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

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted from 11/3/21 through 11/4/21. 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 11/3/21 through 11/4/21. No complaints were investigated during the survey. Corrections are required for compliance 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 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(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 (that is, a deterioration in health, 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	F 580		

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

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treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to notify the physician of a potential need to alter treatment for one of 29 residents in the survey sample, Resident #11.

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The facility staff failed to notify the physician (or nurse practitioner) when the physician ordered medication divalproex (1) was not available for administration to Resident #11 on 10/1/21, 10/2/21 and 10/3/21.

The findings include:

Resident #11 was admitted to the facility on 6/1/20. Resident #11's diagnoses included but were not limited to dementia, major depressive disorder and high blood pressure. Resident #11's quarterly minimum data set with an assessment reference date of 8/3/21, coded the resident's cognitive skills for daily decision making as severely impaired.

Review of Resident #11's clinical record revealed a physician's order dated 9/30/21 for divalproex 250 mg (milligrams) - two tablets (500 mg) three times a day for Alzheimer's dementia.

Review of Resident #11's October 2021 MAR (medication administration record) revealed a physician's order dated 9/30/21 for divalproex 250 mg- two tablets three times a day. Further review of the October 2021 MAR revealed the medication was not administered to Resident #11 at all on 10/1/21 or 10/2/21, and twice on 10/3/21.

A nurse's note dated 9/30/21 documented Resident #11 was refusing divalproex 500mg tablets because the tablets were too big. The note further documented a new order was received for divalproex 250mg- two tablets three times a day.

A late entry nurse's note dated 10/2/21 for

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10/1/21 documented, "On 10/1/2021, late entry; divalproex medications, was not delivered; and a call was placed to pharmacy staff; spoke to (name) who stated that divalproex meds [medications] was re-ordered too soon. Writer-nurse related that dosage was changed to 250mg; to give 2 tabs three times a day and that divalproex 500 mg has been discontinued, and on med card next re-order date will be 10/7/2021. She said resident's insurance will not pay or process it at this time. Shift supervisor made aware to notify MD (medical doctor)."

A nurse's note dated 10/2/21 documented, "Divalproex medications, still not delivered; shift supervisor updated..."

Further review of nurses' notes dated 10/1/21, 10/2/21 and 10/3/21 failed to reveal the physician or nurse practitioner was made aware divalproex was not administered to Resident #11 on those dates.

Review of the facility STAT box (a box containing various medications) list revealed three tablets of divalproex 250 mg was available in the box.

On 11/4/21 at 10:24 a.m., an interview was conducted with RN (registered nurse) #1, the nurse who documented the 10/1/21 and 10/2/21 notes, regarding the process staff follows for medications that are not available for administration. RN #1 stated nurses should check the STAT box for the medication and take the medication from there if available. RN #1 stated nurses should call the pharmacy if the medication is not available in the STAT box. RN #1 stated the shift supervisor is responsible for notifying the physician when an ordered

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medication is not administered. In regards to the above notes, RN #1 stated Resident #11 was complaining that she could not swallow divalproex 500 mg pills so the physician's order was changed to two tablets of divalproex 250 mg. RN #1 stated divalproex 250 mg tablets for Resident #11 had not arrived on 10/1/21 so she called the pharmacy. RN #1 stated the pharmacy staff said they had already sent divalproex 500 mg tablets and for insurance purposes the medication could not be sent until a specific date. RN #1 stated she told the pharmacy staff the dose had changed then she reported the situation to the shift supervisor. RN #1 stated she did not check the STAT box for divalproex 250 mg tablet because she thought the last time she looked, the medication was not available in the STAT box.

