STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495171	A. BUILDING **02 - GOODWIN HOUSE BAILEY S CROSSROADS** B. WING _____	**11/14/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODWIN HOUSE BAILEY'S CROSSROADS	**3440 S JEFFERSON STREET FALLS CHURCH, VA 22041**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 29282 Description of structure: The facility occupies the second floor of a 13 story building with a construction type of I(443). Sprinkler status: The facility is a fully sprinklered building. An unannounced recertification Life Safety Code survey was conducted 11/14/2018 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 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	K 325	1. All ABHR dispensers have been tested to ensure proper dispensing of solutions per code. 2. All ABHR dispensers have been identified and inspected to ensure compliance with all regulations. 3. All Environmental staff responsible for ABHR will be instructed on proper filling and testing per regulations. The Housekeeping Manager will perform weekly inspections to ensure all ABHR dispensers are tested when refilled and document compliance. 4. The Director of Facility Management will review the data weekly initially, then monthly to ensure compliance. All data will be reported and reviewed at QAPI quarterly. 5. All corrective action will be completed by December 21, 2019.	

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

Karen Daylemon, LNHA | Administrator of Health Services | 12-7-18

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.

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K 325	Continued From page 1 * 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 11/14/2018 at approximately 11:30 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 11:30 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	K 353	1. All items resting on sprinkler piping have been identified and are scheduled to be re-tied to other support structures in the ceiling. In the closet of room 207, items have been removed to provide the required clearance for the sprinkler head. 2. The sprinkler piping in the ceilings and closets on the Health Care Center will be inspected to ensure compliance with Fire Safety Code. 3. Quarterly inspection of the Sprinkler system, to include maintenance and testing and ensure compliance with NFPA 25, is scheduled for December 3, 2018 and will continue per regulation. Any above ceiling	

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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 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 11/14/2018 at approximately 11:18 AM, it was revealed by document review there were no sprinkler inspection reports for the 2018 annual inspection(in the second quarter) and the quarterly inspection for the 4th quarter of 2017. On 11/14/2018 at approximately 11:50 AM, it was revealed by observation there were items resting on sprinkler piping above ceiling by room 234. On 11/14/2018 at approximately 11:58 AM, it was revealed by observation there were items resting on sprinkler piping above ceiling by room 226. On 11/14/2018 at approximately 12:00 PM, it was revealed by observation there were items resting on sprinkler piping above ceiling by the elevator. On 11/14/2018 at approximately 12:00 PM, it was revealed by observation there were items resting on sprinkler piping above ceiling by the Magnolia	K 353	work performed internally or from an outside contractor will be inspected by the Director of Facility Management or designee to ensure compliance. 4. All quarterly safety inspections of the sprinkler system will be reviewed quarterly at the Safety meeting and QAPI. 5. All corrective action will be completed by December 21, 2018.	

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K 353	Continued From page 3 rated doors. On 11/14/2018 at approximately 12:10 PM, it was revealed by observation there were items resting on sprinkler piping above ceiling by room 245. On 11/14/2018 at approximately 12:35 PM, it was revealed by observation there were items resting on sprinkler piping above ceiling by the linen chute. On 11/14/2018 at approximately 12:43 PM, it was revealed by observation there were items resting on sprinkler piping above ceiling by room 216. On 11/14/2018 at approximately 12:48 PM, it was revealed by observation there were items resting on sprinkler piping above ceiling by room 200. On 11/14/2018 at approximately 12:54 PM, it was revealed by observation there was less then the required clearance from a sprinkler head in room 207 closet. On 11/14/2018 at approximately 13:01 PM, it was revealed by observation there were items resting on sprinkler piping above ceiling by room 213. An interview on 11/14/2018 at approximately 11:18 AM with the maintenance director confirmed this evidence.	K 353		
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	K 363	1. The device used to prop open the door in room 238 was removed immediately. The door latch in room 212 was repaired on November 14, 2018. 2. All doors on the Health Care Center have been inspected for proper latching and to ensure there were not any non-approved devices used to keep the doors open.	

