PRINTED: 11/09/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR BUPPLIER GOODWIN HOUSE BAILEY'S CROSSROADS 3440 S.JEFFERSON STREET FALLS CHURCH, VA. 22041 CAPIT DEFICIENCY MUST BE PRECEDED BY YILL PRECEDED AND RECOULATORY OR USE DENTIFYING INFORMATION) E 000 Initial Comments An unannounced Emergency Preparedness survey was conducted from 11/3/21 through 11/14/21. The facility was in substantial ompliance with 42 CFR part 48/3-73. Requirement for Long-Term Care Facilities. F 000 INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/3/21 through 11/4/21. The facility was in substantial ompliance with 42 CFR part 48/3-73. Requirement for Long-Term Care Facilities. F 000 INITIAL COMMENTS I	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED			
An unannounced Emergency Preparedness survey was conducted from 11/3/21 through 11/4/21. The facility was in substantial compliants are requirements. The Life Safety Code survey/report will follow. The consult in this 73 bed Medicare certified facility was 60 at the time of the survey. The survey sample included Medicare cord reviews. F 580			495171	B. WING _			11/04/2021
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An unannounced Emergency Preparedness survey was conducted from 11/3/21 through 11/4/21. The facility was in substantial compilance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. F 000 An unannounced Medicare/Medicaid standard survey was conducted 11/3/21 through 11/4/21. No complaints were investigated during the survey. Corrections are required for compilance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 73 bed Medicare certified facility was 60 at the time of the survey. The survey sample included twenty-six current resident reviews and three closed record reviews. F 580 Notify of Changes (injury/Decline/Room, etc.) F 581 S483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is: (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	COMPLETION
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a need to discontinue an existing form of		(i) A facility must immonsult with the residence consistent with his or representative(s) who (A) An accident involvesults in injury and physician intervention (B) A significant charmental, or psychosodeterioration in health status in either life-the clinical complications	nediately inform the resident; dent's physician; and notify, r her authority, the resident en there is- lving the resident which has the potential for requiring n; nge in the resident's physical, cial status (that is, a h, mental, or psychosocial breatening conditions or s);				
		a need to discontinu	e an existing form of				00) 5 : = -

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.

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495171	B. WING		11/04/2021	
	ROVIDER OR SUPPLIER	OSSROADS	3	TREET ADDRESS, CITY, STATE, ZIP CODE 440 S JEFFERSON STREET ALLS CHURCH, VA 22041		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 580	commence a new fo (D) A decision to trainesident from the fact §483.15(c)(1)(ii). (ii) When making no (14)(i) of this section all pertinent informatis available and proxiphysician. (iii) The facility must resident and the section (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a computation to a computation that compropart, and must specific room changes between the section of the facility staff failed potential need to alter the section to the facility staff failed potential need to alter the section to the section to the facility staff failed potential need to alter the section to t	verse consequences, or to rm of treatment); or insfer or discharge the cility as specified in stification under paragraph (g) in the facility must ensure that the facility in the facility in the facility in the facility ensurement en	F 580			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495171	B. WING		11/04/2021	
	ROVIDER OR SUPPLIER N HOUSE BAILEY'S CR	OSSROADS		STREET ADDRESS, CITY, STATE, ZIP CODE 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 580	Continued From pa	ge 2	F 58			
	nurse practitioner) w	ed to notify the physician (or when the physician ordered ex (1) was not available for esident #11 on 10/1/21,				
	The findings include	:				
	6/1/20. Resident #1 were not limited to c disorder and high bl quarterly minimum c reference date of 8/6	dmitted to the facility on 11's diagnoses included but lementia, major depressive ood pressure. Resident #11's data set with an assessment 3/21, coded the resident's aily decision making as				
	a physician's order	#11's clinical record revealed dated 9/30/21 for divalproex - two tablets (500 mg) three eimer's dementia.				
	(medication adminis physician's order da mg- two tablets thre of the October 2021 medication was not	#11's October 2021 MAR stration record) revealed a ted 9/30/21 for divalproex 250 e times a day. Further review MAR revealed the administered to Resident #11 10/2/21, and twice on 10/3/21.				