On 11/4/21 at 10:48 a.m., a telephone interview was conducted with RN #2, the shift supervisor RN #1 stated she reported to. RN #1 stated Resident #11 was refusing divalproex 500 mg tablets so she told the nurse practitioner who changed the medication to a smaller dose then the pharmacy sent the medication. RN #2 stated she did not know when the pharmacy sent the medication. RN #2 stated she remembered RN #1 making her aware the 500 mg tablet was too big for Resident #11 but she did not recall RN #1 making her aware the pharmacy would not send the 250 mg tablets so she did not notify the physician. RN #2 stated the medication was in the STAT box and RN #1 could have obtained it from there.

On 11/4/21 at 11:25 a.m., ASM (administrative staff member) #1 (the director of nursing) and ASM #2 (the administrator) were made aware of the above concern.

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F 580	Continued From page 5 The facility pharmacy policy titled, "7.0 Medication Shortages/Unavailable Medications" documented, "If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions." No further information was presented prior to exit. Reference: (1) Divalproex is used to treat seizures, mania and prevent migraine headaches. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682412.html	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		

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§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain a safe and homelike environment for one of 57 resident rooms on the health care unit, Room #254.

The facility staff failed to maintain the carpet in Room #254 in good repair.

The findings include:

On 11/3/2021 at 1:24 p.m., an observation was made of current resident rooms in the facility. Observation of room #254 revealed the current resident lying in bed asleep, a carpet covered the bedroom floor. The carpet leading from the doorway to the resident bed was observed to

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have visible buckling in two areas near the center of the carpet.

Additional observations on 11/4/2021 at 8:25 a.m. revealed the findings above.

On 10/4/2021 at 10:15 a.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated that they reported any environmental repairs needed to their environmental services department by telephone. CNA #3 stated that they also reported any repairs or issues to the nurse assigned to the area. CNA #3 stated that the maintenance and housekeeping departments were in the same area. CNA #3 stated that any buckling in the carpet was reported right away because it was a safety hazard for the residents, the staff and visitors. CNA #3 stated that buckling carpet did not make rooms look homelike.

On 10/4/2021 at 10:20 a.m., an interview was conducted with CNA #2. CNA #2 stated that they reported any environmental problems to environmental services and they would come up to fix things. CNA #2 stated that they had a few areas on the unit with the carpet buckling. CNA #2 stated that they knew the environmental services department was notified of the carpet buckling about a week ago and they had come up to look at it. CNA #2 stated that they knew that they had to schedule people from the outside to come in to fix the areas. CNA #2 stated that the carpet buckling could be a hazard for falls or tripping.

On 10/4/2021 at 10:25 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that they reported any repairs

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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.

On 11/4/2021 at 11:54 a.m., ASM (administrative staff member) #2, the director of nursing stated that they were notified by maintenance that a

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F 584	Continued From page 9 contractor would be coming today to repair the carpet in Room #254. ASM #2 stated that there was not any evidence of a work order or any repairs for Room #254 prior to today. On 11/4/2021 at approximately 1:37 p.m., a request was made to ASM #2 for the facility policy for maintaining a homelike environment. The facility policy, "Homelike Environment" dated February 2021 documented in part, "Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible..." On 11/4/2021 at 1:55 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concern. No further information was presented prior to exit.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		

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paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal

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hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide notification of a hospital transfer for one of 29 residents in the survey sample, Resident #62.

Resident #62 was transferred to the hospital on 9/24/21. The facility staff failed to provide notification of the transfer to the ombudsman.

The findings include:

Resident #62 was admitted to the facility on 9/22/21. Resident #62's diagnoses included but were not limited to muscle weakness, joint disorders of the right hand and joint disorders of the left hand. There was no minimum data set assessment completed for Resident #62. An admission nursing assessment dated 9/22/21 documented the resident was disoriented to time.

Review of Resident #62's clinical record revealed the resident was transferred to the hospital on 9/22/21 due to a fever and status post hip repair a week before that date. Further review of Resident #62's clinical record failed to reveal the facility provided notice of the transfer to the ombudsman.

