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
	495174	A. BUILDING **02 - DULLES HEALTH & REHAB CENTER** B. WING _____	**11/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULLES HEALTH & REHAB CENTER	**2978 CENTREVILLE ROAD HERNDON, VA 20171**

(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 The Facility is two stories with a construction type of II(111) and is fully sprinkled. An unannounced recertification Life Safety Code survey was conducted on 11/05/2018 in accordance with 42 Code of Federal Regulations, Part 483.150 and 410 to 480: Requirements for Long Term Care Facilities. The Facility was surveyed for compliance using the 2012 Life Safety Code Existing Regulations. The Facility was not in compliance with the Requirements for Participation for Medicare and Medicaid. The Findings that follow demonstrate non-compliance with title 42 Code of Regulations, Part 483.150 and 410 to 480 (Life safety from Fire)	K 000		
K 211 SS=D	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: Surveyor: 29282 Based on observation the facility failed to maintain exits. This has the possibility to affect 40% of the residents. The Findings Include: On 11/5/2018 at approximately 1:00 PM, it was identified by observation there were combustibles	K 211	K211 1. Combustibles were removed from west stairwell. Delayed egress from east stairwell was repaired. 2. The Maintenance director or designee have reviewed all exit areas to ensure doors are properly functioning and are free of combustibles. 3. Maintenance staff will be educated on exit areas being free of combustibles and doors working properly. 4. An audit will be conducted of the paths of egress to ensure they are working properly and are free of combustibles weekly times 4 weeks, then monthly times two months. Results will be reviewed in our QA meeting. 5. Allegation of Compliance: Nov. 5,2018	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Leslie J Riffner, LNHA	Administrator	11-29-18

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.

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
	495174	A. BUILDING 02 - DULLES HEALTH & REHAB CENTER B. WING _____	11/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULLES HEALTH & REHAB CENTER	2978 CENTREVILLE ROAD HERNDON, VA 20171

(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 211	Continued From page 1 stored in the west stairwell. On 11/5/2018 at approximately 1:49 PM, it was identified by observation the delayed egress lock was not function properly on exit door in the east stairwell.	K 211		
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 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	K 325	K325 1. All hand sanitizer dispensers have been tested and are in good working order. 2. Director of Housekeeping audited all hand sanitizer dispensers to ensure they are properly working. 3. Housekeeping staff will be educated on how to properly check and document that dispensers are working properly. 4. An audit of hand sanitizers will be done weekly times 4 weeks, and then monthly times 2 months. Results will be forwarded to QA committee. 5. Allegation of Compliance: November 9, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495174	A. BUILDING **02 - DULLES HEALTH & REHAB CENTER** B. WING _____	**11/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULLES HEALTH & REHAB CENTER	**2978 CENTREVILLE ROAD HERNDON, VA 20171**

(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 325	Continued From page 2 possibility to affect 100% of the residents. The Findings Include: On 11/5/2018 at approximately 11:31 AM, it was revealed by document review the facility did not conduct tests of alcohol base hand sanitizers after each refill. An interview on 11/5/2018 at approximately 11:31 PM with the maintenance director confirmed this evidence.	K 325		
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: 29282 Based on observations it was determined the health care facility failed to maintain the fire suppression system. This has the possibility to affect 70% of the residents.	K 353	K353 1. The items that were resting on the sprinkler pipe that were identified have been corrected. The sprinkler head in the beauty salon and kitchen janitorial closet and kitchen bathroom were replaced 2. Maintenance director or designee reviewed all areas where sprinkler pipes were to ensure there were no other items resting on the sprinkler pipes. 3. Maintenance team will be educated that items cannot be resting on sprinkler lines or on sprinkler heads. 4. An audit will be conducted of sprinkler lines and sprinkler heads to make sure they are clear of any items, weekly times 4 weeks, and then monthly times 2 months. Results will be forwarded to QA committee. 5. Allegation of Compliance: December 20, 2018	

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
	495174	A. BUILDING **02 - DULLES HEALTH & REHAB CENTER** B. WING _____	**11/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULLES HEALTH & REHAB CENTER	**2978 CENTREVILLE ROAD HERNDON, VA 20171**