	Resident #11 was re tablets because the note further docume	d 9/30/21 documented efusing divalproex 500mg tablets were too big. The ented a new order was bex 250mg- two tablets three				
	A late entry nurse's	note dated 10/2/21 for				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495171	B. WING		11/04/2021
	ROVIDER OR SUPPLIER	OSSROADS	;	STREET ADDRESS, CITY, STATE, ZIP CODE 8440 S JEFFERSON STREET FALLS CHURCH, VA 22041	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 580	divalproex medication call was placed to phe (name) who stated the [medications] was rewriter-nurse related 250mg; to give 2 tabe divalproex 500 mg hemed card next re-ord She said resident's in process it at this time aware to notify MD (Anurse's note dated "Divalproex medications upervisor updated Further review of nur 10/2/21 and 10/3/21 or nurse practitioner was not administered dates. Review of the facility various medications divalproex 250 mg with a medication sthat are administration. RN and check the STAT box the medication is not available.	I, "On 10/1/2021, late entry; ons, was not delivered; and a narmacy staff; spoke to hat divalproex meds to redered too soon. That dosage was changed to so three times a day and that has been discontinued, and on der date will be 10/7/2021. Insurance will not pay or e. Shift supervisor made medical doctor)." I 10/2/21 documented, ions, still not delivered; shift ." I rses' notes dated 10/1/21, failed to reveal the physician was made aware divalproex downwas to Resident #11 on those I STAT box (a box containing of list revealed three tablets of was available in the box. a.m., an interview was registered nurse) #1, the ted the 10/1/21 and 10/2/21 process staff follows for not available for the medication and take there if available. RN #1 docall the pharmacy if the failable in the STAT box. RN upervisor is responsible for	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	I . ,	(X3) DATE SURVEY COMPLETED	
		495171	B. WING _		1	1/04/2021	
	ROVIDER OR SUPPLIER I HOUSE BAILEY'S C	ROSSROADS	,	STREET ADDRESS, CITY, STATE, ZIF 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041	•		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 580	above notes, RN # complaining that s 500 mg pills so the changed to two tal #1 stated divalproe #11 had not arrived pharmacy. RN #1 they had already s and for insurance not be sent until a she told the pharm changed then she shift supervisor. R the STAT box for d because she though medication was not to be sent until a she told the pharm changed then she shift supervisor. R the STAT box for d because she though medication was not to be sent until a she told the pharmacy sent she did not know which was conducted with RN #1 stated she Resident #11 was tablets so she told changed the medication. RN #2 #1 making her aware the 250 mg tablets physician. RN #2 the STAT box and from there. On 11/4/21 at 11:2 staff member) #1 (administered. In regards to the stated Resident #11 was he could not swallow divalproex a physician's order was olets of divalproex 250 mg. RN ex 250 mg tablets for Resident d on 10/1/21 so she called the stated the pharmacy staff said ent divalproex 500 mg tablets ourposes the medication could specific date. RN #1 stated acy staff the dose had reported the situation to the line #1 stated she did not check ivalproex 250 mg tablet got the last time she looked, the at available in the STAT box. 8 a.m., a telephone interview h RN #2, the shift supervisor reported to. RN #1 stated refusing divalproex 500 mg the nurse practitioner who cation to a smaller dose then the medication. RN #2 stated when the pharmacy sent the 2 stated she remembered RN are the 500 mg tablet was too 11 but she did not recall RN #1 the pharmacy would not send so she did not notify the stated the medication was in RN #1 could have obtained it	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495171	B. WING			11/	04/2021
	ROVIDER OR SUPPLIER	SSROADS	•	3	STREET ADDRESS, CITY, STATE, ZIP CODE 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Shortages/Unavailabl "If an emergency delinurse should contact obtain orders or direct No further information Reference: (1) Divalproex is used and prevent migraine information was obtain	policy titled, "7.0 Medication e Medications" documented, very is unavailable, facility the attending physician to tions." I was presented prior to exit. I to treat seizures, mania headaches. This ned from the website:	F	580			
F 584 SS=D	tml Safe/Clean/Comfortal CFR(s): 483.10(i)(1)-0 §483.10(i) Safe Envir The resident has a rig comfortable and hom but not limited to rece supports for daily livir The facility must prov §483.10(i)(1) A safe, homelike environmen use his or her person possible. (i) This includes ensu receive care and serv physical layout of the independence and do (ii) The facility shall ex	onment. Int to a safe, clean, elike environment, including iving treatment and Ig safely.	F	584			

_ ` · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION G	COMPLETED		
		495171	B. WING		11/04/2021		
	ROVIDER OR SUPPLIER	COSSROADS		STREET ADDRESS, CITY, STATE, ZIP CODE 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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F 584	§483.10(i)(2) House services necessary and comfortable into §483.10(i)(3) Clean in good condition; §483.10(i)(4) Privative resident room, as space of the services in all areas; §483.10(i)(5) Adequate levels in all areas; §483.10(i)(6) Comfort levels. Facilities initimated in the services of the servic	ekeeping and maintenance to maintain a sanitary, orderly, erior; bed and bath linens that are e closet space in each pecified in §483.90 (e)(2)(iv); uate and comfortable lighting ortable and safe temperature fally certified after October 1, a temperature range of 71 to e maintenance of comfortable NT is not met as evidenced from, staff interview and facility was determined that the maintain a safe and homelike e of 57 resident rooms on the om #254. ed to maintain the carpet in repair.	F 58				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495171	B. WING _			11/04/2021