On 11/4/21 at 1:30 p.m., an interview was conducted with OSM (other staff member) #1 (social worker). OSM #1 stated that typically she receives resident transfer paperwork from the assistant director of nursing, faxes transfer notification to the ombudsman and keeps a copy of the fax confirmation. OSM #1 stated she could not find a fax confirmation to evidence the

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F 623	Continued From page 13 ombudsman was notified regarding Resident #62's transfer to the hospital on 9/22/21. On 11/4/21 at 1:37 p.m., ASM (administrative staff member) #1 (the director of nursing) was made aware of the above concern. The facility policy titled, "Facility-Initiated Transfer (Hospital) Required Documentation for HCC (health care center) Residents" documented, "6. The Social Worker is responsible for notifying the State Ombudsman of facility-initiated transfers..." No further information was presented prior to exit.	F 623		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure treatment and care in accordance with professional standards of practice, and the comprehensive plan of care for one of 29 residents in the survey sample, Resident #11. The facility staff failed to administer the physician ordered medication divalproex (1) to Resident	F 684		

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#11 on 10/1/21, 10/2/21 and 10/3/21.

The findings include:

Resident #11 was admitted to the facility on 6/1/20. Resident #11's diagnoses included but were not limited to dementia, major depressive disorder and high blood pressure. Resident #11's quarterly minimum data set with an assessment reference date of 8/3/21, coded the resident's cognitive skills for daily decision making as severely impaired.

Review of Resident #11's clinical record revealed a physician's order dated 9/30/21 for divalproex 250 mg (milligrams) - two tablets (500 mg) three times a day for Alzheimer's dementia.

Review of Resident #11's October 2021 MAR (medication administration record) revealed a physician's order dated 9/30/21 for divalproex 250 mg- two tablets three times a day. Further review of the October 2021 MAR revealed the medication was not administered to Resident #11 at all on 10/1/21 or 10/2/21, and twice on 10/3/21.

Resident #11's comprehensive care plan with a start date of 8/13/21 failed to document specific information regarding divalproex administration.

A nurse's note dated 9/30/21 documented Resident #11 was refusing divalproex 500mg tablets because the tablets were too big. The note further documented a new order was received for divalproex 250mg- two tablets three times a day.

A late entry nurse's note dated 10/2/21 for 10/1/21 documented, "On 10/1/2021, late entry;

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divalproex medications, was not delivered; and a call was placed to pharmacy staff; spoke to (name) who stated that divalproex meds was re-ordered too soon. Writer-nurse related that dosage was changed to 250mg; to give 2 tabs three times a day and that divalproex 500 mg has been discontinued, and on med card next re-order date will be 10/7/2021. She said resident's insurance will not pay or process it at this time. Shift supervisor made aware to notify MD (medical doctor)."

A nurse's note dated 10/2/21 documented, "Divalproex medications, still not delivered; shift supervisor updated..."

Review of the facility STAT box (a box containing various medications) list revealed three tablets of divalproex 250 mg was available in the box.

On 11/4/21 at 10:24 a.m., an interview was conducted with RN (registered nurse) #1 (the nurse who documented the 10/1/21 and 10/2/21 notes), regarding the process for medications that are not available for administration. RN #1 stated nurses should check the STAT box for the medication and take the medication from there if available. RN #1 stated nurses should call the pharmacy if the medication is not available in the STAT box. In regards to the above notes, RN #1 stated Resident #11 was complaining that she could not swallow divalproex 500 mg pills so the physician's order was changed to two tablets of divalproex 250 mg. RN #1 stated divalproex 250 mg tablets for Resident #11 had not arrived on 10/1/21 so she called the pharmacy. RN #1 stated the pharmacy staff said they had already sent divalproex 500 mg tablets and for insurance purposes the medication could not be sent until a

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specific date. RN #1 stated she told the pharmacy staff the dose had changed then she reported the situation to the shift supervisor. RN #1 stated she did not check the STAT box for divalproex 250 mg tablet because she thought the last time she looked, the medication was not available in the STAT box.

