PRINTED: 08/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		I''	(X3) DATE SURVEY COMPLETED	
		495269	B. WING		- Table Market	08/	12/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH TAYLOR STREET ARLINGTON, VA 22203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	survey was conducte 8/12/2021. Correctio compliance with 42 C Term Care requireme survey/report will folk	edicare/Medicaid standard d 8/10/2021 through ns are required for FR Part 483 Federal Long ents. The Life Safety Code	F	000	F 000 Responses to the cited deficiencies d constitute an admission or agreement be facility of the truth of facts alleged or concluset forth in the Statement of Deficiencies Plan of Correction is prepared solely as a of compliance with federal and/or state law	by the lusions	
F 700 SS=E	at the time of the sun	vey. The survey sample nt Resident reviews and five s.	F	700	F 700 A. With respect to the spect		09/14/2021
	alternatives prior to in a bed or side rail is un correct installation, un rails, including but not elements. §483.25(n)(1) Assess	mpt to use appropriate installing a side or bed rail. If sed, the facility must ensure se, and maintenance of bed it limited to the following is the resident for risk of rails prior to installation.			resident/situation cited: Resident #20 was discharged to home planned on 08/20/2021. Resident informed consent for use of bed rails obtained on 08/11/2021. Resident informed consent for use of bed rails obtained on 08/10/2021. Resident #13 transferred to hospital on 08/24/2 Resident #8 was discharged to ALF planned on 08/12/2021.	#22: was #74: was was 021.	
	bed rails with the resirepresentative and of to installation. §483.25(n)(3) Ensure are appropriate for the §483.25(n)(4) Follow recommendations and	e that the bed's dimensions e resident's size and weight. the manufacturers' d specifications for installing			B. With respect to how the facility identify residents/situations with potential for the identified concerns: A facility wide audit for Informed confor use of bed rails will be conducted designated nursing staff. Any area concerns will be corrected.	the sent d by	
		Γ is not met as evidenced					
ABODATODY	DIDECTOR'S OF PROVINCE	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(YA) DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WNU711

Facility ID: VA0132

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495269	B. WNG		08/	12/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH TAYLOR STREET ARLINGTON, VA 22203			
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 700	by: Based on observation document review and was determined that implement bed rail residents in the surversidents in the surversident staff failed prior to the use of before the surversident staff failed prior to the use of before the surversident staff failed prior to the use of before the surversident staff from the findings included. 1. The facility staff from the surversident staff failed prior to the use of before the surversident staff failed prior to the surverside	on, staff interview, facility d clinical record review, it the facility staff failed to equirements for five of 17 ey sample, Residents #20, 8. d to obtain informed consent ed rails for Residents #20, 8.	F 70	C. With respect to who	nto place to: ator or her me rehab staff ge Policy and emonth, the es (DNS) or y audits of the sto verify the ed rails are usage. the plan of d: s, the findings se of bed rails at Quality Improvement and at the oths, the QAPI		
	resident as being cognitively intact. Review of Resident #20's clinical record revealed a therapy communication form dated 7/22/21 that documented Resident #20 needed halo bars (bed rails) to help with bed mobility and transfers. Resident #20's comprehensive care plan initiated on 7/22/21 documented, "Halo bar for enhanced bed mobility." A physician's order dated 8/10/21 documented, "Halo bar for enhanced bed mobility." Further review of Resident #20's clinical record failed to reveal informed consent was obtained for			necessary action or extenperiod. The Executive Director and Nursing Administrator are resouring implementation compliance with the compound of Correction and action initiated if required and action initiated if required.	and/or Skilled responsible for and ongoing onents of this ddressing and ay occur. The Skilled Nursing le for ensuring Correction is QAPI meetings		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495269	B. WING		08/12/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH TAYLOR STREET ARLINGTON, VA 22203	-
(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 CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTION
F 700	observed lying in bed On 8/11/21 at 2:37 p conducted with LPN LPN #2 stated nurse residents' use of bed On 8/11/21 at 3:52 p conducted OSM (oth physical therapist). Or residents for the use recommendations but informed consent. On 8/11/21 at 5:06 p staff member) #1 (the (the director of nursin above concern. The facility documen documented, "Acknot Use of an Assistive Ethe use of an assistive permitted by state, th (RCD)/Health Care M the resident and/or le potential risks and be assistive device. Rev and Consent for the Device form and obte	bed rails. .m., Resident #20 was d with bilateral bed rails up. .m., an interview was (licensed practical nurse) #2. s obtain informed consent for rails. .m., an interview was er staff member) #3 (the DSM #3 stated he assesses of bed rails and writes	F 700		
	•	iled to obtain informed #22's use of bed rails.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495269	B. WNG_			08/	12/2021
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS 900 NORTH TAYL ARLINGTON, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACI	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD I-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 700	Resident #22 was add 7/27/21. Resident #2 were not limited to os weakness and heart of admission minimum of assessment reference resident's cognition and Review of Resident # a therapy communicated documented Resident rails) for safe mobility. Resident #22's compon 7/22/21 document bed mobility." A physician's order do "Halo bar for enhance Further review of Resident to reveal information the resident's use of 10 ms/11/21 at 1:52 p. observed lying in bed on 8/11/21 at 2:37 p. conducted with LPN LPN #2 stated nurses residents' use of bed on 8/11/21 at 3:52 p. conducted OSM (other physical therapist). Cresidents for the use	mitted to the facility on 2's diagnoses included but teoporosis, muscle disease. Resident #22's data set assessment with an e date of 8/3/21, coded the s moderately impaired. 22's clinical record revealed tion form dated 7/29/21 that t #22 needed halo bars (bed . rehensive care plan initiated ed, "Halo bar for enhanced ated 8/10/21 documented, ed bed mobility." sident #22's clinical record need consent was obtained for oed rails. m., Resident #22 was I with bilateral bed rails up. m., an interview was (licensed practical nurse) #2. s obtain informed consent for rails. m., an interview was er staff member) #3 (the DSM #3 stated he assesses of bed rails and writes	F	00			