	ROVIDER OR SUPPLIER I HOUSE BAILEY'S CRO	DSSROADS		STREET ADDRESS, CITY, STATE, Z 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE / CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIAT	DATE
F 584	of the carpet. Additional observation revealed the findings On 10/4/2021 at 10:1 conducted with CNA #3. CNA #3 stated the environmental repairse environmental servic CNA #3 stated that the or issues to the nurse #3 stated that the mathousekeeping depart area. CNA #3 stated carpet was reported asafety hazard for the visitors. CNA #3 stated carpet was reported asafety hazard for the visitors. CNA #3 stated carpet was reported asafety hazard for the visitors. CNA #3 stated carpet was reported asafety hazard for the visitors. CNA #3 stated that they has reported any environmental service to fix things. CNA #2 areas on the unit with #2 stated that they know the services department buckling about a week to look at it. CNA #2 they had to schedule come in to fix the are carpet buckling could tripping. On 10/4/2021 at 10:2 conducted with LPN	in two areas near the center ons on 11/4/2021 at 8:25 a.m. above. 15 a.m., an interview was (certified nursing assistant) nat they reported any s needed to their es department by telephone. ney also reported any repairs e assigned to the area. CNA aintenance and tments were in the same I that any buckling in the right away because it was a residents, the staff and ted that buckling carpet did thomelike. 20 a.m., an interview was #2. CNA #2 stated that they	F 5	584		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
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needed to the environ and put in a help tick issue. LPN #1 state to assess the carpet were going to have anot remember exact observed the buckle stated that the carpet planned to be replace buckled carpet was residents, staff and succeeded with OSM director of facilities of that they had a design conducted all of the the unit to observe a OSM #3 stated that replacing all of the cunit. OSM #3 stated for them for any envito assess and repair were unsure if there for Room #254 but the way and the progress for them until OSM #3 observed the stated that the buckles and staff. The made to OSM #3 for work orders for the band the progress for On 11/4/2021 at 11:3	commental services department and the for them to assess the did that someone had been up and advised them that they are replace it all but they did by when they came. LPN #1 did carpet in Room #254 and at in the room was already and at in the room was already and at in the room was already and and at in the room was already and and at in the room was already and and and are the an potential safety hazard for a potential safety hazard for a visitors. 10 a.m., an interview was and (other staff member) #3, and an	F	584				
	SUMMARY S (EACH DEFICIEN REGULATORY OF REGUL	CORRECTION IDENTIFICATION NUMBER: 495171	A BUILDI ROVIDER OR SUPPLIER I HOUSE BAILEY'S CROSSROADS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 needed to the environmental services department and put in a help ticket for them to assess the issue. LPN #1 stated that someone had been up to assess the carpet and advised them that they were going to have to replace it all but they did not remember exactly when they came. LPN #1 observed the buckled carpet in Room #254 and stated that the carpet in the room was already planned to be replaced. LPN #1 stated that the buckled carpet was a potential safety hazard for residents, staff and visitors. On 11/4/2021 at 11:10 a.m., an interview was conducted with OSM (other staff member) #3, director of facilities management. OSM #3 stated that they had a designated staff member who conducted all of the inspections and rounded on the unit to observe any environmental problems. OSM #3 stated that they were in the process of replacing all of the carpet and wallpaper on the unit. OSM #3 stated that staff placed work orders for them for any environmental concerns for them to assess and repair. OSM #3 stated that they were in the process of replacing they contacted the carpet company who would come out to flatten out the areas for them until they could replace the carpet. OSM #3 observed the carpet in Room #254 and stated that the buckling could be a trip hazard for residents and staff. At that time a request was made to OSM #3 for documentation of any active work orders for the buckled carpet in Room #254 and the progress for repairs in place. On 11/4/2021 at 11:54 a.m., ASM (administrative staff member) #2, the director of nursing stated	THOUSE BAILEY'S CROSSROADS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 needed to the environmental services department and put in a help ticket for them to assess the issue. LPN #1 stated that someone had been up to assess the carpet and advised them that they were going to have to replace it all but they did not remember exactly when they came. LPN #1 observed the buckled carpet in Room #254 and stated that the carpet in the room was already planned to be replaced. LPN #1 stated that the buckled carpet was a potential safety hazard for residents, staff and visitors. On 11/4/2021 at 11:10 a.m., an interview was conducted with OSM (other staff member) #3, director of facilities management. OSM #3 stated that they had a designated staff member who conducted all of the inspections and rounded on the unit to observe any environmental problems. OSM #3 stated that they were in the process of replacing all of the carpet and wallpaper on the unit. OSM #3 stated that staff placed work orders for them for any environmental concerns for them to assess and repair. OSM #3 stated that they were unsure if there were any active work orders for Room #254 but they would check on it. OSM #3 stated that when they find problems with the carpet buckling they contacted the carpet company who would come out to flatten out the areas for them until they could replace the carpet. OSM #3 observed the carpet in Room #254 and stated that the buckling could be a trip hazard for residents and staff. At that time a request was made to OSM #3 for documentation of any active work orders for the buckled carpet in Room #254 and the progress for repairs in place. 