STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495171	A. BUILDING _____ B. WING _____	01/30/2020

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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 01/28/2020 through 01/30/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/28/2020 through 01/30/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 73 certified bed facility was 66 at the time of the survey. The survey sample consisted of 33 resident reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		3/10/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/18/2020

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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F 578	Continued From page 1 residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility document review, it was determined that the facility staff failed to implement advance directive requirements for two of 33 residents in the survey sample, Resident #15 and Resident #218. The facility Staff failed to provide Resident #15, and Resident #218, information about advanced directives, and failed to complete the advance directive questionnaire on admission to obtain or ascertain the Advanced Directive status for the residents. The findings include:	F 578	1. Resident # 15 completed the advance directive questionnaire 2/14/2020. Resident # 218 completed the advance directive questionnaire 2/14/2020. An audit of completed advance directive questionnaires will be performed on all residents and any missing questionnaires will be completed. 2. All residents have the potential to be affected by this deficient practice. 3. Social Work staff will be reeducated on the policy and procedure for advance directives and completion of the advance directive questionnaire. This questionnaire	

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F 578	Continued From page 2 1. The facility staff failed to evidence the presence of advance directive documentation for Resident #15. Resident #15 was admitted to the facility on 1/21/20 with diagnoses that included but were not limited to: fracture of the left femur (break in the thighbone) (1), peripheral vascular disease (plaque blocking blood vessels outside of the heart) (2), anxiety (mild to severe apprehension) (3). The most recent MDS (minimum data set) assessment was not completed (admission 1/21/20), however, Section C- Cognitive, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. The admission nursing assessment was completed on admission. The facility's "Advance Directives" policy documents "Upon each admission to the facility, social work staff will determine if the resident has an advance directive. Procedure: Admission-the advance directive questionnaire will be reviewed and signed by the resident or resident representative." Review of Resident #15's clinical record did not evidence any advance directive acknowledgement forms or advanced directive documentation. An interview was conducted on 1/29/20 at 10:15 AM with OSM (other staff member) #5, the social worker. When shown content of the advanced directive section of the clinical record for resident #15 and asked where the advanced directive was	F 578	has been updated to include a link to sample forms of Advance Directives suggested by the Virginia Hospital and Healthcare Association. Advance directives will be reviewed with resident or resident representative on admission and with every MDS. 4. 100 % of new admissions will be audited for completion of the advance directive questionnaire for 30 days, then 50% of new admissions will be audited for the completion of the advance directive questionnaire for 60 days and then at least 25% of new admissions will be audited for the completion of the advance directive questionnaire quarterly. All audits will be reviewed for compliance and reported at QAPI quarterly. 5. Corrective action will be completed by March 10, 2020.	

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F 578	Continued From page 3 located in the clinical record, OSM #5 stated, "I will have to check on it." An interview was conducted on 1/29/20 at 11:25 AM with OSM #5, the social worker. When asked if the advanced directive information was located, OSM #5 stated, "She (Resident #15) came from independent living, so we don't ask the same questions here, I will find out what they have." When asked if the facilities share the same forms, OSM #5 stated, "We don't receive those forms when they come to the health care center but I will check if independent living has the forms." An interview was conducted on 1/30/20 at 7:39 AM with OSM #5, the social worker. When asked if he had been able to find advance directive documentation for Resident #15, OSM #5 stated, "I talked with the two social workers from independent living, they did not have advance directive documentation for this resident. Independent living does not complete the advanced directives questionnaire form. We did look through the contract for this resident and it was not included in the contract." When asked if their policy on advance directive would include admissions from independent living, OSM #5 stated, "Yes, it would. We can strengthen this process and add specific wording to the social work progress notes." An interview was conducted on 1/30/20 at 10:00 AM with ASM (administrative staff member) #2, the director of nursing. When asked if their policy on advance directive would include admissions from independent living, ASM #2 stated, "Yes, it would."	F 578		