	recommendations but informed consent.	The sace has ablain					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495269	B. WNG_			08/12/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 900 NORTH TAYLOR STREET ARLINGTON, VA 22203	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C X (EAGH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 700	staff member) #1 (the (the director of nursing above concern. 3. The facility staff fathe use of halo bed in the use of halo bed in Resident #74 was as 8/9/2021. Resident were not limited to difailure (abnormal concirculatory congestion water by the kidneys and low back pain. A MDS (minimum dathe been completed as the admitted to the facility and Health Assessment documented the resistant or long-term medocumented as being decisions regarding the Section, "ADL (activity Assessment (nursing documented, "Bed Mineeded, "Yes" was concepted as the mobility enables of Resident #74 in health at the commented Resident #74 in health at documented Resident #75 in health at documented #75 in health at documented #	m., ASM (administrative e administrator) and ASM #2 ng) were made aware of the siled to obtain a consent for ails, for Resident #74. Imitted to the facility on #74's diagnoses included but abetes, congestive heart adition characterized by an and retention of salt and (1) (1), high blood pressure, ta set) assessment had not the resident was newly y. The "Service Evaluation ent" dated 8/9/2021 dent had no difficulty with emory. Resident #74 was goindependent in making tasks of daily living. In the ties of daily living. In the ties of daily living. The form lobility assistive devices thecked. "Select All that it was documented next to,	F7	700		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495269	B. WING_	Mildin 1972 de de constante de c		08/12/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 900 NORTH TAYLOR STREET ARLINGTON, VA 22203	DE			
(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 OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 700	(edge of bed) with pt's (patient's) inde mobility." Further record failed to evi the bed rails. Resident #74 had 8/11/2021 for "Atta encourage independence of the comprehensive documented in par "Interventions" data part, "Halo bar for On 8/11/2021 at 10 staff member) #2, presented a docum "Acknowledgement Transfer Assistive Resident #74's nailed and the engineering is initiated by there evaluation and assorder for them [beddepartment then cand the engineering on. An interview was capractical nurse) #2 regarding the role assessment or obti	t, "Resident #74 is up at EOB use of hallo bars to increase pendence/safety in bed eview of Resident #74's clinical dence a consent for the use of a physician order dated ch bilateral halo bars to indence during bed mobility." e care plan dated, 8/10/2021, t, "Focus: Bed mobility." The ed, 8/11/2021, documented in enhanced bed mobility." 0:54 a.m., ASM (administrative the director of nursing,	F 7	700				

PRINTED: 08/17/2021

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495269	B. WNG		l c	8/12/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 900 NORTH TAYLOR STREET ARLINGTON, VA 22203	<u>.</u>	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 700	physician order for the high risk for falls." We knows the resident restated, "We do an assessment." When assessment is locate computer. LPN #2 secomes in, the nurse assessment and if a then the nurses dona later time, the nurse doctor." When asked resident or the responsible to the resident is not all get consent." LPN # consent form at that sure there is a consent the assessment is let the admission assessections to complete An interview was comember) #3, the phyat 3:52 p.m. When a obtaining the consent OSM #3 stated no. ASM #1, the administrator of nursing, was above concerns on the References: (1) Barron's Dictional contents of the properties of the properties of the consents of the physical properties of th	s necessary. We need a nem for residents who are then asked how the nurse needs the rails, LPN #2 assessment, a side rail asked where that ed, LPN #2 stated it's in the tated, "When an admission does a bed rail or bar at that time they don't need it it bring it up to the doctor. If at as feels the resident would get an order from the diff they get consent from the misble party for the use of the "When we get the order, if ert or cannot give consent we 2 was asked if staff fill in a time, LPN #2 stated, "I'm ent form." When asked where located, LPN #2 stated, "it's on asment as one of the 12	F 7			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495269	B. WING		Market	08/12/2021	
NAME OF PI	ROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH TAYLOR STREET IRLINGTON, VA 22203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 700	Continued From page Chapman, page 138.		F	700			
	the use of bed rails, he Resident #13 was ad 6/25/2021 with a read diagnoses that include fractures of thoracic via spine), diabetes, and. The most recent MD: assessment, an administration assessment reference the resident as scoring interview for mental stresident was moderate cognitive decisions. I Status, the resident via extensive assistance members for moving. Observation was madwith halo rails on each p.m. Review of Resident #2 a therapy communicated that documented Resident #3 at the properties of the part, for log rolling R (right (bilateral upper extresident was a first part).	S (minimum data set) ission assessment, with an e date of 7/16/2021, coded ng a "10" on the BIMS (brief status) score, indicating the tely impaired to make daily n Section G - Functional was coded as requiring of one or more staff					
	p.m. Review of Resident # a therapy communicathat documented Resident (bars (bed rails) to he transfers. A therapy documented in part, for log rolling R (right (bilateral upper extre bars." Further review	#13's clinical record revealed ation form dated 7/13/2021 sident #13's needed halo lp with bed mobility and note dated 7/30/2021 l'Max (maximum) A (assist) on the control of the control					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	COMPLETED	
		495269	B. WING			08/	12/2021
NAME OF PE	ROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH TAYLOR STREET RLINGTON, VA 22203		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 700	The "Service Evaluat form dated 6/25/2021 assistive devices need Resident #8 had a ph 8/11/2021 that documbilateral halo bars for transfers." The comprehensive of documented in part, "Interventions" dated part, "Remind and enenabler/device when halo bars." On 8/11/2021 at 10:5 staff member) #2, the presented a docume and Consent for the Device." This form hat the date of 8/10/2020. An interview was cor administrator, on 8/1 asked about bed rails don't have side rails, is initiated by therapy evaluation and asses order for them. The calls the engineering engineering departm. An interview was cor practical nurse) #2 or regarding the role at the side rails and interview was corporactical nurse) #2 or regarding the role at the side rails and side rails.	ion and Health Assessment" , documented, "Bed Mobility Eded, a "No" was checked. Pysician order dated hented, "Resident to use as afe bed mobility and care plan dated, 6/26/2021, "Focus: Bed mobility." The yorly 7/9/2021, documented in accourage me to use my repositioning in bed, has a director of nursing, and titled, "Acknowledgement Use of a Transfer Assistive and Resident #74's name and I. Inducted with ASM #1, the 1/2021 at 11:33 a.m. When a s, ASM #1 stated all beds If someone needs one, that a transfer the sament. Then they write an anursing department then department and the ent would put them on. Inducted with LPN (licensed in 8/11/2021 at 2:37 p.m., nurse plays in doing an	F	700			