On 11/4/21 at 10:48 a.m., a telephone interview was conducted with RN #2 (the shift supervisor RN #1 stated she reported to). RN #1 stated Resident #11 was refusing divalproex 500 mg tablets so she told the nurse practitioner who changed the medication to a smaller dose then the pharmacy sent the medication. RN #2 stated she did not know when the pharmacy sent the medication. RN #2 stated she remembered RN #1 making her aware the 500 mg tablet was too big for Resident #11 but she did not recall RN #1 making her aware the pharmacy would not send the 250 mg tablets. RN #2 stated the medication was in the STAT box and RN #1 could have obtained it from there.

On 11/4/21 at 11:25 a.m., ASM (administrative staff member) #1 (the director of nursing) and ASM #2 (the administrator) were made aware of the above concern. ASM #1 stated the current STAT box list (that documented divalproex 250 mg tablets were in the box) held the same contents during the beginning of October 2021.

The facility pharmacy policy titled, "7.0 Medication Shortages/Unavailable Medications" documented, "1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy..."

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F 684	Continued From page 17 No further information was presented prior to exit. Reference: (1) Divalproex is used to treat seizures, mania and prevent migraine headaches. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682412.html	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to ensure a safe environment free of accident hazards in one of 57 resident rooms on the health care unit, Room #254. The facility staff failed to maintain the carpet in Room #254 in good repair. The findings include: On 11/3/2021 at 1:24 p.m., an observation was made of current resident rooms in the facility. Observation of room #254 revealed the current resident lying in bed asleep, a carpet covered the bedroom floor. The carpet leading from the	F 689		

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doorway to the resident bed was observed to have visible buckling in two areas near the center of the carpet.

Additional observations on 11/4/2021 at 8:25 a.m. revealed the findings above.

On 10/4/2021 at 10:15 a.m., an interview was conducted with CNA (certified nursing assistant) #3. CNA #3 stated that they reported any environmental repairs needed to their environmental services department by telephone. CNA #3 stated that they also reported any repairs or issues to the nurse assigned to the area. CNA #3 stated that the maintenance and housekeeping departments were in the same area. CNA #3 stated that any buckling in the carpet was reported right away because it was a safety hazard for the residents, the staff and visitors.

On 10/4/2021 at 10:20 a.m., an interview was conducted with CNA #2. CNA #2 stated that they reported any environmental problems to environmental services and they would come up to fix things. CNA #2 stated that they had a few areas on the unit with the carpet buckling. CNA #2 stated that they knew the environmental services department was notified of the carpet buckling about a week ago and they had come up to look at it. CNA #2 stated that they knew that they had to schedule people from the outside to come in to fix the areas. CNA #2 stated that the carpet buckling could be a hazard for falls or tripping.

On 10/4/2021 at 10:25 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that they reported any repairs

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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.

On 11/4/2021 at 11:54 a.m., ASM (administrative staff member) #2, the director of nursing stated that they were notified by maintenance that a

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F 689	Continued From page 20 contractor would be coming today to repair the carpet in Room #254. ASM #2 stated that there was not any evidence of a work order or any repairs for Room #254 prior to today. On 11/4/2021 at 1:55 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concern. No further information was presented prior to exit.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to store respiratory equipment in a clean and sanitary manner for two of 29 residents in the survey, Residents #1 and #26. The findings include: 1. The facility staff failed to store Resident #1's incentive spirometers (1) in a clean and sanitary manner. Resident #1 was admitted to the facility on	F 695		

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11/30/16. Resident #1's diagnoses included but were not limited to chronic kidney disease, acute respiratory failure and high cholesterol. Resident #1's five day Medicare assessment with an assessment reference date of 6/14/21, coded the resident as being cognitively intact.