(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 353	Continued From page 3 The Findings Include: On 11/5/2018 at approximately 11:40 AM, it was revealed by observation there were items resting on sprinkler piping above ceiling by room 315. On 11/5/2018 at approximately 12:10 PM, it was revealed by observation there was spackling on a sprinkler head in the beauty salon. On 11/5/2018 at approximately 12:15 PM, it was revealed by observation there were items resting on sprinkler piping above ceiling by the second floor elevators. On 11/5/2018 at approximately 12:54 PM, it was revealed by observation there were items resting on sprinkler piping above ceiling by room 207. On 11/5/2018 at approximately 1:12 PM, it was revealed by observation there was paint on a sprinkler head in the kitchen janitorial closet. On 11/5/2018 at approximately 1:13 PM, it was revealed by observation there was paint on a sprinkler head in the kitchen rest room. On 11/5/2018 at approximately 1:36 PM, it was revealed by observation there were items resting on sprinkler piping above ceiling by the room 118.	K 353		
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	K 372	K372 1. The fire rated doors that were not working properly will be fixed when parts are available. Parts were ordered on 11/28/2018 2. Maintenance director checked all fire barrier doors to ensure proper function. 3. Maintenance staff will be educated on the proper closure of fire rated doors. 4. Fire rated doors will be audited for proper function weekly times 4 weeks, and then monthly times 2 months. Results will be forwarded to QA committee. 5. Allegation of Compliance: 12/20/2018	

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
	495174	A. BUILDING **02 - DULLES HEALTH & REHAB CENTER** B. WING _____	**11/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULLES HEALTH & REHAB CENTER	**2978 CENTREVILLE ROAD HERNDON, VA 20171**

(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 372	Continued From page 4 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 and observation the facility failed to maintain separations. This has the possibility to affect 60% of the residents. The Findings Include: On 11/5/2018 at approximately 11:42 AM, it was identified by observation the rated doors by room 315 were not closing properly. On 11/5/2018 at approximately 12:20 PM, it was identified by observation the rated door to the linen chute would not close and latch properly.	K 372		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Surveyor: 29282	K 511	K511 1. The area around the panel box was cleared to make sure it can open and close properly. 2. Maintenance director looked at all areas where panels are to ensure the area is clear of any items. 3. Maintenance staff will be educated for proper area that should be clear near the panel box. 4. An audit will be conducted of panel area to ensure there is proper area around it that is clear weekly times 4 weeks, and monthly times 2 months. Results will be forwarded to QA committee. 5. Allegation of compliance: Nov. 7, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495174	A. BUILDING **02 - DULLES HEALTH & REHAB CENTER** B. WING _____	**11/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULLES HEALTH & REHAB CENTER	**2978 CENTREVILLE ROAD HERNDON, VA 20171**

(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 511	Continued From page 5 Based on observation the facility failed to maintain panel box clearance. This has the possibility to affect 10% of the residents. The Findings Include: On 11/5/2018 at approximately 1:35 PM, it was identified by observation there was less then the required clearance around a panel box in the first floor storage closet.	K 511		
K 521 SS=F	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 control utility related deficiencies. This has the possibility to affect 65% of the residents. The findings include: On 11/5/2018 at approximately 11:35 PM, it was identified by observation there was an excessive accumulation of dust on the exhaust vent in 300-A. On 11/5/2018 at approximately 1:22 PM, it was identified by observation there were combustibles stored in the first floor data room. On 11/5/2018 at approximately 1:26 PM, it was	K 521	K521 1. The dryer vent on the dryer in the rehab was fixed. 2. Maintenance director or designee looked at all areas where a dryer is connected for ensure proper connection and ventilation. 3. Maintenance staff will be educated to make sure that dryer vent is attached properly and in good working order. 4. An audit will be conducted of the dryer vent for proper working function weekly times 4 weeks, and monthly times 2 months. Results will be forwarded to QA committee. 5. Allegation of compliance: Nov. 5, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495174	A. BUILDING **02 - DULLES HEALTH & REHAB CENTER** B. WING _____	**11/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULLES HEALTH & REHAB CENTER	**2978 CENTREVILLE ROAD HERNDON, VA 20171**

