STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495361	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WOODBRIDGE, LLC	**14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191**

(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 is a two story with a basement and a construction type of II(222). Sprinkler status: The facility is a fully sprinklered building. An unannounced recertification Life Safety Code survey was conducted 12/18/18 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	*Envoy of Woodbridge is filing this plan of correction for purposes of regulatory compliance. The Facility is submitting this plan of correction to comply with the applicable law. The submission of the plan of correction does not represent an admission or statement of agreement with respect to the alleged deficiencies.* K 211 1. The storage in the South stairwell was removed. 2. Additional stairwells were reviewed for storage. 3. The Executive Director educated the Maintenance Director on the importance of NFPA 101 Means of Egress-General specific to keeping stairwells free of storage, and will continue to monitor in accordance with NFPA standards. 4. Any findings will be reported to the monthly QAPI Committee for further review. 5. Date of Compliance-1/15/19	
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 an exit. This has the possibility to affect 50% of the residents.	K 211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rochelle Rafael | TITLE: Executive Director | (X6) DATE: 1/10/19

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 211	Continued From page 1 The Findings Include: On 12/18/2018 at approximately 12:35 PM, it was identified by observation there was storage in the south stairwell.	K 211		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING	K 222	K 222 1. The delayed egress on the South stairwell was repaired to function properly by a qualified vendor, and appropriate delayed egress signage was placed on the South stairwell door. 2. Additional delayed egress doors were reviewed for proper function and appropriate signage. 3. The Executive Director educated the Maintenance Director on the importance of NFPA 101 Egress Doors specific to proper functioning delayed egress doors with appropriate signage, and will continue to monitor in accordance with NFPA standards. 4. Any findings will be reported to the monthly QAPI Committee for further review. 5. Date of Compliance- 1/15/19	

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K 222	Continued From page 2 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: 29282 Based on observation the facility failed to maintain correct operation of a delayed egress as well as proper signage. This has the possibility to affect 25% of the residents. The Findings Include: On 12/18/2018 at approximately 12:10 PM, it was identified by observation the delayed egress on the south stairwell did not function properly. On 12/18/2018 at approximately 12:11 PM, it was identified by observation there was not appropriate delayed egress signage on the south	K 222		

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K 222	Continued From page 3 stairwell door.	K 222		
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 document review, interview and observations it was determined the health care facility failed to maintain the fire suppression system. This has the possibility to affect 100% of the residents. The Findings Include: On 12/18/2018 at approximately 11:05 AM, it was revealed by document review there were no sprinkler inspection reports for the 2018 annual inspection and a quarterly inspection. On 12/18/2018 between approximately 10:50 AM and 1:00 PM, it was revealed by observation	K 353	K 353 1. The annual sprinkler inspection was completed by a qualified vendor on 12/29/2018. Items resting on sprinkler piping were moved. The wire up against the sprinkler head in the activities closet was moved. The missing ceiling tile in the first floor janitor's closet was replaced. The hole in the ceiling behind the dryers was repaired. The wires attached to the sprinkler risers were removed. 2. Additional sprinkler reports were reviewed for missing inspections/ documentation. Additional sprinkler piping, sprinkler heads, and sprinkler risers were reviewed for items resting on, up against, or attached to them. Additional ceiling areas were reviewed for missing ceiling tiles and holes.	

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K 353	Continued From page 4 there were items resting on sprinkler piping through out the facility. On 12/18/2018 at approximately 12:16 PM, it was revealed by observation there was a wire up against a sprinkler head in activities closet. On 12/18/2018 at approximately 12:20 PM, it was revealed by observation there was a missing ceiling tile in the first floor janitors closet. On 12/18/2018 at approximately 12:40 PM, it was revealed by observation there was a hole in the ceiling behind the dryers. On 12/18/2018 at approximately 12:45 PM, it was revealed by observation there were wires attached to the sprinkler risers. An interview on 12/18/2018 at approximately 11:05 AM with the maintenance director confirmed this evidence.	K 353	3. The Executive Director educated the Maintenance Director on the importance of NFPA 101 Sprinkler System-Maintenance and Testing specific to the timely completion of annual and quarterly sprinkler inspections, having no items resting on/ attached to sprinkler equipment, and maintaining ceiling areas by replacing missing tiles and repairing holes. These items will continue to be monitored in accordance with NFPA standards. 4. Any findings will be reported to the monthly QAPI Committee for further review. 5. Date of Compliance-	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observations it was determined the health care facility failed to maintain a fire extinguisher. This has the possibility to affect 20% of the residents.	K 355	K 355 1. The pin keeper was replaced on the fire extinguisher by room 203. 2. Additional fire extinguishers were reviewed for missing pin keepers. 3. The Executive Director educated the Maintenance Director on the importance of NFPA 101 Portable Fire Extinguishers specific to	

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K 355	Continued From page 5 The Findings Include: On 12/18/2018 at approximately 11:55 AM, it was revealed by observation the fire extinguisher by room 203 was missing the pin keeper.	K 355	maintaining the pin keepers on the facility's fire extinguishers, and will continue to monitor in accordance with NFPA standards. 4. Any findings will be reported to the monthly QAPI Committee for further review. 5. Date of Compliance- 1/15/19	
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 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.	K 363	K 363 1. The door to resident room 231 that was obstructed from closing was corrected on site, as noted in the 2567. 2. Additional resident rooms were reviewed for obstructions that might inhibit closing. 3. The Executive Director educated the Maintenance Director on the importance of NFPA 101 Corridor- Doors specific to keeping resident room doors free of obstructions that might inhibit closing, and will continue to monitor in accordance with NFPA standards. 4. Any findings will be reported to the monthly QAPI Committee for further review. 5. Date of Compliance-1/15/19	