Review of Resident #1's clinical record revealed a physician's order dated 10/18/21 for incentive spirometry use every shift. Resident #1's comprehensive care plan with a start date of 10/27/21 failed to document information regarding the storage of an incentive spirometer.

On 11/3/21 at 12:32 p.m., an uncovered incentive spirometer was observed on Resident #1's over bed table and another incentive spirometer was observed on the resident's nightstand. Both incentive spirometers were uncovered and the mouth pieces were exposed. On 11/3/21 at 2:09 p.m., an interview was conducted with Resident #1. The resident stated he uses the incentive spirometers multiple times each day. On 11/3/21 at 4:31 p.m., both incentive spirometers remained uncovered with the mouth pieces exposed. On 11/4/21 at 9:57 a.m., another interview was conducted with Resident #1. The resident stated no employee had ever offered a bag or anything else to cover the incentive spirometers.

On 11/4/21 at 10:24 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated incentive spirometers should be stored in a plastic bag to prevent contamination from dirt, germs and bacteria.

On 11/4/21 at 11:25 a.m., ASM (administrative staff member) #1 (the director of nursing) and ASM #2 (the administrator) were made aware of

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the above concern.

The facility policies titled, "Oxygen Administration & Safety" and "Oxygen Storage in Nursing Areas" failed to document information regarding the storage of incentive spirometers.

No further information was presented prior to exit.

Reference:

(1) An incentive spirometer is "A device used to help you keep your lungs healthy. Using the incentive spirometer teaches you how to take slow deep breaths." This information was obtained from the website:https://medlineplus.gov/ency/patientinstructions/000451.htm

2. The facility staff failed to Resident #26's oxygen tubing/nasal cannula (1) in a clean and sanitary manner.

Resident #26 was admitted to the facility on 6/1/21. Resident #26's diagnoses included but were not limited to chronic obstructive pulmonary disease (lung disease), urinary tract infection and chronic kidney disease. Resident #26's quarterly minimum data set assessment with an assessment reference date of 8/31/21, coded the resident's cognition as severely impaired.

Review of Resident #26's clinical record revealed a physician's order dated 6/1/21 for continuous oxygen at three liters per minute via nasal cannula. Resident #26's comprehensive care plan with a start date of 9/9/21 failed to document information regarding the storage of oxygen tubing.

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On 11/3/21 at 12:35 p.m., Resident #26 was out of the room. The oxygen tubing/nasal cannula connected to the oxygen concentrator was uncovered and was hanging over the arm rest of a chair.

On 11/3/21 at 1:42 p.m., Resident #26 was in a wheel chair in the room receiving oxygen from tubing via a portable tank. The oxygen tubing/nasal cannula connected to the oxygen concentrator was uncovered and laying on the bed.

On 11/3/21 at 1:49 p.m., an employee entered Resident #26's room, assisted the resident with combing her hair and exited the room. On 11/3/21 at 1:51 p.m., the oxygen tubing/nasal cannula remained uncovered on the bed.

On 11/4/21 at 10:24 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated oxygen tubing should be stored in a plastic bag to prevent contamination from dirt, germs and bacteria.

On 11/4/21 at 11:25 a.m., ASM (administrative staff member) #1 (the director of nursing) and ASM #2 (the administrator) were made aware of the above concern.

The facility policies titled, "Oxygen Administration & Safety" and "Oxygen Storage in Nursing Areas" failed to document information regarding the storage of oxygen tubing.

No further information was presented prior to exit.

Reference:

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F 695	Continued From page 24 (1) A nasal cannula is the part of oxygen tubing that is placed into the nostrils. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000048.htm	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §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. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility document review, it was determined that the facility staff failed to evidence an assessment and consent for the use of side rails for one of 29 residents in the survey sample,	F 700		

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Resident #214.

The findings include:

Resident #214 was admitted to the facility with diagnoses that included but were not limited to acute respiratory failure with hypoxia (1) and severe sepsis (2).