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K 363	Continued From page 4 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. 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 resident's room doors. This has the possibility to affect 25% of the residents.	K 363	3. All licensed nursing staff on the Health Care Center will be re-educated regarding the policy of non-approved devices used to prop open doors. Facility management staff will inspect all doors for proper latching and identify any non-approved devices used to keep doors open during monthly preventative maintenance inspections. 4. The Director of Facility Management will review monthly inspection reports to identify any items that do not meet regulatory compliance and ensure items are addressed timely. Compliance will be reported quarterly at QAPI. 5. All corrective action will be completed by December 21, 2018.	

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K 363	Continued From page 5 The Findings Include: On 11/14/2018 at approximately 12:15 PM, it was identified by observation the door to resident room 238 was propped open with an unapproved hold open device.(Corrected on site) On 11/14/2018 at approximately 1:00 PM, it was identified by observation the door to resident room 212 would not close and latch.	K 363		
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 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 11/14/2018 at approximately 11:32 AM, it was identified by document review the facility failed to conduct required annual fire door inspections.	K 372	1. The unsealed penetration above the Magnolia doors were sealed per code. The Tulip trash room door was repaired and now closes and latches properly. 2. All doors on the Health Care Center that are fire-rated doors will be inspected to ensure compliance with all fire door regulations. 3. All fire-rated door inspections will be performed by a licensed contractor by December 28, 2018 and annually thereafter to ensure all regulations are met which include that all penetrations are sealed and all doors latch properly. 4. Director of Facility Management will ensure scheduling of the annual fire door inspections and report to the Executive Director the dates for the inspections. Compliance with annual inspection of all fire-rated doors will be reported at QAPI quarterly. 5. All corrective action will be completed by December 28, 2018.	

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K 372	Continued From page 6 On 11/14/2018 at approximately 12:05 PM, it was identified by observation there was an unsealed penetration above the Magnolia rated doors. On 11/14/2018 at approximately 12:45 PM, it was identified by observation the rated door to the Tulip trash chute would not close and latch properly. An interview on 11/14/2018 at approximately 11:32 AM with the maintenance director confirmed this evidence.	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 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 11/14/2018 at approximately 12:02 PM, it was identified by observation there was less then the required clearance around a panel box in the pantry.(Corrected on site)	K 511	1. The trash receptacle was removed immediately to maintain panel box clearance per code. 2. All electrical panel boxes were inspected to ensure required clearance was met. 3. All dining and environmental service staff that work in this area will be re-educated on the policy and procedure for required clearance for electrical panel boxes. Daily inspection will be performed by the dining supervisors to ensure compliance. 4. Compliance will be monitored daily for 30 days, then weekly for 30 days, then monthly and reported to the Dining Service Director or designee. Data for compliance will be reported monthly at Safety Meeting and quarterly at QAPI. 5. All corrective action will be completed by December 21, 2018.	

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K 521 K 521 SS=F	Continued From page 7 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, interview and observation the facility failed to control utility related deficiencies. This has the possibility to affect 100% of the residents. The findings include: On 11/14/2018 at approximately 11:35 AM, it was identified by document review the facility failed to conduct required damper testing. On 11/14/2018 at approximately 12:20 PM, it was identified by observation there were combustibles stored in the AV room off of the community room. An interview on 11/14/2018 at approximately 11:35 AM with the maintenance director confirmed this evidence.	K 521 K 521	1. We have contracted with a licensed contractor to conduct damper testing which will be completed by December 28, 2018. 2. All areas required to have damper testing will be reviewed for compliance. 3. Scheduling of the testing of the damper system every four years is the responsibility of the Director of Facility Management. The Director of Facility Management will ensure scheduling of the damper testing every four years and report to the Executive Director the dates for testing. 4. Compliance with testing of the damper system every four years will be reported at QAPI annually. 5. All corrective action will be completed by December 28, 2018.	
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	K 918	1. The testing of the battery backup for the emergency lighting will be completed by December 10, 2018 and documented. 2. All battery backup testing for emergency lighting will be tested per regulation.	