	bed rails. LPN #2 sta	ning a consent for the use of ated, "The residents don't necessary. We need a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495269	B. WING		AND THE RESIDENCE OF THE PROPERTY OF THE PROPE	08	/12/2021
NAME OF PI	ROVIDER OR SUPPLIER			900 N	ET ADDRESS, CITY, STATE, ZIP CODE NORTH TAYLOR STREET INGTON, VA 22203	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 700	high risk for falls." Will knows the resident in stated, "We do an as assessment." When assessment is locate computer. LPN #2 stromes in, the nurse dassessment and if at then the nurses don't a later time, the nurse doctor." When asked resident or the resporails, LPN #2 stated, the resident is not ale get consent." LPN #2 consent form at that sure there is a conset the admission assess sections to complete. An interview was commember) #3, the phy at 3:52 p.m. When as obtaining the consent OSM #3 stated no. ASM #1, the administ director of nursing, wabove concerns on 8 No further information.	nem for residents who are then asked how the nurse eeds the rails, LPN #2 sessment, a side rail asked where that d, LPN #2 stated it's in the ated, "When an admission does a bed rail or bar that time they don't need it is bring it up to the doctor. If at the feels the resident would get an order from the if they get consent from the msible party for the use of the "When we get the order, if the ert or cannot give consent we was asked if staff fill in a time, LPN #2 stated, "I'm ant form. When asked where cated, LPN #2 stated it's on sment as one of the 12	F	700			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
		495269	B. WING			08/12/2021	
NAME OF P	ROVIDER OR SUPPLIER		900	EET ADDRESS, CITY, STATE, ZIP CODE NORTH TAYLOR STREET LINGTON, VA 22203			
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 700	Resident #8 was a 6/28/2021 with dia not limited to: der mental decline, es judgement, often a (1), high blood prefemur (thighbone) The most recent Massessment, an arassessment refere the resident as so interview for ment resident was sever cognitive decision. Status, the resider extensive assistar moving in the bed. Observation was with halo bars up 8/10/2021 at 1:30. Review of Reside therapy communic that documented (bed rails) to help A therapy note da part, "bed mob (m A (minimum assis review of Resider evidence a conserails. The "Service Evaform dated 6/28/2 assistive devices	admitted to the facility on agnoses that included but were tentia (- a progressive state of pecially memory function and accompanied by disorientation.) assure and fracture of right. MDS (minimum data set) dmission assessment, with an ence date of 7/5/2021, coded foring a "7" on the BIMS (brief al status) score, indicating the crely impaired to make daily so In Section G - Functional and was coded as requiring the cree of one staff member for	F 700				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495269	B. WNG		_	08/12/2021	
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, S 900 NORTH TAYLOR STR ARLINGTON, VA 2220	STATE, ZIP CODE	JOHN ELECTRICAL PROPERTY OF THE PROPERTY OF TH	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 700	7/9/2021 that dock enhanced bed more than the comprehensive documented in part, "Halo bar for "Interventions" date "Resident requires bed mobility." On 8/11/2021 at 1 staff member) #2, presented a documented a documented in part, "Halo bar for "Intervention" date "Resident requires bed mobility." On 8/11/2021 at 1 staff member) #2, presented a documented in the staff member of the	umented," Halo bar for bility." /e care plan dated, 6/29/2021, rt, "Focus: Bed mobility." The ted, 8/10/2021, documented in enhanced bed mobility." The ed 8/10/2021, documented, so one person physical assist for 0:54 a.m., ASM (administrative the director of nursing,	F	700			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495269	B. WING			08/	12/2021
NAME OF PE	ROVIDER OR SUPPLIER			900	REET ADDRESS, CITY, STATE, ZIP CODE D NORTH TAYLOR STREET RLINGTON, VA 22203		
(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 700	computer. LPN #2 state comes in, the nurse of assessment and if at then the nurses don't a later time, the nurse need them, then we doctor." When asked resident or the responsils, LPN #2 stated, the resident is not ale get consent." LPN #2 consent form at that is sure there is a conse the assessment is loot the admission assess sections to complete. An interview was commember) #3, the phy at 3:52 p.m. When as obtaining the consen OSM #3 stated no. ASM #1, the administ director of nursing, we above concerns on 8. No further information	d, LPN #2 stated it's in the ated, "When an admission loes a bed rail or bar that time they don't need it bring it up to the doctor. If at a feels the resident would get an order from the if they get consent from the insible party for the use of the "When we get the order, if art or cannot give consent we was asked if staff fill in a ime, LPN #2 stated, "I'm ant form." When asked where cated, LPN #2 stated, "it's on sment as one of the 12" ducted with OSM (other staff sical therapist, on 8/11/2021 sked if therapy has a role in the forthe use of the bed rails, trator, and ASM #2, the ere made aware of the	F	700			
	` '	g Information -(4)	F	732			
	3 .00.00(3) 110.00 00						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE S COMPL	
		495269	B. WNG		08/1	12/2021