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WIMG THOUSE BAILEY'S CROSSROADS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST E PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 8 needed to the environmental services department and put in a help ticket for them to assess the carpet and advised them that they were going to have to replace it all but they did not remember exactly when they came. LPN #1 observed the buckled carpet in Room #254 and stated that the carpet in the room was already planned to be replaced. LPN #1 stated that stated that the buckled carpet more may be a conducted with OSM (other staff member) #3, director of facilities management. OSM #3 stated that they had a designated staff member who conducted all of the inspections and rounded on the unit to observe any environmental problems. OSM #3 stated that they were unsure if there were any active work orders for them for any active work orders for Room #254 and stated that they would check on it. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495171	B. WING			11/04/2021	
	ROVIDER OR SUPPLIER	SSROADS		3	TREET ADDRESS, CITY, STATE, ZIP CODE 440 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623 SS=D	carpet in Room #254. was not any evidence repairs for Room #256. On 11/4/2021 at appropring request was made to for maintaining a hom. The facility policy, "How February 2021 documere provided with a sate homelike environment their personal belong? On 11/4/2021 at 1:55 administrator and ASI were made aware of the No further information Notice Requirements CFR(s): 483.15(c)(3)-\$483.15(c)(3) Notice Before a facility transfersident, the facility most resident, the facility most representative(s) of the reasons for the manguage and mannefacility must send a corepresentative of the Long-Term Care Omb (ii) Record the reason discharge in the residence and mannefacility must send a corepresentative of the Long-Term Care Omb (iii) Record the reason discharge in the residence with paralland	coming today to repair the ASM #2 stated that there of a work order or any 4 prior to today. coximately 1:37 p.m., a ASM #2 for the facility policy delike environment. comelike Environment" dated mented in part, "Residents afe, clean, comfortable and t and encouraged to use sings to the extent possible" p.m., ASM #1, the M #2, the director of nursing the above concern. In was presented prior to exit. Before Transfer/Discharge (6)(8) before transfer. fers or discharges a must- and the resident's me transfer or discharge and ove in writing and in a or they understand. The popy of the notice to a Office of the State budsman.		623			
	() Include in the floti	co alo nomo decombed III					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495171	B. WING		11/04/2021
	ROVIDER OR SUPPLIER N HOUSE BAILEY'S CRO	DSSROADS		STREET ADDRESS, CITY, STATE, ZIP CODE 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 623	(c)(8) of this section, discharge required up made by the facility a resident is transferred (ii) Notice must be more before transfer or dis (A) The safety of individual be endangered under this section; (B) The health of individual be endangered, under this section; (C) The resident's he allow a more immediated under paragraph (c)((D) An immediate transferred by the residual under paragraph (c)((E) A resident has not days. §483.15(c)(5) Conternotice specified in paragraph (c)(i) The reason for transferred or discharge (iii) The location to work transferred or discharge (iv) A statement of the including the name, and telephone number receives such request to obtain an appeal for	of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or inder this section must be at least 30 days before the d or discharged. ade as soon as practicable charge when- viduals in the facility would in paragraph (c)(1)(i)(C) of viduals in the facility would er paragraph (c)(1)(i)(D) of valth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; insfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or at resided in the facility for 30 ints of the notice. The written aragraph (c)(3) of this section owing: ansfer or discharge; of transfer or discharge; hich the resident is rged; e resident's appeal rights, address (mailing and email),	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
		495171	B. WING			11/	04/2021
	ROVIDER OR SUPPLIER I HOUSE BAILEY'S CRO	SSROADS		3	TREET ADDRESS, CITY, STATE, ZIP CODE 440 S JEFFERSON STREET FALLS CHURCH, VA 22041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	telephone number of Long-Term Care Omk (vi) For nursing facility and developmental di disabilities, the mailin telephone number of the protection and ad developmental disabi C of the Developmen and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilit disorder or related disemail address and tel agency responsible for advocacy of individual established under the for Mentally III Individual S483.15(c)(6) Change If the information in the effecting the transfer must update the recipas practicable once the becomes available. §483.15(c)(8) Notice In the case of facility of the state Survey A State Long-Term Care the facility, and the recipas practicy, and the recipas process of the state Survey A State Long-Term Care the facility, and the recipas practicy, and the recipas practicy and the recipas practicy and the recipas practication prictication prictica	is (mailing and email) and the Office of the State oudsman; y residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and als with a mental disorder e Protection and Advocacy uals Act. The set to the notice. The notice changes prior to or discharge, the facility of the notice as soon the updated information The facility must provide or to the impending closure gency, the Office of the et Ombudsman, residents of sident representatives, as et transfer and adequate	F	623			