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F 578	Continued From page 4 ASM #1, the administrator, and ASM #2, the director of nursing were made aware of the above concerns on 1/30/20 at 12:46 PM. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 232/218. (2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 445. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 42. 2. Resident #218 was admitted to the facility on 1/16/20 with diagnoses that included but were not limited to: depression (dejected state of mind with feelings of sadness, discouragement and hopelessness) (1), encephalopathy (brain disease or disorder) (2), and high blood pressure. The most recent MDS (minimum data set) assessment was not yet completed (admission 1/16/20), however, Section C- Cognitive, coded the resident as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. The admission nursing assessment was completed on admission. Review of Resident #218's clinical record evidences any advance directive acknowledgement form or advanced directive documentation. An interview was conducted on 1/29/20 at 10:15 AM with OSM (other staff member) #5, the social worker. When shown content of the advanced	F 578		

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F 578	Continued From page 5 directive section of the clinical record for Resident #218 and asked where the advanced directive was located in the clinical record, OSM #5 stated, "I will have to check on it." An interview was conducted on 1/29/20 at 11:25 AM with OSM #5, the social worker. When asked if advanced directive information for Resident #218 was located, OSM #5 stated, "She came from independent living, so we don't ask the same questions here, I will find out what they have." When asked if the facilities share the same forms, OSM #5 stated, "We don't receive those forms when they come to the health care center but I will check if independent living has the forms." An interview was conducted on 1/30/20 at 7:39 AM with OSM #5, the social worker. When asked if he had been able to find advance directive documentation for Resident #218, OSM #5 stated, "I talked with the two social workers from independent living, they did not have advance directive documentation for this resident. Independent living does not complete the advanced directives questionnaire form. We did look through the contract for this resident and it was not included in the contract." When asked if their policy on advance directive would include admissions from independent living, OSM #5 stated, "Yes, it would. We can strengthen this process and add specific wording to the social work progress notes." An interview was conducted on 1/30/20 at 10:00 AM with ASM (administrative staff member) #2, the director of nursing. When asked if their policy on advance directive would include admissions from independent living, ASM #2 stated, "Yes, it	F 578		

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F 578	Continued From page 6 would." ASM #1, the administrator, and ASM #2, the director of nursing were made aware of the above concerns on 1/30/20 at 12:46 PM. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 157. (2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 189.	F 578		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		3/10/20

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F 761	Continued From page 7 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to properly, store drugs and biologicals in two of 69 medication cabinets reviewed. In rooms #1 and #2, the facility staff failed to ensure expired medications were disposed of and not available for use. The findings included: On 01/30/2020 at 12:00p.m., a review of facility medication cabinets was conducted with Registered Nurse (RN) #1. Upon reviewing the medications in Cabinet #1, it was found to contain a blister pack of Senexon-S (a laxative) 8.6mg - 50mg with an expiration date of 12/31/2019. Several of the blisters on the blister pack were opened with tablets removed. Upon showing this to RN #1, she stated, "Oh, I bet this order was discontinued". When asked if the medication should have been removed, RN #1 stated "Yes". Upon reviewing Cabinet #2, it was found to contain an unopened blister pack of Acetaminophen 325mg with an expiration date of 11/30/2019. Upon showing this to RN #1, she stated, "sometimes if a resident doesn't need the pain medication, it can sit in the cabinet for a while, but it should still have been removed when it expired." Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end	F 761	1. Medication in cabinet # 01 was removed by RN # 01 immediately. Medication in cabinet #2 was removed by RN # 01 immediately. An audit of all medication cabinets will be performed to ensure all expired medications have been removed. 2. All residents have the potential to be affected by this deficient practice. 3. The licensed nurses will be reeducated and newly hired licensed nursing staff will be educated on the policy and procedure for proper storage of drugs and biologicals in resident medication cabinets including the removal and disposal of expired medications and biologicals. The current policy and procedure has been updated to include a monthly resident medication cabinet review. The licensed nurses will complete a monthly resident medication cabinet review during the last 5 days of the month and dispose of expired drugs and biologicals per policy and procedure. 4. 10% of resident medication cabinets will be audited monthly for compliance and reported at QAPI quarterly. 5. Corrective action will be completed by March 10, 2020.	