NAME OF PE THE JEFF (X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH TAYLOR STREET ARLINGTON, VA 22203 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 732	must post the following basis: (i) Facility name. (ii) The current date. (iii) The total number by the following cate unlicensed nursing s resident care per shi (A) Registered nurses (B) Licensed practical vocational nurses (as (C) Certified nurse and (iv) Resident census §483.35(g)(2) Posting (i) The facility must proposed in paragraphical paragr	equirements. The facility ng information on a daily and the actual hours worked gories of licensed and taff directly responsible for fit: is. all nurses or licensed sedefined under State law). Ides. If g requirements, sost the nurse staffing data on (g)(1) of this section on a ginning of each shift, sted as follows: ole format, acce readily accessible to see access to posted nurse icility must, upon oral or enurse staffing data ic for review at a cost not to ity standard.	F 73	A. With respect to the resident/situation cited: 08/10/2021 Nursing Staffing was the evening of 08/10/2021. B. With respect to how the fidentify residents/situations potential for the identified condon 08/10/2021 evening, Downsing Services (DNS) and Activated out 11th, 12th of 202 Staffing ready to be posted. On morning, the Nursing Starconfirmed and posted according. The DNS and Administrator refrecord of daily staffing inforconfirm that records are accordingly. C. With respect to what measures have been put intraddress the stated concern: Moving forward, the posting of staffing will occur before the meeting and will be confirm member of the leadership attendance or designee immediatendance or designee immediatendance or designee immediatendance.	acility will with the cerns: irrector of dministrator of dmini	09/14/2021

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495269	B. WING	Action to the contract of the	08/	12/2021	
NAME OF PF		ATEMENT OF DEFICIENCIES	9			ON (X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE	
F 732	information. Nurse s 8/10/21 was not post nurse staffing information. The findings include: On 8/10/21 at 11:55 observation of the nuposted across from to conducted. The nurse dated 8/8/21 and corfor that date. On 8/10/21 at 4:59 producted with ASM member) #1 (the adrested and the director for posting the daily ASM #1 stated she had daily nurse staffing in information at the more the director of nursin nurse staffing information at the more than the director of nursin nurse staffing information. On 8/11/21 at 5:06 producted with director of nursin nurse staffing information. The facility policy titl Staffing Data" documents of the daily spersonnel per CMS Medicaid Services) a record of the daily	cost current nurse staffing taffing information for ed on 8/10/21. Instead, ation for 8/8/21 was posted. a.m. and 4:09 p.m., urse staffing information he unit nurse's station was se staffing information was ntained staffing information .m., an interview was (administrative staffininistrator). ASM #1 stated of nursing were responsible nurse staffing information. and printed out a copy of the information and discussed the orning meeting but she and ig had been busy and the ation for 8/10/21 was not a.m., ASM #1 and ASM #2 ng) were made aware of the ed, "Posting of Daily Nurse mented, "It is the community's taffing of direct care nursing (Centers for Medicare and requirements, and to maintain	F 732	D. With respect to how the correction will be monitored: Over the next three months, the from Posted Nursing Staffing In audits will be reviewed at Assurance / Performance Imp (QAPI) meetings. During and conclusion of the three months, committee will re-evaluate and in necessary action or extend the period. The Executive Director and/or Nursing Administrator are responsiving implementation and compliance with the component Plan of Correction and address resolving variances that may or Executive Director and/or Skiller Administrator are responsible for the status of this Plan of Correviewed and discussed at QAPI and action initiated if required.	e findings formation Quality provement at the the QAPI nitiate any ne review or Skilled nsible for ongoing ts of this ssing and ccur. The d Nursing ensuring rection is		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495269	B. WING	The Thirty of the Control of the Con	08/12/2021
NAME OF PI	ROVIDER OR SUPPLIER		9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH TAYLOR STREET ARLINGTON, VA 22203	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 761 SS=D	CFR(s): 483.45(g)(h) §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of S483.45(h)(1) In accordance in the second professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of S483.45(h)(2) In according in locked temperature controls personnel to have according to the comprehensive In a control in the comprehensive In the comprehensive In a control in the control in	of Drugs and Biologicals is used in the facility must be ewith currently accepted is, and include the y and cautionary expiration date when of Drugs and Biologicals ordance with State and illity must store all drugs and compartments under proper and permit only authorized cess to the keys. Cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit aution systems in which the himal and a missing dose can on, staff interview and facility was determined that the store medications according ards for one of one	F 761	A. With respect to the seresident/situation cited: Two expired vials of Aplisol PPD seresident/situation cited: Two expired vials of Aplisol PPD seresidents/situations with the series of the identification of the identified concer. The DNS or designee will audit arooms, medication carts, and merefrigerators for expired medication confirm appropriate storage and medications and biologicals within decreased. C. With respect to what symeasures have been put into paddress the stated concern: DNS or designee will re-educations of the series of the policy/procedure on: label/store drubiologicals. The DNS or designed conduct a weekly audit on label/store and biologicals for the next 3 months.	ity will the the ns: all med dication ons to use of ate. stemic lace to the and logs and les will e drugs

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE COMPI	
		495269	B. WNG		AND	08/	12/2021
NAME OF PE	ROVIDER OR SUPPLIER ERSON			90	TREET ADDRESS, CITY, STATE, ZIP CODE 30 NORTH TAYLOR STREET RLINGTON, VA 22203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	medication room refr LPN (licensed practic containing one vial of was approximately of written date of 6/10/2 bottle containing one that was approximate written date of 6/10/2 would ask the direct written date meant. It is good for 30 days a stated PPD vials that days should not be use to the pharmacy. On 8/10/21 at 4:21 proconducted with ASM member) #2 (the direct was shown the vials the hand written date vials were opened. It check to see how lost after being opened. On 8/10/21 at 4:36 procalled the pharmacy 30 days once opened vials of PPD solution than 30 days and the The Aplisol PPD solitinstructions docume 30 days should be dispensed.		F	761	D. With respect to how the placorrection will be monitored: Over the next three months, the fifrom DN label/store drugs and biologaudits will be reviewed at Assurance / Performance Improve (QAPI) meetings. During and at conclusion of the three months, the committee will re-evaluate and initial necessary action or extend the period. The Executive Director and/or Nursing Administrator are responsions ensuring implementation and compliance with the components Plan of Correction and addressing resolving variances that may occur executive Director and/or Skilled In Administrator are responsible for each the status of this Plan of Correction and action initiated if required.	indings ogicals Quality vement the QAPI ate any review Skilled ible for ongoing of this and ur. The Nursing ensuring ction is	

