STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495057	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/21/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODWIN HOUSE ALEXANDRIA	**4800 FILLMORE AVE ALEXANDRIA, VA 22311**

(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 building is a five story on a garage with a construction type of II(222). Sprinkler status: The facility is a fully sprinklered building. An unannounced recertification Life Safety Code survey was conducted 3/21/2019 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		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered	K 161	1. The structural beam fire proofing has been resolved to meet requirements. 2. Facility staff will complete an assessment of the building and correct any other areas of fire proofing deficiency. 3. A semi-annual inspection will be completed by Maintenance Manager or designee to ensure compliance. 4. Maintenance manager will report on inspection status to the QAPI Committee upon initial assessment then x1 after 6 months.	May 3. 2019

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

ADMINISTRATOR 4/19/19

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 161	Continued From page 1 Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. 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 resistant rating of a structural beam. This has the possibility to affect 20% of the residents. The Findings Include: On 3/21/2019 at approximately 9:27 PM, it was revealed by observation there was missing/damaged fire proofing above ceiling by room 564.	K 161	5. Corrective action will be complete on or before May 3, 2019.	
K 222 SS=D	Egress Doors CFR(s): NFPA 101	K 222		

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K 222	Continued From page 2 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 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	K 222	1. Vendor has ordered replacement part to repair the door on the 5th floor. 2. All other egress doors were inspected and are in compliance. 3. Maintenance Manager or designee will include delayed egress operation as part of the monthly wander system inspection. 4. Maintenance manager or designee will report on inspection status to the QAPI Committee every x3 months. 5. Corrective action will be complete on or before May 3, 2019.	May 3, 2019

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K 222	Continued From page 3 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 lock. This has the possibility to affect 20% of the residents. The Findings Include: On 3/21/2019 at approximately 9:29 AM, it was identified by observation the delayed egress on the 5th floor stair one egress door did not function properly.	K 222		
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	K 325	1. All sanitizer dispensers have been inspected and labeled. 2. All resident rooms and staff work areas are at risk of being out of compliance. 3. Staff who switch sanitizer bags will be trained on how to inspect and label the bag. 4. Maintenance manager or designee will audit sanitizer machines for compliance and report once a month x 3 months to the QAPI Committee. 5. Corrective action will be complete on or before May 3, 2019	May 3, 2019

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K 325	Continued From page 4 * 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 possibility to affect 100% of the residents. The Findings Include: On 3/21/2019 at approximately 10:59 AM, it was revealed by document review the facility did not conduct tests of alcohol base hand sanitizers after each refill. An interview on 3/21/2019 at approximately 10:59 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	K 353		

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K 353	Continued From page 5 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 3/21/2019 at approximately 9:32 AM, it was revealed by observation the ceiling access door in the Shenandoah oxygen room was left open. On 3/21/2019 at approximately 9:40 AM, it was revealed by observation there was a missing ceiling tile in the Pollen clean utility room. On 3/21/2019 at approximately 9:54 AM, it was revealed by observation there was a missing escutcheon ring in the Rappahannock den. On 3/21/2019 at approximately 11:07 AM, it was	K 353	1. Ceiling access door, missing tiles, missing escutcheon ring are resolved. 2. Facility staff will complete an assessment of the building and correct any other areas of deficiency. A vendor will be contracted to complete quarterly sprinkler assessments. 3. A monthly inspection will be completed by Maintenance Manager or designee to ensure compliance. Maintenance staff will be trained on deficient practices and how to resolve them. A vendor will be contracted with to complete quarterly sprinkler assessments. 4. Maintenance manager or designee will audit for compliance and report once a month x 3 months to the QAPI Committee. 5. Corrective action will be complete on or before May 3, 2019.	May 3, 2019

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K 353	Continued From page 6 revealed by document review there were no sprinkler inspection reports for the first and second quarter of 2018. An interview on 3/21/2019 at approximately 11:07 AM with the maintenance director confirmed this evidence.	K 353		
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. The Findings Include: On 3/21/2019 at approximately 9:01 AM, it was revealed by observation the fire extinguisher in the Willis kitchen was obstructed.(Corrected on site)	K 355	1. Corrected on site 2. All kitchens are at risk to be out of compliance 3. Dining Services and other pertinent staff will be trained on the correct location to park their carts. 4. Small House Sous Chef or designee will audit weekly x 4 and monthly x2 thereafter for compliance and report once a month x 3 months to the QAPI Committee. 5. Corrective action will be complete on or before May 3, 2019.	May 3, 2019
K 372 SS=F	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		