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F 761	Continued From page 8 of day meeting on 01/30/2020. No further documentation was provided.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to maintain the kitchen in a sanitary manner. The facility staff failed to store pans in a sanitary manner during the facility task-kitchen observation on 1/28/20 at 7:05 PM. The findings include: On 1/28/20 at 7:05 PM, an observation was conducted in the dry storage room of the main kitchen. Two rectangular steam table serving	F 812	1. The pans were removed immediately. Staff washed the pans and dried them as per policy and procedure. 2. All residents have the potential to be affected by this deficient practice. 3. All dining services staff will be re-educated and newly hired staff will be educated on the policy and procedure regarding the proper dry storage of pots, dishes, flatware and utensils following washing and drying. 4. The Dining Supervisor will monitor the	3/10/20

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F 812	Continued From page 9 pans were observed stacked inside of each other with drops of water on both of them. OSM (other staff member) #1, the sous chef, was conducting the tour of the kitchen and was present during observation. An interview was conducted on 1/28/20 at 7:10 PM with OSM #1. When asked to describe the process for sanitation of serving pans, OSM #1 stated, "The serving pans are washed, rinsed and placed on vertical drying rack. Then the pans are placed in the dry storage area. When asked if the pans observed were dry prior to staff placing them in dry storage, OSM #1 stated, "It does not appear they were." An interview was conducted on 1/30/20 at 8:00 AM with OSM #4, the dietician/dietary director. When asked about the policy for sanitation of serving pans, OSM #4 stated, "I will bring you the policy. We air dry pans vertically before placing them in dry storage. We don't use any towels to dry due to potential for contamination." The facility's "Washing and Sanitizing Dishes/Utensils" policy, documents "Air dry the dishes and utensils (do NOT use towels for drying dishes or utensils as this could spread contamination)." ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing were made aware of the above concerns on 1/30/20 at 12:46 PM. No further information was provided prior to exit.	F 812	sanitation and dry storage of pots, dishes, flatware and utensils daily for 30 days and monthly thereafter. Audit results will be reported at QAPI quarterly. 5. Corrective action will be completed by March 10, 2020.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	495171	A. BUILDING: _____ B. WING _____	1/30/2020

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined the facility staff failed to complete a death in facility tracking record within seven days of the event for one of 33 residents in the survey sample, Resident #2. The findings include: Resident #2 was admitted to the facility on 7/1/19; diagnoses include but are not limited to: high blood pressure, cancer, and GERD (gastroesophageal reflux disease- [backflow of the contents of the stomach into

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The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 640	Continued From Page 1

the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn]. (1)

The most recently completed MDS (minimum data set) assessment, a significant change assessment, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact and able to make daily decisions. She was coded as requiring supervision with set up assistance for most of her activities of daily living.

A nurse's note dated 10/9/19 at 1:28 a.m. documented in part, "Resident was observed in bed unresponsive to verbal or tactile stimuli. On assessment resident had no breath sounds auscultated over either lung field, heart sounds absent, pupils fixed and dilated, BP (blood pressure) and pulses absent, second nurse verified findings."

Review of the clinical record failed to evidence a discharge tracking of the resident's death.

On 1/30/2020 at 10:47 a.m., an interview was conducted with RN (registered nurse) #4, the MDS nurse. RN #4 was shown the nurse's note above and the tracking of the MDS assessments. When asked if the resident should have had a discharge tracking record, RN #4 stated she should have had an open discharge assessment. When asked if the discharge tracking assessment was missed? RN #4 stated, "It sure did." When asked what policy the facility follows for the completion of the MDS assessments, RN #4 stated they follow the RAI (resident assessment instrument) manual as their resource.

According to the RAI Manual v 1.17.1 October 2019 page 2-10, "Death in Facility refers to when the resident dies in the facility or dies while on a leave of absence (LOA) (see LOA definition). The facility must complete a Death in Facility tracking record. No Discharge assessment is required."

ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 1/30/2020 at 12:42 p.m.

No further information was obtained prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.