirming the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.	

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K 920	Continued From page 6 doorway.(Corrected onsite) On 5/7/2019 at approximately 10:58 AM, it was identified by observation there was an unapproved multi plug in the social worker's office. On 5/7/2019 at approximately 11:00 AM, it was identified by observation there was an unapproved multi plug in room 300.	K-521	**A. With respect to the specific resident/situation cited:** The Director of Housekeeping has confirmed that the return vent in the Physical Therapy Directors office has been cleaned. This was completed on 5/8/19.	6/2/19
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."		**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Director of Housekeeping or designee will conduct observational rounds to confirm ventilation vents are clean. **C. With respect to how the plan of correction will be monitored:** The Director of Housekeeping and/or designee will conduct monthly observational inspections for 3 months to confirm that: 1). Ventilation vents are clean. Issues identified will be addressed and resolved. The findings of the monthly inspections will be presented by the Director of Housekeeping in the Quality Assurance Performance Improvement (QAPI) meetings. **D. With respect to how the plan will be reported during QAPI and for how long:** The Administrator is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, addressing, and resolving variances that may occur. The Administrator is responsible for confirming the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.	

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K 923	Continued From page 7 Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to maintain control of oxygen storage, use and signage. This has the possibility to affect 25% of the residents. The Findings Include: On 5/7/2019 at approximately 10:48 AM, it was identified by observation there was an oxygen cylinder stored in the Physical Therapy closet not in a rack.(Corrected onsite) On 5/7/2019 at approximately 10:49 AM, it was identified by observation there was oxygen in use in Physical Therapy without signage.	K-920	**A. With respect to the specific resident/situation cited:** The Director of Engineering has confirmed that the following items have been corrected: 1). Power strip located in PT office. Licensed electrician came and installed the appropriate outlet. Completed on 5/8/19 2). A hospital grade power strip was installed in the Social Worker's office. This was completed on 5/7/19 3). Room 300: an unapproved multi plug was found. This was removed by the Director of Engineering on 5/7/19. **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Director of Engineering or designee will conduct observational rounds of the facility to confirm power cords are used appropriately and that extension cords or unapproved multi plugs are not used. Issues that may be identified will be addressed and resolved by the Maintenance/Facilities department. **C. With respect to how the plan of correction will be monitored:** The Director of Engineering and/or designee will conduct monthly operational inspections for 3 months to confirm that: 1). power cords are used appropriately and that multi plugs are not in use. Issues identified will be addressed and resolved. The findings of the monthly inspections will be presented by the Director of Housekeeping in the Quality Assurance Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.	6/2/19

K-920	6/2/19	**D. With respect to how the plan will be reported during QAPI and for how long:** The Administrator is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, addressing, and resolving variances that may occur. The Administrator is responsible for confirming the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.
K-923	6/2/19	**A. With respect to the specific resident/situation cited:** The Administrator and The Director of Engineering have confirmed that no oxygen is being stored in the physical therapy room.
	6/2/19	**B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The Administrator, Director of Engineering or designee will conduct observational rounds of the physical therapy room to confirm that no oxygen is being stored in this area. Issues that may be identified will be addressed and resolved.
	6/2/19	**C. With respect to how the plan of correction will be monitored:** The Director of Engineering and/or designee will conduct monthly observational inspections for 3 months to confirm that: 1). No oxygen is being stored in the physical therapy room. Issues identified will be addressed and resolved. The findings of the monthly inspections will be presented by the Director of Engineering in the Quality Assurance Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate necessary action or extend the review period.
	6/2/19	**D. With respect to how the plan will be reported during QAPI and for how long:** The Administrator is responsible for confirming implementation and ongoing compliance with the components of this plan of correction, addressing, and resolving variances that may occur. The Administrator is responsible for confirming the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.

Responses on the enclosed plan of correction do not constitute an admission or agreement of the truth of the facts alleged or the conclusion set forth in the regulatory report. The responses are prepared solely as a matter of compliance with law.