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495171	B. WING		11/04/2021	
	ROVIDER OR SUPPLIER N HOUSE BAILEY'S CR	COSSROADS		STREET ADDRESS, CITY, STATE, ZIP CODE 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 623	This REQUIREMENT by: Based on staff inter and clinical record of the facility staff faile hospital transfer for survey sample, Resident #62 was to 9/24/21. The facility notification of the transfer for survey sample, Resident #62 was a 9/22/21. Resident #were not limited to or disorders of the right the left hand. There assessment comples admission nursing a documented the resident was tra 9/22/21 due to a few week before that da Resident #62's clinic facility provided notion ombudsman. On 11/4/21 at 1:30 processes resident transfer for the fax confirmation to the or of the fax confirmation.	IT is not met as evidenced rview, facility document review eview, it was determined that d to provide notification of a one of 29 residents in the sident #62. Transferred to the hospital on y staff failed to provide ansfer to the ombudsman.	F 623	3		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495171	B. WING _		11/04/2021
	ROVIDER OR SUPPLIER	OSSROADS		STREET ADDRESS, CITY, STATE, ZIP CODE 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 623	#62's transfer to the On 11/4/21 at 1:37 p staff member) #1 (th made aware of the a The facility policy titl (Hospital) Required (health care center) The Social Worker is State Ombudsman of No further information Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a f applies to all treatment facility residents. Ba assessment of a residents receive accordance with pro-	tified regarding Resident hospital on 9/22/21. a.m., ASM (administrative e director of nursing) was above concern. ed, "Facility-Initiated Transfer Documentation for HCC Residents" documented, "6. is responsible for notifying the of facility-initiated transfers"	F 6	23	
	care plan, and the re This REQUIREMEN by: Based on staff inter and clinical record re the facility staff failed care in accordance of practice, and the cord one of 29 residents in Resident #11. The facility staff failed	-			

	NT OF DEFICIENCIES N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495171	B. WING _			11/04/2021
	ROVIDER OR SUPPLIER I HOUSE BAILEY'S CRO	PSSROADS		STREET ADDRESS, CITY, STATE, Z 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICII	ACTION SHOULD BE TO THE APPROPRIAT	DATE
F 684	6/1/20. Resident #11 were not limited to de disorder and high blo quarterly minimum da reference date of 8/3. cognitive skills for da severely impaired. Review of Resident # a physician's order da 250 mg (milligrams) - times a day for Alzhe Review of Resident # (medication administic physician's order date mg- two tablets three of the October 2021 I medication was not a at all on 10/1/21 or 10 Resident #11's comp start date of 8/13/21 f information regarding A nurse's note dated Resident #11 was ref tablets because the t note further documer	mitted to the facility on 's diagnoses included but ementia, major depressive od pressure. Resident #11's ata set with an assessment /21, coded the resident's illy decision making as #11's clinical record revealed ated 9/30/21 for divalproex two tablets (500 mg) three imer's dementia. #11's October 2021 MAR ration record) revealed a ed 9/30/21 for divalproex 250 times a day. Further review MAR revealed the dministered to Resident #11 0/2/21, and twice on 10/3/21. ##11 of the major of the maj	F 6	984		
	A late entry nurse's n	ote dated 10/2/21 for "On 10/1/2021, late entry:				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495171	B. WING _			11/	04/2021
	ROVIDER OR SUPPLIER I HOUSE BAILEY'S CRO	SSROADS		STREET ADDRESS, CITY, STATE, ZIP CO 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041	'DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 684	call was placed to pha (name) who stated the re-ordered too soon. dosage was changed three times a day and been discontinued, as re-order date will be a resident's insurance withis time. Shift super MD (medical doctor). A nurse's note dated "Divalproex medications approvisor updated" Review of the facility various medications) divalproex 250 mg was conducted with RN (runurse who documents are not available for a nurses should check medication and take the available. RN #1 state pharmacy if the medic STAT box. In regard stated Resident #11 would not swallow div physician's order was divalproex 250 mg. Fing tablets for Reside 10/1/21 so she called stated the pharmacy sent divalproex 500 m.	as, was not delivered; and a armacy staff; spoke to at divalproex meds was Writer-nurse related that to 250mg; to give 2 tabs I that divalproex 500 mg has and on med card next 10/7/2021. She said will not pay or process it at visor made aware to notify 10/2/21 documented, ons, still not delivered; shift 10/2/21 documented, ons, at interview was egistered nurse) #1 (the ed the 10/1/21 and 10/2/21 process for medications that administration. RN #1 stated	F	684			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495171	B. WING		11/04/2021
	ROVIDER OR SUPPLIER	DSSROADS		STREET ADDRESS, CITY, STATE, ZIP CODE 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 684	reported the situation #1 stated she did not divalproex 250 mg to the last time she look available in the STAT On 11/4/21 at 10:48 was conducted with RN #1 stated she represent the she she told the changed the medical the pharmacy sent the she did not know who medication. RN #2 should for Resident #11 making her aware big for Resident #11 making her aware the 250 mg tablets. Was in the STAT box obtained it from there on 11/4/21 at 11:25 staff member) #1 (the ASM #2 (the administ the above concern. STAT box list (that do mg tablets were in the contents during the burner of the state	stated she told the ose had changed then she of to the shift supervisor. RN is check the STAT box for oblet because she thought sted, the medication was not obox. a.m., a telephone interview RN #2 (the shift supervisor ported to). RN #1 stated fusing divalproex 500 mg are nurse practitioner who stion to a smaller dose then the medication. RN #2 stated are the pharmacy sent the stated she remembered RN at the 500 mg tablet was too but she did not recall RN #1 are pharmacy would not send RN #2 stated the medication and RN #1 could have as a.m., ASM (administrative are director of nursing) and strator) were made aware of ASM #1 stated the current ocumented divalproex 250 are box) held the same beginning of October 2021. A policy titled, "7.0 Medication of the Medications" documented, not administer to a resident, numediately initiate action to	F 684	4	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPLI	