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K 372	Continued From page 7 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 rated separations. This has the possibility to affect 100% of the residents. The Findings Include: On 3/21/2019 between approximately 9:45 AM and 10:45 AM, it was identified by observation the rated trash chute doors throughout the facility would not self close from the fully open position. On 3/21/2019 at approximately 9:53 AM, it was identified by observation there was an unsealed penetration above ceiling by room 486. On 3/21/2019 at approximately 10:15 AM, it was identified by observation there was an unsealed penetration above ceiling in Maherin housekeeping.	K 372	1. Replacement parts have been ordered to resolve issue with trash chutes. Penetrations have been fire caulked. 2. Facility staff will complete an assessment of the building and correct any other areas of deficiency. All trash chutes will have parts replaced and all penetrations will be fire caulked. 3. A monthly inspection will be completed by Maintenance Manager or designee to ensure compliance. Maintenance staff will be trained on deficient practices and how to resolve them. 4. Maintenance manager or designee will audit monthly for compliance and report once a month x 3 months to the QAPI Committee. 5. Corrective action will be complete on or before May 3, 2019.	May 3, 2019
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	K 511		

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K 511	Continued From page 8 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to maintain a junction box. This has the possibility to affect 10% of the residents. The Findings Include: On 3/21/2019 at approximately 9:07 AM, it was identified by observation there was an open box above ceiling by room 585.(Corrected on site)	K 511	1. Corrected on site 2. Facility staff will complete an assessment of the building and correct any other areas of deficiency. 3. A monthly inspection will be completed by Maintenance Manager or designee to ensure compliance. Maintenance staff will be trained on deficient practices and how to resolve them. 4. Maintenance manager or designee will audit monthly for compliance and report once a month x 3 months to the QAPI Committee. 5. Corrective action will be complete on or before May 3, 2019	May 3, 2019
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 document review and interview the facility failed to maintain dampers. This has the possibility to affect 100% of the residents. The findings include: On 3/21/2019 at approximately 11:10 AM, it was identified by document review the facility failed to conduct required damper testing.	K 521	1. Damper Testing has been completed and recorded. 2. The facility is at risk of being out of compliancy in the future. 3. A vendor has been contracted with to complete damper testing every other year per regulation. 4. Maintenance manager or designee will report findings of the 2019 damper testing to the QAPI Committee. 5. Corrective action will be complete on or before May 3, 2019.	May 3, 2019

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K 521	Continued From page 9 An interview on 3/21/2019 at approximately 11:10 AM with the maintenance director confirmed this evidence.	K 521		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) 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 a a required risk assessment. This has the possibility to affect 100% of the residents. The Findings Include: On 3/21/2019 at approximately 11:20 AM, it was revealed by document review the facility did not conduct a risk assessment as required in NFPA 99. An interview on 3/21/2019 at approximately 11:20 AM with the maintenance director confirmed this evidence.	K 901	1. Proper paperwork of required documentation was already completed. It was located after Fire Marshal left. 2. The facility will continue to update the risk assessment based on the code's timeline 3. Maintenance Manager will put risk assessment in office bookshelf next to other required documentation. 4. Maintenance manager or designee will report correction to the QAPI Committee. 5. Corrective action will be complete on or before May 3, 2019.	May 3, 2019
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords	K 920		

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K 920	Continued From page 10 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 a power strip. This has the possibility to affect 20% of the residents. The Findings Include: On 3/21/2019 at approximately 9:16 AM, it was identified by observation there was a power strip in use within the patient care vicinity in room 590. (Corrected on site)	K 920	1. Corrected on site 2. Facility staff will complete an assessment of the building and correct any other areas of deficiency. 3. A monthly inspection will be completed by Maintenance Manager or designee to ensure compliance. Maintenance staff will be trained on deficient practices and how to resolve them. 4. Maintenance manager or designee will audit monthly for compliance and report once a month for 3 months to the QAPI Committee. 5. Corrective action will be complete on or before May 3, 2019.	May 3, 2019
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance	K 921		

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K 921	Continued From page 11 Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Surveyor: 29282 Based on document review and interview the facility failed to conduct preventive maintenance. This has the possibility to affect 100% of the residents. The Findings Include: On 3/21/2019 at approximately 11:13 AM, it was identified by document review the facility did not	K 921	1. Proper paperwork of required documentation was already completed. It is now consolidated into one binder. 2. The facility will assess other potential equipment which may be used throughout year that will need to be tested. Lamps will be added to the patient-care electrical equipment to be tested. 3. Maintenance Manager will work with procured contractors to consolidate documentation in his office. Maintenance staff will be trained on deficient practices and how to resolve them. 4. Maintenance manager or designee will report correction to the QAPI Committee. 5. Corrective action will be complete on or before May 3, 2019.	May 3, 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495057	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/21/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODWIN HOUSE ALEXANDRIA	**4800 FILLMORE AVE ALEXANDRIA, VA 22311**

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K 921	Continued From page 12 conduct required physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment. An interview on 3/21/2019 at approximately 11:13 AM with the maintenance director confirmed this evidence.	K 921		