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K 363	Continued From page 6 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 doors. This has the possibility to affect 25% of the residents. The Findings Include: On 12/18/2018 at approximately 11:24 AM, it was identified by observation the door to resident room 231 was obstructed from closing(Correctted on site)	K 363	K 372 1. The rated door by room 219 was made to properly close and latch. The unsealed floor penetration in the second floor manager's office closet was repaired. The excessive gap in the rated doors by room 220 was repaired. 2. Additional rated doors were reviewed for proper closing and latching. Additional floors were reviewed for unsealed penetrations. Additional rated doors were reviewed for excessive gaps. 3. The Executive Director educated the Maintenance Director on the importance of NFPA 101 Subdivision of Building Spaces- Smoke Barrier Construction specific to rated doors properly closing, latching, and not having excessive gaps, and floors having unsealed penetrations, and will continue to monitor in accordance with NFPA standards. 4. Any findings will be reported to the monthly QAPI Committee for further review. 5. Date of Compliance- 1/15/19	
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 in REMARKS. This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to maintain separations. This has the possibility to	K 372		

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K 372	Continued From page 7 affect 50% of the residents. The Findings Include: On 12/18/2018 at approximately 11:35 AM, it was identified by observation the rated door by room 219 would not close and latch. On 12/18/2018 at approximately 11:45 AM, it was identified by observation there was an unsealed floor penetration in the second floor manager's office closet. On 12/18/2018 at approximately 12:04 PM, it was identified by observation there was an excessive gap between the rated doors by room 220.	K 372		
K 511 SS=E	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 Based on observation the facility failed to prevent electrical hazards. This has the possibility to affect 50% of the residents. The Findings Include: On 12/18/2018 at approximately 11:44 AM, it was identified by observation there were dead end	K 511	K 511 1. The dead end wires in the second floor manager's closet were corrected. The open box in the activities closet was corrected on site, as noted in the 2567. The open box above the ceiling by room 102 was corrected. 2. Additional closets and ceiling areas were reviewed for dead end wires and open boxes. 3. The Executive Director educated the Maintenance Director on the importance of NFPA 101 Utilities- Gas and Electric specific to the facility not having dead end wires and open boxes, and will continue to monitor in accordance with NFPA standards. 4. Any findings will be reported to the monthly QAPI Committee for further review. 5. Date of Compliance- 1/15/19	

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K 511	Continued From page 8 wires in the second floor manager's office closet. On 12/18/2018 at approximately 12:15 PM, it was identified by observation there was an open box in activities closet.(Corrected on site) On 12/18/2018 at approximately 12:25 PM, it was identified by observation there was an open box above ceiling by room 102.	K 511	K 522 1. The combustibles stored by the dryers in the laundry room were removed. 2. There is only dryer area in the laundry room, therefore no additional reviews were needed. 3. The Executive Director educated the Maintenance Director on the importance of NFPA 101 HVAC- Any Heating Device specific to keeping the area around the dryers in the laundry room free of combustible storage, and will continue to monitor in accordance with NFPA standards. 4. Any findings will be reported to the monthly QAPI Committee for further review. 5. Date of Compliance-1/15/19	
K 522 SS=D	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to maintain combustible storage. This has the possibility to affect 25% of the residents. The Findings Include: On 12/18/2018 at approximately 12:41 PM, it was identified by observation there were combustibles stored behind the dryers in the laundry room.	K 522		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		

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K 918	Continued From page 9 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 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.	K 918	K 918 1. The annual 60 minute testing of the battery back up emergency lighting was completed. 2. There is only one required annual testing of the battery back up emergency lighting therefore no additional reviews were needed. 3. The Executive Director educated the Maintenance Director on the importance of NFPA 101 Electrical systems-Essential Electrical Systems Maintenance and Testing_ specific to conducting the annual battery back up emergency lighting testing. This annual task will be added to the facility's TELS Preventative Maintenance (PM) calendar, and will continue to monitor in accordance with NFPA standards. 4. Any findings will be reported to the monthly QAPI Committee for further review. 5. Date of Compliance- 1/15/19	

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K 918	Continued From page 10 The Findings Include: On 12/18/2018 at approximately 10:55 AM, it was identified by document review the facility did not conduct the annual 60 minute testing of the battery back up emergency lighting. An interview on 12/18/2018 at approximately 10:55 AM, with the maintenance direct confirmed this evidence.	K 918		
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."	K 923	K 923 1. The oxygen in use in Physical Therapy without signage was corrected on site, as noted in the 2567. The oxygen in use in room 114 without signage was also corrected. 2. Additional rooms with oxygen in use were reviewed for proper signage. 3. The Executive Director educated the Maintenance Director and nursing staff on the importance of NFPA 101 Gas Equipment- Cylinder and Container Storage specific to having proper signage on rooms with oxygen in use, and will continue to monitor in accordance with NFPA standards. 4. Any findings will be reported to the monthly QAPI Committee for further review. 5. Date of Compliance- 1/15/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495361	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF WOODBRIDGE, LLC	14906 JEFFERSON DAVIS HIGHWAY WOODBRIDGE, VA 22191

(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 11 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 use and signage. This has the possibility to affect 30% of the residents. The Findings Include: On 12/18/2018 at approximately 11:50 AM, it was identified by observation there was oxygen in use in Physical Therapy without signage.(Corrected on site) On 12/18/2018 at approximately 12:29 AM, it was identified by observation there was oxygen in use in room 114 without signage.	K 923		