STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495416	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**08/05/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHBY PONDS INC	**21160 MAPLE BRANCH TERRACE ASHBURN, VA 20147**

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K 000	INITIAL COMMENTS Surveyor: 29282 Description of structure: The facility is a one story with a construction type of V (111). Sprinkler status: The facility is a fully sprinklered building. An unannounced recertification Life Safety Code survey was conducted 8/5/19 in accordance with 42 Code of Federal Regulation, Part 483: 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		
K 325 SS=F	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an	K 325	1) All hand sanitizer dispensers were tested on 8/16/19. 2) An Inspection Card was placed on each hand sanitizer dispenser to track testing at time of refill. 3) Sr. Facilities Manager or designee will educate Housekeeping staff regarding the test procedure and record keeping. 4) Hand sanitizer locations will be inspected monthly for three months, and quarterly thereafter to ensure proper testing and documentation are being done. 5) Corrective action to be completed by 9/20/2019.	

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

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 325	Continued From page 1 ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on document review and interview it was determined the health care facility failed to test alcohol based hand sanitizers. This has the possibility to affect 100% of the residents. The Findings Include: On 8/5/2019 at approximately 9:50 AM, it was revealed by document review the facility did not conduct tests of alcohol base hand sanitizers after each refill. An interview on 8/5/2019 at approximately 9:50 PM with the maintenance director confirmed this evidence.	K 325		
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 _____	K 353	1) Installation of the missing sprinkler escutcheon plate in the loading dock men's restroom has been scheduled for correction. 2) Restrooms' sprinklers will be inspected for complete fire sprinkler system installation. Deficiencies found will be scheduled for correction. 3) Sr. Facilities Manager or designee will educate maintenance staff on inspection process for fire sprinkler inspections.	

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K 353	Continued From page 2 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 an escutcheon ring. This has the possibility to affect 10% of the residents. The Findings Include: On 8/5/2019 at approximately 10:12 AM, it was revealed by observation there was a missing escutcheon ring in the loading area men's restroom.	K 353	(Continued from page 2) 4) Fifteen fire sprinklers will be inspected monthly for three months starting 8/30/2019 to ensure escutcheon plates are in place. 5) To be completed by 9/20/2019.	
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	K 363	1) The hold-open device on apartment 109 was removed during Life Safety Inspection on 08/05/2019. 2) All apartments will be inspected for removal of unapproved hold-open devices on 8/26/19. 3) Sr. Facilities Manager or designee will educate maintenance staff on inspection process to identify and remove any unapproved hold-open devices. 4) Apartment doors will be randomly inspected quarterly to ensure unapproved hold-open devices are not in place. 5) To be completed by 9/20/19.	

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K 363	Continued From page 3 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 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 8/5/2019 at approximately 10:45 AM, it was identified by observation the door to resident room 109 was propped open with an unapproved hold open device.(Corrected onsite)	K 363	(Refer to page 3 for K 363 POC)	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction	K 372	1) First Observation - Annual Testing and Inspection of fire doors has been scheduled for 8/30/19. 2) Fire doors by location will be inspected	

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K 372	Continued From page 4 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: 29282 Based on document review interview and observation the facility failed to maintain separations. This has the possibility to affect 100% of the residents. The Findings Include: On 8/5/2019 at approximately 9:40 AM, it was identified by document review the rates doors have not had their annual testing/ inspection On 8/5/2019 at approximately 10:10 AM, it was identified by observation the rated door to the maintenance office was missing the door closer. An interview on 8/5/2019 at approximately 9:40 AM with the maintenance director confirmed this evidence.	K 372	Continued from page 4 2) Fire doors by location will be inspected semi-annually. Deficiencies found will be scheduled for correction. 3) Sr. Facilities Manager or designee will educate maintenance staff on inspection scheduling process and documentation. 4) Fire doors by location will be inspected semi-annually to ensure they are intact, close, and latch properly, and documentation is complete. 5) Corrective action to be completed by 9/20/2019. 1) Second observation –Missing closer was replaced on the Maintenance Office fire rated door on 8/16/19. 2) Fire doors by location will be inspected semi-annually. Deficiencies found will be scheduled for correction. 3) Sr. Facilities Manager or designee will educate maintenance staff on inspection process to identify and address missing door closer. 4) Fire doors by location will be inspected semi-annually to ensure door closers are present. 5) Corrective action to be completed by 9/20/2019.	
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	K 521	1) Combustible material stored in Mechanical Room 3, and in Mechanical Room located in the Training Room were removed on 8/22/19. 2) Audit of Mechanical Rooms will be conducted on 8/26/19 for storage of combustible materials. Deficiencies found	

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K 521	Continued From page 5 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 control utility related deficiencies. This has the possibility to affect 45% of the residents. The findings include: On 8/5/2019 at approximately 10:06 AM, it was identified by observation there were combustibles stored in mechanical room 3. On 8/5/2019 at approximately 11:23 AM, it was identified by observation there were combustibles stored in the training room mechanical room.	K 521	Continued from page 5 will be scheduled for correction. 3) Sr. Facilities Manager or designee will educate maintenance staff on inspection process to identify and address stored combustible materials. 4) Mechanical Rooms will be inspected quarterly to ensure no combustible materials are being stored. 5) Corrective action to be completed by 9/20/2019.	
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	K 920	1) Unapproved multi plugs found in the main lobby, apartment 109, hallway 1 nook, and hallway 3 laundry were all removed during Life Safety Inspection on 08/05/2019. The unapproved power strip within the patient care vicinity apartment 134 was also removed at the time. 2) Apartments, common areas, and laundry rooms will be inspected for unapproved multi plug and power strips on or before 8/30/19. Deficiencies found will be scheduled for correction. 3) Sr. Facilities Manager or designee will educate maintenance staff on inspection process to identify unapproved multi plug and powers strips.	

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K 920	Continued From page 6 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 75% of the residents. The Findings Include: On 8/5/2019 at approximately 10:02 AM, it was identified by observation there was an unapproved multi plug cord in use in the lobby. (Corrected onsite) On 8/5/2019 at approximately 10:15 AM, it was identified by observation there was an unapproved multi plug in use in room 109. (Corrected onsite) On 8/5/2019 at approximately 10:30 AM, it was identified by observation there was an unapproved multi plug in use in the hallway 1 nook. On 8/5/2019 at approximately 11:04 AM, it was identified by observation there was a power strip in use within the patient care vicinity in room 134. (Corrected onsite) On 8/5/2019 at approximately 11:10 AM, it was identified by observation there was an	K 920	Continued from page 6 4) Quarterly inspections will be made to ensure no multi plugs and/or power strips are in use. 5) Corrective action to be completed by 9/20/19. (Intentionally left blank)	

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K 920	Continued From page 7 unapproved multi plug in use in the hallway 3 laundry.	K 920		
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." 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.	K 923	1) The appropriate Oxygen signage was placed in the Physical Therapy Room during the Life Safety Inspection on 08/05/2019. 2) Oxygen Storage areas will be inspected for proper signage. Deficiencies found will be scheduled for correction. 3) Sr. Facilities Manager or designee will educate maintenance staff on inspection process to identify proper signage is in place. 4) Quarterly inspections will be made to ensure proper signage is in place. 5) Corrective action to be completed by 9/20/2019.	

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K 923	Continued From page 8 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 correct oxygen signage. This has the possibility to affect 20% of the residents. The Findings Include: On 8/5/2019 at approximately 11:00 AM, it was identified by observation there was oxygen in physical therapy without signage.	K 923	(Intentionally left blank)	