Resident #214's MDS (minimum data set) was not due at the time of the survey. The admission nursing assessment for Resident #214 dated 11/2/2021 coded Resident #214 being alert and oriented. The admission nursing assessment coded Resident #214 as requiring assistance of one person for transfers and two persons for ambulation.

The admission nursing assessment coded Resident #214 as being oriented to side rails on admission.

On 11/3/2021 at 3:02 p.m., an observation was conducted of Resident #214 in bed with bilateral upper side rails in the up position on the bed. At that time an interview was conducted with Resident #214, when asked about the side rails, Resident #214 stated that he was admitted the day before and was able to grab on to turn in bed and position himself. Resident #214 stated that he did not remember if he had signed anything about the side rails or not.

An additional observation on 11/4/2021 at approximately 8:35 a.m., revealed the same observation as stated above.

The comprehensive care plan for Resident #214 dated 11/3/2021, documented, "Safety, [Name of

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 _____	11/04/2021

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
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Resident #214] preference is to have upper 1/4 siderails on his bed to aid in bed mobility." Under interventions it documented in part, "Obtain consent for use of siderails from resident and/or POA (power of attorney). Discuss risks involved with use of siderails..."

The physician's orders for Resident #214 documented in part, "Side rails up at all times when in bed to aid in bed mobility. Order Date: 11/02/21; Start Date: 11/02/21." The physician's orders further documented, "2 (two) Upper 1/4 (quarter) side rails. [Name of physician] Order Date: 11/02/21; Start Date: 11/02/21."

Review of Resident #214's clinical record failed to evidence a consent for the use of side rails or a side rail assessment.

On 11/3/2021 at approximately 6:00 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the bed inspection for Resident #214's bed.

On 11/4/2021 at approximately 8:30 a.m., ASM #2 provided a book of bed inspections from maintenance documenting a bed inspection completed on 9/15/2021 for the bed in Resident #214's room.

On 11/4/2021 at approximately 10:58 a.m., a request was made to ASM #2, the director of nursing for evidence of a use of side rail assessment and consent for Resident #214.

On 11/4/2021 at 1:35 p.m., ASM #2 stated that they did not have a side rail assessment or consent for Resident #214 and they had asked the staff to complete it today.

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On 11/4/2021 at 1:40 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that when a resident required side rails they obtained an order from the physician, performed an assessment to ensure that the side rails were appropriate for the resident and obtained a consent. LPN #1 stated that the assessment should be completed prior to installing the side rails on the bed or the resident using them.

On 11/4/2021 at 1:50 p.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that the staff were expected to complete a side rail assessment and obtain a consent for the use of the side rails. ASM #2 stated that they expected this to be done the day of admission.

On 11/4/2021 at approximately 1:37 p.m., a request was made to ASM #2 for the facility policy for side rails.

The facility policy, "Bed Rail Safety Program" dated 7/24/2018 documented in part, "...Side Rail and Entrapment Risk Evaluation Form: This form is used to determine appropriate side rails use for each resident. An analysis of the information gathered in the Bed Safety Inspection and the Entrapment Assessment is performed with a determination of appropriate side rail use of each resident. The analysis is performed with each MDS assessment and subsequently care planned. Consent form: This form is used for residents/resident representatives to be fully informed of the risks and benefits of side rails use. Upon completion of the above assessments, evaluations, and forms, an MD

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(medical doctor) order will be obtained for the appropriate side rail usage, and the correct information will be care planned..."

On 11/4/2021 at approximately 1:50 p.m., ASM #2 provided a side rail consent for Resident #214 dated 11/04/2021 at 1:47 p.m. and a side rail & entrapment risk evaluation dated 11/04/2021 at 1:51 p.m.

On 11/4/2021 at 1:55 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concern.

No further information was presented prior to exit.

References:

1. Respiratory failure: When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

2. Sepsis: An illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: <https://medlineplus.gov/ency/article/000666.htm>.