		495171	B. WING _			11/	04/2021
	ROVIDER OR SUPPLIER I HOUSE BAILEY'S CRO	SSROADS	·	STREET ADDRESS, CITY, STATE, ZIP CODE 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Reference: (1) Divalproex is used and prevent migraine information was obtain	n was presented prior to exit. If to treat seizures, mania	F	584			
F 689 SS=D	S483.25(d) Accidents The facility must ensu §483.25(d)(1) The res as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observatio document review, it w facility staff failed to e free of accident hazar rooms on the health of The facility staff failed: Room #254 in good re The findings include: On 11/3/2021 at 1:24 made of current resid Observation of room is resident lying in bed as	ire that - sident environment remains izards as is possible; and sident receives adequate stance devices to prevent is not met as evidenced in, staff interview and facility was determined that the ensure a safe environment rds in one of 57 resident care unit, Room #254.	F	689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495171	B. WING	····		11/04/2021	
	ROVIDER OR SUPPLIER I HOUSE BAILEY'S CR	OSSROADS		STREET ADDRESS, CITY, STATE, ZIP CO 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 689	have visible buckling of the carpet. Additional observation revealed the finding On 10/4/2021 at 100 conducted with CNA #3. CNA #3 stated environmental repaisenvironmental servic CNA #3 stated that or issues to the nurse #3 stated that the management of the state	dent bed was observed to g in two areas near the center ons on 11/4/2021 at 8:25 a.m. s above. 215 a.m., an interview was a (certified nursing assistant) that they reported any irs needed to their ces department by telephone. they also reported any repairs se assigned to the area. CNA	F 68				
	come in to fix the ar carpet buckling coul tripping. On 10/4/2021 at 10: conducted with LPN	eas. CNA #2 stated that the ld be a hazard for falls or					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING		
		495171	B. WING			1	1/04/2021
	ROVIDER OR SUPPLIER	ROSSROADS		3440 S JEFF	DRESS, CITY, STATE, ZIP CODE FERSON STREET IURCH, VA 22041	·	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 689	and put in a help t issue. LPN #1 state to assess the carp were going to have not remember examples observed the buck stated that the carplanned to be replouckled carpet was residents, staff and On 11/4/2021 at 1 conducted with Ost director of facilities that they had a deconducted all of the unit to observed OSM #3 stated that replacing all of the unit. OSM #3 stated that they have unsure if the for Room #254 bu #3 stated that whe carpet buckling the company who wou areas for them unit OSM #3 observed stated that the buckling the company who wou areas for them unit OSM #3 observed stated that the buckling the company who would are so of them unit OSM #3 observed stated that the buckling the company who would areas for them unit OSM #3 observed stated that the buckling the company who would areas for them unit OSM #3 observed stated that the buckling the company who would areas for them unit OSM #3 observed stated that the buckling the company who would areas for them unit OSM #3 observed stated that the buckling the company who would stated the company who would	ironmental services department icket for them to assess the ated that someone had been up bet and advised them that they et to replace it all but they diductly when they came. LPN #1 kled carpet in Room #254 and pet in the room was already aced. LPN #1 stated that the s a potential safety hazard for	F	589			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495171	B. WING		11/04/2021
	ROVIDER OR SUPPLIER	DSSROADS		STREET ADDRESS, CITY, STATE, ZIP CODE 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 689	carpet in Room #252 was not any evidence repairs for Room #252 On 11/4/2021 at 1:553 administrator and AS were made aware of	coming today to repair the ASM #2 stated that there e of a work order or any full prior to today. full p.m., ASM #1, the full #2, the director of nursing	F 68	39	
F 695 SS=D	Respiratory/Tracheo CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care at the facility must ensineeds respiratory care and tracheal sucare, consistent with practice, the comprecare plan, the reside and 483.65 of this suths REQUIREMEN' by: Based on observation interview and clinical determined that the respiratory equipment manner for two of 29 Residents #1 and #2 The findings include: 1. The facility staff faincentive spirometer manner.	ory care, including nd tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of hensive person-centered nts' goals and preferences, abpart. T is not met as evidenced on, resident interview, staff record review, it was facility staff failed to store nt in a clean and sanitary residents in the survey, 6.	F 69	95	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	\Diamond	(X3) DATE SURVEY COMPLETED	
		495171	B. WING _			11/04/2021	