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE S COMPL	
		495269	B. WING			08/	12/2021
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH TAYLOR STREET ARLINGTON, VA 22203		0 NORTH TAYLOR STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 761	Continued From page On 8/11/21 at 5:06 p.	m., ASM #1 (the	F	761			
F 814 SS=F	administrator) and AS the above concern. The facility pharmacy guidance documente Aplisol PPD solution, discard unused portion. No further information. Reference: (1) Aplisol PPD solution of tuberculosis (a lunion was obtained from the https://dailymed.nlm. m?setid=1e91a67c-134 Dispose Garbage an CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose properly. This REQUIREMENT by: Based on observation document review, it is facility staff failed to a sanitary manner. On 8/10/21, the facility	medication storage d the following regarding "Date when opened and on after 30 days." n was presented prior to exit. ion is used in the diagnosis g disease). This information e website: nih.gov/dailymed/drugInfo.cf 694-4523-9548-58f7a88711 d Refuse Properly se of garbage and refuse T is not met as evidenced on, staff interview and facility was determined that the dispose of garbage in a	F	814	A. With respect to the spresident/situation cited: The area around the trash compact cleaned at the time of survey and was covered to the extent possible. B. With respect to how the facili identify residents/situations with potential for the identified concern. There is no other trash compactor.	or was I trash ty will h the ns:	09/14/2021
		actor was covered. Multiple lying above the trash.			facility. The Director of Housek reviewed all trash areas within community and grounds to verify thrash was covered	n the	
	On 8/10/21 at 1:25 p	.m., observation of the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495269	B. WING	the second secon	08/12/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH TAYLOR STREET ARLINGTON, VA 22203		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 814	garbage compactor v (other staff member) services). The cover compactor was full a compactor were not observed flying abov OSM #1 stated the fakeep all trash covere full and the housekeet to call the trash compactor. On 8/11/21 at 12:47 conducted with OSM director). OSM #2 stais supposed to comp trash is placed into the moves into the cover OSM #2 was made a observation and statt way to maintain the total stated someone profesore.	was conducted with OSM #1 (the director of dining red portion of the garbage and multiple trash bags in the covered. Multiple flies were re the exposed trash bags. redility staff was not able to red when the compactor was reping department would have repactor company to empty the p.m., an interview was red (the housekeeping staff red the trash every time red portion of the compactor.	F 814	C. With respect to what sysmeasures have been put into planaddress the stated concern: Refresher training will be conduct utility staff by the Dining Secondinator on regarding the need that area around the trash compactor to be from debris with trash covered. It is cleaning process / schedule was reso that the area is checked and cleaning process / schedule was reso that the area is checked and cleaning by dining utility staff. Dining Secondinator/designee will conduct reweekly for the next three months by verify that the area around the compactor is free from debris and the compactor is free from debris and the covered. If an issue is identified, the will be cleaned and the cleaning schwill be re-evaluated. D. With respect to how the placement of the correction will be monitored:	ed for ervices for the pe free The evised eaned s each ervices andom the to trash eash is e area nedule	
	staff member) #1 (the (the director of nursing above concern. The facility policy title documented, "Emploimportance of proper removal aids in pest sanitary conditions. Dumpsters:	oyees will understand the r trash disposal. Proper trash control & maintaining Outdoor Garbage		Over the next three months, the fir from periodic rounds will be review Quality Assurance / Perforr Improvement (QAPI) meetings. Durin at the conclusion of the three month QAPI committee will re-evaluate initiate any necessary action or exter review period. The Executive Director	ved at mance and	
·		when not in use" The policy ecific instructions for the		The Executive Director and Administrator are responsible for en implementation and ongoing comp	0 1	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495269	B. WNG_		08/12/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH TAYLOR STREET ARLINGTON, VA 22203	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI: TAG		HOULD BE COMPLETION
	No further informat Resident Records (CFR(s): 483.20(f)(5) Resident Records (ii) A facility may no resident-identifiable (iii) The facility may resident-identifiable accordance with a agrees not to use except to the extert to do so. §483.70(i) Medical §483.70(i)(1) In acprofessional stand must maintain medithat are- (i) Complete; (ii) Accurately docu (iii) Readily access (iv) Systematically §483.70(i)(2) The all information con regardless of the frecords, except whith (i) To the individual representative who (ii) Required by La (iii) For treatment, operations, as per with 45 CFR 164.5 (iv) For public hean neglect, or domes	ion was presented prior to exit. Identifiable Information Ident-identifiable information. It release information that is a to the public. Ir release information that is a to an agent only in contract under which the agent or disclose the information in the facility itself is permitted records. It records and practices, the facility dical records on each resident umented; Isible; and I organized facility must keep confidential tained in the resident's records, form or storage method of the men release is- I, or their resident ere permitted by applicable law; Iw; I payment, or health care mitted by and in compliance		with the components of the Correction and addressing are variances that may occur. The Director and/or Administrates responsible for ensuring the self-and of Correction is revidiscussed at QAPI meetings initiated if required.	nd resolving e Executive trator are tatus of this riewed and

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE S COMPL	