(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 521	Continued From page 6 identified by observation the exhaust vent hose for the dryer in physical therapy was damaged and not connected to the dryer. On 11/5/2018 at approximately 1:40 PM, it was identified by observation there were combustibles stored in the administrative janitorial closet.	K 521		
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 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	K 918	K918 1. Testing of emergency backup lighting was conducted for at least 90 minutes. 2. Testing of emergency backup lighting was conducted throughout the center 3. Maintenance staff will be educated on the importance of testing emergency backup lighting. 4. An audit will be conducted to make sure that emergency back up lighting is being tested monthly time 3 months. Results will be forwarded to QA committee 5. Allegation of compliance: Dec. 13, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495174	A. BUILDING **02 - DULLES HEALTH & REHAB CENTER** B. WING _____	**11/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULLES HEALTH & REHAB CENTER	**2978 CENTREVILLE ROAD HERNDON, VA 20171**

(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 918	Continued From page 7 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: 29282 Based on document review and interview the facility failed to conduct required testing of emergency lighting. This has the possibility to affect 100% of the residents. The Findings Include: On 11/5/2018 at approximately 11:15 AM, it was identified by document review the facility did not conduct the annual 90 minute testing of the battery back up emergency lighting. An interview on 11/5/2018 at approximately 11:15 AM, with the maintenance direct confirmed this evidence.	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	K 920	K920 1. Power strip in room 314, and 420 were removed. The unsupported power strip in the kitchen was corrected. The daisy chained surge protector in the kitchen was corrected. In room 215 and 409 the power strip was removed and a certified electrician will install a four outlet plate. 2. Maintenance director or designee reviewed all other patient care areas to make sure there were no other unapproved power strips. 3. Maintenance staff will be educated on the approved power strips. 4. An audit will be conducted of power strips utilized in the center to ensure they are ones that are appropriate to code, weekly times 4 weeks, and monthly times 2 months. 5. Allegation of Compliance: 12/20/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495174	A. BUILDING **02 - DULLES HEALTH & REHAB CENTER** B. WING _____	**11/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULLES HEALTH & REHAB CENTER	**2978 CENTREVILLE ROAD HERNDON, VA 20171**

(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 920	Continued From page 8 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 70% of the residents. The Findings Include: On 11/5/2018 at approximately 11:43 AM, it was identified by observation there was a power strip in use within the patient care vicinity in room 314. On 11/5/2018 at approximately 12:18 PM, it was identified by observation there were daisy chained power strips in the second floor data room. (Corrected on site) On 11/5/2018 at approximately 12:30 PM, it was identified by observation there was an unapproved multi plug cord in use in room 420. On 11/5/2018 at approximately 12:40 PM, it was identified by observation there was a power strip in use within the patient care vicinity in room 409. On 11/5/2018 at approximately 1:15 PM, it was identified by observation there was an unsupported power strip in the kitchen.(Corrected on site)	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495174	A. BUILDING **02 - DULLES HEALTH & REHAB CENTER** B. WING _____	**11/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULLES HEALTH & REHAB CENTER	**2978 CENTREVILLE ROAD HERNDON, VA 20171**

(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 920	Continued From page 9 On 11/5/2018 at approximately 1:20 PM, it was identified by observation there was a power strip in use within the patient care vicinity in room 215.	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	K 923	K932 1. Room 306 and 314 have proper oxygen signage on the outside of the door. 2. Resident rooms were checked to make sure all rooms with oxygen equipment had the proper signage. 3. Leadership team will be educated on the significance of making sure Oxygen signage is maintained properly. 4. Room round sheets will be audited to ensure proper signage is identified and placed on doors weekly times 4 weeks and monthly times 2 months. Results will be reviewed at QA committee. 5. Allegation of compliance: Nov. 5, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495174	A. BUILDING **02 - DULLES HEALTH & REHAB CENTER** B. WING _____	**11/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DULLES HEALTH & REHAB CENTER	**2978 CENTREVILLE ROAD HERNDON, VA 20171**

(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 923	Continued From page 10 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 correct oxygen signage. This has the possibility to affect 20% of the residents. The Findings Include: On 11/5/2018 at approximately 11:44 AM, it was identified by observation there was oxygen in room 314 without signage. On 11/5/2018 at approximately 11:50 AM, it was identified by observation there was oxygen in room 306 without signage.	K 923		