	ROVIDER OR SUPPLIER I HOUSE BAILEY'S CRO	SSROADS		STREET ADDRESS, CITY, STATE, 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 695	were not limited to che respiratory failure and #1's five day Medicar assessment reference resident as being coordinates of Review of Resident # physician's order date spirometry use every comprehensive care 10/27/21 failed to do regarding the storage On 11/3/21 at 12:32 properties of the physician's order date spirometer was observed on the residence of the physician was also bed table and another observed on the residence of the physician was also bed table and another observed on the residence of the physician was also bed table and another observed on the residence of the physician was also bed table and another observed on the residence of the physician was also bed table and another observed on the residence of the physician was also bed table and another observed with pieces were expensed to the physician was also bed table and another observed with the manufacture of the physician was also bed table and another observed with the manufacture of the physician was also bed table and another observed with the manufacture of the physician was also bed table and another observed with the manufacture of the physician was also bed table and another observed with the manufacture of the physician was also bed table and another observed with the manufacture of the physician was also bed table and another observed with the manufacture of the physician was also bed table and another observed on the resident was also bed table and another observed with the manufacture of the physician was also bed table and another observed on the resident was also bed table and another observed on the resident was also bed table and another observed on the resident was also bed table and another observed on the resident was also bed table and another observed on the resident was also bed table and another observed on the resident was also bed table and another observed on the resident was also bed table and another observed on the resident was also bed table and another observed on the resident was also bed table and another observe	et's diagnoses included but pronic kidney disease, acute di high cholesterol. Resident de assessment with an de date of 6/14/21, coded the unitively intact. Et's clinical record revealed a ded 10/18/21 for incentive shift. Resident #1's plan with a start date of cument information of an incentive spirometer. Ether the start date of cument information of an incentive spirometer. Ether the start date of cument information of an incentive spirometer. Ether the start date of cument information of an incentive spirometer. Ether the start date of cument information of an incentive spirometer was dent's nightstand. Both were uncovered and the exposed. On 11/3/21 at 2:09 is conducted with Resident ded he uses the incentive times each day. On 11/3/21 entive spirometers remained touth pieces exposed. On another interview was dent #1. The resident stated or offered a bag or anything	F	595			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	ROSSROADS		STREET ADDRESS, CITY, STATE, ZIP CODE 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041	
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F 695	& Safety" and "Oxygrailed to document is storage of incentive No further information Reference: (1) An incentive spin help you keep your incentive spiromete	titled, "Oxygen Administration gen Storage in Nursing Areas" nformation regarding the	F 69	5	
	obtained from the website:https://med ctions/000451.htm 2. The facility staff f oxygen tubing/nasa sanitary manner. Resident #26 was a 6/1/21. Resident #2 were not limited to disease (lung disea	lineplus.gov/ency/patientinstru failed to Resident #26's I cannula (1) in a clean and admitted to the facility on 26's diagnoses included but chronic obstructive pulmonary se), urinary tract infection and ase. Resident #26's quarterly			
	assessment referent resident's cognition Review of Resident a physician's order oxygen at three liter cannula. Resident plan with a start dat	#26's clinical record revealed dated 6/1/21 for continuous rs per minute via nasal #26's comprehensive care e of 9/9/21 failed to document ng the storage of oxygen			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		ONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		495171	B. WING _			11/	04/2021	
	ROVIDER OR SUPPLIER I HOUSE BAILEY'S CRO	SSROADS		344	REET ADDRESS, CITY, STATE, ZIP CODE 10 S JEFFERSON STREET LLS CHURCH, VA 22041	JEFFERSON STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 695	Continued From page		F	695				
	of the room. The oxy	o.m., Resident #26 was out gen tubing/nasal cannula gen concentrator was anging over the arm rest of						
	wheel chair in the roc tubing via a portable tubing/nasal cannula	m., Resident #26 was in a om receiving oxygen from tank. The oxygen connected to the oxygen covered and laying on the						
	Resident #26's room, combing her hair and	the oxygen tubing/nasal						
	conducted with RN (r stated oxygen tubing	a.m., an interview was egistered nurse) #1. RN #1 should be stored in a plastic mination from dirt, germs						
	staff member) #1 (the	n.m., ASM (administrative director of nursing) and trator) were made aware of						
	& Safety" and "Oxyge	led, "Oxygen Administration en Storage in Nursing Areas" formation regarding the bing.						
	No further information	n was presented prior to exit.						
	Reference:							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495171	B. WING			11/	04/2021
NAME OF PROVIDER OR SUPPLIER GOODWIN HOUSE BAILEY'S CROSSROADS				34	TREET ADDRESS, CITY, STATE, ZIP CODE 440 S JEFFERSON STREET ALLS CHURCH, VA 22041		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page 24		F	695			
	that is placed into the was obtained from the	the part of oxygen tubing nostrils. This information website: ov/ency/patientinstructions/0					
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-	-(4)	F	700			
	§483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.						
		the resident for risk of rails prior to installation.					
	bed rails with the resi	the risks and benefits of dent or resident or resident otain informed consent prior					
		that the bed's dimensions e resident's size and weight.					