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NAME OF P	ROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH TAYLOR STREET RLINGTON, VA 22203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	law enforcement purpurposes, research predical examiners, fa serious threat to he by and in compliance §483.70(i)(3) The fact record information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 ye legal age under State §483.70(i)(5) The medical formation of the record of the r	coses, organ donation curposes, or to coroners, uneral directors, and to avert ealth or safety as permitted with 45 CFR 164.512. It is ility must safeguard medical painst loss, destruction, or a required by State law; or the date of discharge when eat in State law; or ars after a resident reaches to law. It is identify the resident; sident's assessments; ive plan of care and services by preadmission screening evaluations and aucted by the State; be's, and other licensed	F	842	A. With respect to the seresident/situation cited: Resident #18: progress notes of the care physician's assessments obtained during survey. Resident #2 discharged to home as planned 08/20/2021. Resident #22, #74 complete assessment of resident #2 need for bed rails and risk for entral were completed on 08/25/2021 documentations of these assessmere obtained on 08/25/2021. Resident #8 was discovered to ALF as planned on 08/12/2021. B. With respect to how the facility identify residents/situations with potential for the identified concern. DNS or designee will audit recovered to verify the wound assess progress notes are obtained maintained in residents medical stimely. DNS or designee will conduct the atthe residents that have bed rail used verify the documentations of resident of the documentations of resident in place.	wound were 20 was ed on : The 22, #74 apment . The sments esident tal on harged ity will th the ns: ords of sician's ssment and records audit of ages to sidents'	09/14/2021

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SL COMPLE	
		495269	B. WNG	ad 10 - mark	08/12	/2021
NAME OF PR	ROVIDER OR SUPPLIER		9	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NORTH TAYLOR STREET ARLINGTON, VA 22203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIED CONTROL OF THE A	D BE	(X5) COMPLETION DATE
F 842	The findings include: 1. The facility staff far physician notes in Resident #18 was ad 3/11/19. Resident #1 were not limited to di disorder and history Resident #18's signif minimum data set as assessment reference resident's cognition at Review of a facility prevealed Resident #1 acquired left heel prefacility acquired right 6/21/21, a facility accinjury on 7/26/21 and toe pressure injury of Further review of Resincluding the paper revealed nursing assinjuries but failed to rephysician's assessment on 8/11/21 at 3:35 pconducted with ASM member) #2 (the direstated the wound phrassessments to the fail information coordinatic is supposed to upload computer each week on 8/11/21 at 3:40 p	illed maintain wound care esident #18's clinical record. Imitted to the facility on 18's diagnoses included but abetes, major depressive of stroke with paralysis. Incant change in status sessment with an exercise date of 6/28/21, coded the as moderately impaired. In the presented with a facility essure injury document as presented with a facility essure injury on 6/21/21, a heel pressure injury on quired right first toe pressure at a facility acquired left first in 8/2/21. In the pressure injury on the wound care ents. In the pressure exercise and electronic record, essments of the pressure everal any of the wound care ents. In an interview was (administrative staff ector of nursing). ASM #2 yesician sends wound care facility secretary (health tor) and the facility secretary at the assessments into the facility. In ASM #2 presented	F 842	C. With respect to what simeasures have been put into paddress the stated concern: Wound care physician will forw progress notes to DNS and detimely; Health Information Coording place the progress notes to remedical record timely. Skilled Administrator or her designees educate the rehab staff and nurser rails usage Policy and Procedures. Moving forward, documentation on notes will be confirmed each weel of the weekly At Risk Meeting. For next three month, the Dir Nursing Services (DNS) or design audit the residents that need becassure the documentation of assignments.	eard the esignees later will esident's Nursing will reson bed f wound as part	
		n assessments for all of				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE S COMPL	
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NAME OF PI	ROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH TAYLOR STREET RLINGTON, VA 22203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 842	On 8/11/21 at 4:41 p. conducted with OSM health information co she files every docun filing bin and she files assessments into the #4 stated the wound for Resident #18 wer bin. On 8/11/21 at 5:06 p. administrator) and As the above concern. care physician was p to the former assistal longer employed but notes to her (ASM #2 On 8/12/21 at 7:42 a could not find a polic and accurate clinical On 8/12/21 at 7:49 a obtained the wound presented on 8/11/2 physician's office on No further informatio 2. The facility staff fa assessment of Resident #20 was according to the risk for entral Resident #20 was according to the risk for entral resident #	ure injuries. The ated 6/28/21, 7/5/21, 6/21, 8/2/21 and 8/9/21. m., an interview was (other staff member) #4 (the ordinator). OSM #4 stated ment that is placed in her is wound care physician apper clinical record. OSM care physician assessments are never placed in her filling. m., ASM #1 (the SM #2 were made aware of ASM #2 stated the wound areviously sending his notes into director who was nothe will now be sending his experience. m., ASM #1 stated she are physician notes in from the wound care grown are physician notes in from the wound care 8/11/21. In was presented prior to exit. illed to document a complete fient #20's need for bed rails	F	842	D. With respect to how the progrection will be monitored: Over the next three months, the from DNS/designees on wound physician's progress notes documentation for bed rails usages will be reviewed at Quality Assur Performance Improvement meetings. During and at the concluthe three months, the QAPI commit re-evaluate and initiate any neaction or extend the review period. The Executive Director and/or Nursing Administrator are responsensuring implementation and compliance with the components Plan of Correction and addressi resolving variances that may occ Executive Director and/or Skilled Administrator are responsible for ethe status of this Plan of Correreviewed and discussed at QAPI mand action initiated if required.	andings care and audits ance / (QAPI) sion of tee will cessary Skilled ible for ongoing of this ng and ur. The Nursing ensuring ction is	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495269	B. WNG			08/	12/2021