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K 918	Continued From page 8 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. The Findings Include:	K 918	3. The monthly battery backup testing for emergency lighting and the annual 90 minute testing will be incorporated into the preventative maintenance schedule. The Director of Facility Management will review reports monthly to identify any areas of non-compliance and ensure a timely response. 4. Compliance with mandatory testing will be reported monthly at Safety Meeting and quarterly at QAPI. 5. All corrective action will be completed by December 21, 2018.	

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K 918	Continued From page 9 On 11/14/2018 at approximately 11:25 AM, it was identified by document review the facility did not conduct the monthly check and the annual 90 minute testing of the battery back up emergency lighting. An interview on 11/14/2018 at approximately 11:25 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 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	K 920	1. All power strips, unapproved multi plug and extension cords were removed from the identified areas. 2. All areas of the Health Care Center, Rehabilitation, and Fitness gym were inspected to identify the use of any other power strips, unapproved multi plug and extension cords and corrective action was taken. 3. All staff on the Health Care Center, Rehab and Fitness staff, Housekeeping and Maintenance staff will be re-educated on the policy and procedure for power strips, unapproved multi plug and extension cords. Interdisciplinary monthly safety rounds will be conducted to ensure compliance. 4. Monthly safety inspection will be reviewed by the Director of Facility Management and reported monthly at the Safety meeting and quarterly at QAPI. 5. All corrective action will be completed by December 21, 2018.	

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K 920	Continued From page 10 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 11/14/2018 at approximately 12:08 PM, it was identified by observation there was a power strip in use within the patient care vicinity in room 243. (Corrected on site) On 11/14/2018 at approximately 12:14 PM, it was identified by observation there was a power strip in use within the patient care vicinity in room 24. On 11/14/2018 at approximately 12:37 PM, it was identified by observation there was an unapproved multi plug cord in use in room 221. (Corrected on site) On 11/14/2018 at approximately 12:48 PM, it was identified by observation there was a power strip in use within the patient care vicinity in room 200. (Corrected on site) On 11/14/2018 at approximately 12:56 PM, it was identified by observation there was as extension cord in use in the Tulip pantry. On 11/14/2018 at approximately 12:58 PM, it was identified by observation there were unapproved multi plug cords(x3) in use in room 209. On 11/14/2018 at approximately 13:10 PM, it was identified by observation there was a power strip in use within the patient care vicinity in the gym. On 11/14/2018 at approximately 13:20 PM, it was identified by observation there was a power strip in use within the patient care vicinity in Rehab.	K 920		

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	495171	A. BUILDING **02 - GOODWIN HOUSE BAILEY S CROSSROADS** B. WING _____	**11/14/2018**

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GOODWIN HOUSE BAILEY'S CROSSROADS	**3440 S JEFFERSON STREET FALLS CHURCH, VA 22041**

(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 921 K 921 SS=F	Continued From page 11 Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance 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.	K 921 K 921	1. All patient-care related electrical equipment (PCREE) will be inspected per manufacturers' recommendations by December 28, 2018 and documentation retained for review. 2. All equipment on the Health Care Center has been reviewed for manufacturers' recommendations for preventive maintenance and scheduled as appropriate. 3. The Nursing Staff Educator is responsible for monitoring and scheduling preventive maintenance per manufacturers' recommendations and maintaining a record of all maintenance performed on all portable patient-care related electrical equipment. Facility Management is responsible for monitoring and scheduling preventive maintenance per manufacturers' recommendations and maintaining a record of all maintenance performed on all fixed patient-care related electrical equipment. 4. The preventive maintenance schedule and completed maintenance will be reported to the Administrator of Health Services and Director of Facility Management monthly and reported quarterly at QAPI. 5. All corrective action will be completed by December 28, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495171	A. BUILDING **02 - GOODWIN HOUSE BAILEY S CROSSROADS** B. WING _____	**11/14/2018**

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K 921	Continued From page 12 The Findings Include: On 11/14/2018 at approximately 11:27 AM, it was identified by document review the facility did not conduct required physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment. An interview on 11/14/2018 at approximately 11:27 AM with the maintenance director confirmed this evidence.	K 921		