	and maintaining bed of This REQUIREMENT by: Based on observation interview and facility of determined that the fact an assessment and continuous continuou	d specifications for installing					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495171	B. WING		11/04/2021	
NAME OF PROVIDER OR SUPPLIER GOODWIN HOUSE BAILEY'S CROSSROADS				STREET ADDRESS, CITY, STATE, ZIP CODE 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETIC	
F 700	diagnoses that incluacute respiratory fai severe sepsis (2). Resident #214's ME not due at the time on ursing assessment 11/2/2021 coded Resident #210 one person for transambulation. The admission nurs Resident #214 as be admission. On 11/3/2021 at 3:0 conducted of Resideupper side rails in the that time an intervie Resident #214, whee Resident #214 stated day before and was and position himself he did not remember about the side rails.	admitted to the facility with ided but were not limited to lure with hypoxia (1) and in the survey. The admission of the survey is a sessment and esident #214 being alert and esident #214 being alert and esident mursing assessment as requiring assistance of effers and two persons for sing assessment coded eing oriented to side rails on a sent #214 in bed with bilateral ne up position on the bed. At we was conducted with the masked about the side rails, and that he was admitted the able to grab on to turn in bed for the Resident #214 stated that the rif he had signed anything	F 700			
	approximately 8:35 observation as state The comprehensive	a.m., revealed the same				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING _	(X3) DATE SURVEY COMPLETED			
		495171	B. WING		11/04/2021		
NAME OF PROVIDER OR SUPPLIER GOODWIN HOUSE BAILEY'S CROSSROADS			34	TREET ADDRESS, CITY, STATE, ZIP CODE 140 S JEFFERSON STREET ALLS CHURCH, VA 22041	1110112021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLÉTION		
F 700	siderails on his bed interventions it doct consent for use of stock POA (power of attorwith use of siderails). The physician's ord documented in part when in bed to aid in 11/02/21; Start Date orders further docum (quarter) side rails. Date: 11/02/21; Start Review of Resident evidence a consent side rail assessment on 11/3/2021 at apprequest was made to member) #2, the difference on 11/4/2021 at apprequest on 9/15/2/214's room. On 11/4/2021 at apprequest was made to maintenance document on 11/4/2021 at apprequest was made to maintenance document on 11/4/2021 at apprequest was made to mursing for evidence assessment and cool on 11/4/2021 at 1:3 they did not have a	ference is to have upper 1/4 to aid in bed mobility." Under umented in part, "Obtain diderails from resident and/or rney). Discuss risks involved i" ers for Resident #214 , "Side rails up at all times n bed mobility. Order Date: e: 11/02/21." The physician's mented, "2 (two) Upper 1/4 [Name of physician] Order rt Date: 11/02/21." #214's clinical record failed to for the use of side rails or a at. proximately 6:00 p.m., a to ASM (administrative staff rector of nursing for the bed lent #214's bed. proximately 8:30 a.m., ASM of bed inspections from menting a bed inspection 2021 for the bed in Resident proximately 10:58 a.m., a to ASM #2, the director of e of a use of side rail nsent for Resident #214. 85 p.m., ASM #2 stated that side rail assessment or nt #214 and they had asked	F 700				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495171	B. WING		11/04/2021		
NAME OF PROVIDER OR SUPPLIER GOODWIN HOUSE BAILEY'S CROSSROADS			3	STREET ADDRESS, CITY, STATE, ZIP CODE 1440 S JEFFERSON STREET FALLS CHURCH, VA 22041	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION		
F 700	Continued From pa	ge 27	F 700				
	conducted with LPN LPN #1 stated that rails they obtained a performed an asses rails were appropria obtained a consent assessment should installing the side rausing them. On 11/4/2021 at 1:5 conducted with ASM ASM #2 stated that complete a side rail consent for the use stated that they expof admission. On 11/4/2021 at ap	No p.m., an interview was No (licensed practical nurse) #1. when a resident required side an order from the physician, assment to ensure that the side ate for the resident and and and the LPN #1 stated that the be completed prior to ails on the bed or the resident was No #2, the director of nursing the staff were expected to assessment and obtain a of the side rails. ASM #2 proximately 1:37 p.m., a to ASM #2 for the facility policy					
	dated 7/24/2018 do and Entrapment Ris is used to determine each resident. An a gathered in the Bed Entrapment Assess determination of ap resident. The analy MDS assessment a planned. Consent residents/resident rinformed of the risk use. Upon complet	Bed Rail Safety Program" cumented in part, "Side Rail sk Evaluation Form: This form e appropriate side rails use for analysis of the information I Safety Inspection and the ment is performed with a propriate side rail use of each visi is performed with each and subsequently care form: This form is used for epresentatives to be fully s and benefits of side rails ion of the above lations, and forms, an MD					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L L L L L L L L L L L L L L L L L L L		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495171	B. WING			1/04/2021	
NAME OF PROVIDER OR SUPPLIER GOODWIN HOUSE BAILEY'S CROSSROADS				STREET ADDRESS, CITY, STATE, ZIP CODE 3440 S JEFFERSON STREET FALLS CHURCH, VA 22041			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 700	(medical doctor) order appropriate side rail information will be care on 11/4/2021 at app #2 provided a side rail dated 11/04/2021 at entrapment risk eval 1:51 p.m. On 11/4/2021 at 1:55 administrator and AS were made aware of No further information References: 1. Respiratory failure passes from your lurinformation was obtain https://www.nlm.nih.gilure.html. 2. Sepsis: An illness severe, inflammatory other germs. The sy caused by the germs chemicals the body in This information was	er will be obtained for the usage, and the correct are planned" roximately 1:50 p.m., ASM ail consent for Resident #214 1:47 p.m. and a side rail & uation dated 11/04/2021 at 5 p.m., ASM #1, the EM #2, the director of nursing	F 70				