NAME OF PE	ROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH TAYLOR STREET RLINGTON, VA 22203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	disease and muscle admission minimum assessment reference resident as being cook Review of Resident at the atterapy communicated documented Resider rails) to help with beet therapy note dated 7 #20 was able to report of halo bars. Further review of Resident assessment that documentation, failed assessment that documentation, failed assessment that documentation and functional abilities reveal assessment of the such as consideration and functional abilities reveal assessment of the such as consideration and functional abilities reveal assessment of the such as consideration and functional abilities reveal assessment of the such as consideration and functional abilities reveal assessment of the such as consideration and functional abilities reveal assessment of the such as the	abetes, chronic kidney weakness. Resident #20's data set assessment with an e date of 7/28/21, coded the gnitively intact. #20's clinical record revealed ation form dated 7/22/21 that th #20 needed halo bars (bed d mobility and transfers. A //29/21 documented Resident esition self in bed with the use sident #20's clinical record, tessments and therapy d to reveal a complete tumented how the facility resident's need for bed rails n of diagnoses, cognition es/limitations and failed to f the risk for entrapment. .m., Resident #20 was d with bilateral bed rails. .m., an interview was I (other staff member) #3, the d person who determined for bed rails. OSM #3 Is do not have bed rails when d. OSM #3 stated after	F	842			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING			SURVEY LETED
		495269	B. WNG			08/1	12/2021
NAME OF PE	ROVIDER OR SUPPLIER	•		9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH TAYLOR STREET .RLINGTON, VA 22203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 842	assessment but he coin his documentation On 8/11/21 at 5:06 p. staff member) #1 (the (the director of nursin above concern. No further information 3. The facility staff far assessment of Resident #22 was act 7/27/21. Resident #2 were not limited to osweakness and heart admission minimum assessment reference resident's cognition at the rapy communication of the rails for upper extrem Further review of Resident #2 at the rapy communication of the rails for upper extrem Further review of Resident #2 at the rapy communication of the rails for upper extrem Further review of Resident #2 at the rapy communication of the rails for upper extrem Further review of Resident #2 at the rapy communication of the rails for upper extrem Further review of Resident #2 assessment that documentation, failed assessment that documentation and functional abilities and functional abilities.	ation did not reflect this could include this information going forward. m., ASM (administrative administrator) and ASM #2 and were made aware of the and was presented prior to exit. It is determined to document a complete ent #22's need for bed rails present. It is diagnoses included but attempt to the facility on exit attempt to the facility of the facility o	F	842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					K3) DATE SURVEY COMPLETED	
		495269	B. WING	B. WNG		08/	12/2021	
NAME OF PI	ROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE DO NORTH TAYLOR STREET RLINGTON, VA 22203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 842	On 8/10/21 at 1:52 p. observed lying in bed On 8/11/21 at 3:52 p. conducted with OSM physical therapist and Resident #22's need stated residents' bed they are first admitted admission, the therapevaluation to determinassist with bed mobil stated that during his necessity for bed rails current functional leven cognitive level and ris stated his documentation on 8/11/21 at 5:06 p. staff member) #1 (the director of nursinabove concern. No further information 4. The facility staff fac	m., Resident #22 was with bilateral bed rails. m., an interview was (other staff member) #3, the deperson who determined for bed rails. OSM #3 so do not have bed rails when d. OSM #3 stated after by staff complete an one if bed rails are needed to ity and transfers. OSM #3 evaluation, he considers the so, residents' diagnoses, el, functional restrictions, so for entrapment. OSM #3 ation did not reflect this could include this information going forward. m., ASM (administrative e administrator) and ASM #2 ong) were made aware of the on was presented prior to exit. illed to document a complete ent #74's need for bed rails	F	842				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495269	B. WNG		and the second s	08/	12/2021
NAME OF PR	ROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH TAYLOR STREET ARLINGTON, VA 22203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	yet been completed a admitted to the facility and Health Assessment of the residual decisions regarding to the bed. Review of Resident #74 in heat the bed. Review of Resident #8 a therapy communicated that documented Resident #74 in heat the bed. Review of Resident #8 a therapy communicated that documented Resident #8 bars (bed rails) to heat transfers. A therapy documented in part, (edge of bed) with us pt's (patient's) independent in part, (edge of bed) with us pt's (patient's) independent in part, including nursing assessment that docstaff determined the such as consideration and functional abilities reveal assessment of the comprehensive documented in part, "Interventions" dated part, "Halo bar for endors and functional abilities and functional abilities reveal assessment of the comprehensive documented in part, "Interventions" dated part, "Halo bar for endors and functional abilities reveal assessment of the comprehensive documented in part, "Interventions" dated part, "Halo bar for endors and functional abilities reveal assessment of the comprehensive documented in part, "Interventions" dated part, "Halo bar for endors and functional abilities reveal assessment of the comprehensive documented in part, "Interventions" dated part, "Halo bar for endors and functional abilities reveal assessment of the comprehensive documented in part, "Interventions" dated part, "Halo bar for endors and functional abilities reveal assessment of the comprehensive documented in part, "Interventions" dated part, "Halo bar for endors and functional abilities reveal assessment of the comprehensive documented in part, "Interventions" dated part, "Halo bar for endors and functional abilities reveal assessment of the comprehensive documented in part, "Interventions" dated part, "Halo bar for endors and the comprehensive documented in part, "Interventions" dated part, "Halo bar for endors and the comprehensive documented in part, "Interventions" dated part and the comprehensive documented in part, "Interventions" dated part and th	ta set) assessments had not as the resident was newly y. The "Service Evaluation ent" dated 8/9/2021 dent had no difficulty with emory. Resident #74 was g independent in making asks of daily living. de on 8/10/2021 at 4:11 p.m. er bed with halo rails up on #74's clinical record revealed ation form dated 8/10/2021 sident #74's needed halo lp with bed mobility and	F	842			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495269	B. WNG		08/12/2021	
NAME OF PROVIDER OR SUPPLIER THE JEFFERSON			9	STREET ADDRESS, CITY, STATE, ZIP CODE 100 NORTH TAYLOR STREET ARLINGTON, VA 22203		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION	
F 842	physical therapist an Resident #74's need stated residents' bed they are first admitted admission, the therapevaluation to determine assist with bed mobilistated that during his necessity for bed rail current functional level cognitive level and ristated his documentated assessment but he continuated in his documentation. On 8/11/21 at 5:06 p staff member) #1 (the director of nursing above concern. No further information. References: (1) Barron's Dictional Non-Medical Reader Chapman, page 138 5. The facility staff facts assessment of Resident #13 was ac 6/25/2021 with a readiagnoses that including fractures of thoracic spine), diabetes, and The most recent MD	d person who determined for bed rails. OSM #3 s do not have bed rails when d. OSM #3 stated after by staff complete an ine if bed rails are needed to ity and transfers. OSM #3 s evaluation, he considers the s, residents' diagnoses, rel, functional restrictions, sk for entrapment. OSM #3 ation did not reflect this ould include this information going forward. .m., ASM (administrative e administrator) and ASM #2 ng) were made aware of the mass presented prior to exit. ry of Medical Terms for the c, 5th edition, Rothenberg and illed to document a complete dent #13's need for bed rails	F 842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495269	B. WING _		01	3/12/2021	
NAME OF PROVIDER OR SUPPLIER THE JEFFERSON				STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH TAYLOR STREET ARLINGTON, VA 22203	Ē		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		SHOULD BE	(X5) COMPLETION DATE	
F 842	assessment reference the resident as scorin interview for mental seresident was moderate cognitive decisions. It Status, the resident wextensive assistance members for moving. Observation was madwith halo rails up on each of the weak of Resident # a therapy communicate that documented Resident parts. A therapy documented in part, for log rolling R (right (bilateral upper extremely bars." Further review of Resident # a therapy documented in part, for log rolling R (right (bilateral upper extremely bars." Further review of Resident # assessment that documentation failed assessment that documentation failed assessment of the comprehensive of the compre	e date of 7/16/2021, coded g a "10" on the BIMS (brief tatus) score, indicating the tely impaired to make daily in Section G - Functional was coded as requiring of one or more staff in the bed. de of Resident #13 in bed, each side, on 8/10/2021 at each side, on 8/10/2021 at each side in the bed mobility and note dated 7/30/2021 each sident #13's needed halo p with bed mobility and note dated 7/30/2021 each sident #13's needed halo p with bed mobility and note dated 7/30/2021 each sident #13's needed halo p with bed mobility and note dated 7/30/2021 each sident #13's clinical record essments and therapy	F 8	42			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	495269	B. WNG	WANTED AND THE STATE OF THE STA	(8/12/2021		
NAME OF PROVIDER OR SUPPLIER THE JEFFERSON			STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH TAYLOR STREET ARLINGTON, VA 22203				
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
physical therapist and Resident #13's need stated residents' beds they are first admitted admission, the therapevaluation to determinassist with bed mobilistated that during his necessity for bed rails current functional lever cognitive level and risstated his documental assessment but he coin his documentation. On 8/11/21 at 5:06 pustaff member) #1 (the director of nursinabove concern. No further information. No further information. Resident #8 was admit 6/28/2021 with diagnous timited to: demental decline, especially in the director of the side and the risk for entrapeditude to: demental decline, especially in the diagnous femur (thigh bone). The most recent MDS assessment, an admit state of the side and the risk for entrapeditude femur (thigh bone).	m., an interview was (other staff member) #3, the d person who determined for bed rails. OSM #3 s do not have bed rails when d. OSM #3 stated after by staff complete an ne if bed rails are needed to ity and transfers. OSM #3 evaluation, he considers the s, residents' diagnoses, el, functional restrictions, sk for entrapment. OSM #3 ation did not reflect this build include this information going forward. m., ASM (administrative e administrator) and ASM #2 ng) were made aware of the m was presented prior to exit. filed to document a complete ent #8's need for bed rails pment. nitted to the facility on oses that included but were tia (- a progressive state of cially memory function and ompanied by disorientation.) ure and fracture of right	F 84:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495269	B. WING		08/12/	/2021
NAME OF PROVIDER OR SUPPLIER THE JEFFERSON				STREET ADDRESS, CITY, STATE, ZIP CODE 900 NORTH TAYLOR STREET ARLINGTON, VA 22203		
(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
F 842	Continued From page 30		F 842	2		
	the resident as scorir interview for mental seresident was severely cognitive decisions. It Status, the resident wextensive assistance moving in the bed. Observation was madwith halo bars on each 8/10/2021 at 1:30 p.m. Review of Resident # therapy communication that documented Resided rails) to help with A therapy note dated part, "bed mob (mobinal A (minimum assist) under the second review of Resident # therapy note dated part, "bed mob (mobinal additional and functional abilities reveal assessment of the comprehensive documented in part, "Interventions" dated part, "Halo bar for en "Intervention" dated in the second resident resident in the second resident r	ag a "7" on the BIMS (brief status) score, indicating the y impaired to make daily in Section G - Functional was coded as requiring of one staff member for the side of the bed, on in and 4:13 p.m. B's clinical record revealed a on form dated 6/29/2021 sident #8's needed halo bars in bed mobility and transfers. 7/7/2021 documented in lity) training, rolling with min sing halo bar."				
	On 8/11/21 at 3:52 p.	m., an interview was (other staff member) #3 the				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/17/2021 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DESICIENCIES

(X1) PROVIDER/SLIPPLIED CLIA

(X2) MILITIPLE CONSTRUCTION

(X3) DATE SLIPVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495269	B. WING			08/12/2021	
NAME OF PROVIDER OR SUPPLIER THE JEFFERSON				STREET ADDRESS, CITY, STATE 900 NORTH TAYLOR STREET ARLINGTON, VA 22203	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 842	physical therapist a Resident #13's ner stated residents' b they are first admit admission, the the evaluation to deter assist with bed mo stated that during a necessity for bed r current functional a cognitive level and stated his docume assessment but he in his documentati On 8/11/21 at 5:06 staff member) #1 ((the director of nur above concern. No further informat References: (1) Barron's Diction	and person who determined ed for bed rails. OSM #3 eds do not have bed rails when ted. OSM #3 stated after rapy staff complete an mine if bed rails are needed to bility and transfers. OSM #3 nis evaluation, he considers the ails, residents' diagnoses, evel, functional restrictions, risk for entrapment. OSM #3 ntation did not reflect this e could include this information on going forward. p.m., ASM (administrative the administrator) and ASM #2 sing) were made aware of the tion was presented prior to exit.	F	842			