STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/10/2021 through 8/12/2021. 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 31 certified bed facility was 24 at the time of the survey. The survey sample consisted of 12 current Resident reviews and five closed record reviews.	F 000	F 000 Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and/or state law	
F 700 SS=E	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	F 700	F 700 **A. With respect to the specific resident/situation cited:** Resident #20 was discharged to home as planned on 08/20/2021. Resident #22: Informed consent for use of bed rails was obtained on 08/11/2021. Resident #74: Informed consent for use of bed rails was obtained on 08/10/2021. Resident #13 was transferred to hospital on 08/24/2021. Resident #8 was discharged to ALF as planned on 08/12/2021. **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** A facility wide audit for Informed consent for use of bed rails will be conducted by designated nursing staff. Any area of concerns will be corrected.	09/14/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: LNHA — (X6) DATE: 08/25/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	08/12/2021

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F 700	Continued From page 1 by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement bed rail requirements for five of 17 residents in the survey sample, Residents #20, #22, #74, #13 and #8. The facility staff failed to obtain informed consent prior to the use of bed rails for Residents #20, #22, #74, #13 and #8. The findings include: 1. The facility staff failed to obtain informed consent for Resident #20's use of bed rails. Resident #20 was admitted to the facility on 7/21/21. Resident #20's diagnoses included but were not limited to diabetes, chronic kidney disease and muscle weakness. Resident #20's admission minimum data set assessment with an assessment reference date of 7/28/21, coded the 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	F 700	**C. With respect to what systemic measures have been put into place to address the stated concern:** Skilled Nursing Administrator or her designees will re-educate the rehab staff and nurses on bed rails usage Policy and Procedures. For next three month, the Director of Nursing Services (DNS) or designees will conduct weekly audits of the residents that need bed rails to verify the Informed Consent for bed rails are obtained prior to the bed rail usage. **D. With respect to how the plan of correction will be monitored:** Over the next three months, the findings from Informed Consent for use of bed rails audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Skilled Nursing Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Skilled Nursing Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.	

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	495269	A. BUILDING _____ B. WING _____	08/12/2021

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F 700	Continued From page 2 the resident's use of bed rails. On 8/10/21 at 1:37 p.m., Resident #20 was observed lying in bed with bilateral bed rails up. On 8/11/21 at 2:37 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated nurses obtain informed consent for residents' use of bed rails. On 8/11/21 at 3:52 p.m., an interview was conducted OSM (other staff member) #3 (the physical therapist). OSM #3 stated he assesses residents for the use of bed rails and writes recommendations but he does not obtain informed consent. On 8/11/21 at 5:06 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility document titled, "Bed Safety Program" documented, "Acknowledgement and Consent for Use of an Assistive Device: If it is determined that the use of an assistive device is appropriate and permitted by state, the Resident Care Director (RCD)/Health Care Manager (HCM) will: Inform the resident and/or legal representative of the potential risks and benefits of using the proposed assistive device. Review the Acknowledgement and Consent for the Use of a Transfer Assistive Device form and obtain the signature of the resident or legal representative acknowledging the risk of using an assist device..." 2. The facility staff failed to obtain informed consent for Resident #22's use of bed rails.	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	08/12/2021

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F 700	Continued From page 3	F 700		

Resident #22 was admitted to the facility on 7/27/21. Resident #22's diagnoses included but were not limited to osteoporosis, muscle weakness and heart disease. Resident #22's admission minimum data set assessment with an assessment reference date of 8/3/21, coded the resident's cognition as moderately impaired.

Review of Resident #22's clinical record revealed a therapy communication form dated 7/29/21 that documented Resident #22 needed halo bars (bed rails) for safe mobility.

Resident #22'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 #22's clinical record failed to reveal informed consent was obtained for the resident's use of bed rails.

On 8/10/21 at 1:52 p.m., Resident #22 was observed lying in bed with bilateral bed rails up.

On 8/11/21 at 2:37 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated nurses obtain informed consent for residents' use of bed rails.

On 8/11/21 at 3:52 p.m., an interview was conducted OSM (other staff member) #3 (the physical therapist). OSM #3 stated he assesses residents for the use of bed rails and writes recommendations but he does not obtain informed consent.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 700	Continued From page 4 On 8/11/21 at 5:06 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. 3. The facility staff failed to obtain a consent for the use of halo bed rails, for Resident #74. Resident #74 was admitted to the facility on 8/9/2021. Resident #74's diagnoses included but were not limited to diabetes, congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) (1), high blood pressure, and low back pain. A MDS (minimum data set) assessment had not been completed as the resident was newly admitted to the facility. The "Service Evaluation and Health Assessment" dated 8/9/2021 documented the resident had no difficulty with short or long-term memory. Resident #74 was documented as being independent in making decisions regarding tasks of daily living. In the Section, "ADL (activities of daily living) Assessment (nursing); bed mobility," The form documented, "Bed Mobility assistive devices needed, "Yes" was checked. "Select All that Apply," a check mark was documented next to, "bed mobility enabler/halo." Observation was made on 8/10/2021 at 4:11 p.m. of Resident #74 in her bed with halo rails on the bed up. Review of Resident #74's clinical record revealed a therapy communication form dated 8/10/2021 that documented Resident #74's needed halo bars (bed rails) to help with bed mobility and transfers. A therapy note dated 8/11/2021	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 700	Continued From page 5	F 700		

documented in part, "Resident #74 is up at EOB (edge of bed) with use of hallo bars to increase pt's (patient's) independence/safety in bed mobility." Further review of Resident #74's clinical record failed to evidence a consent for the use of the bed rails.

Resident #74 had a physician order dated 8/11/2021 for "Attach bilateral halo bars to encourage independence during bed mobility."

The comprehensive care plan dated, 8/10/2021, documented in part, "Focus: Bed mobility." The "Interventions" dated, 8/11/2021, documented in part, "Halo bar for enhanced bed mobility."

On 8/11/2021 at 10:54 a.m., ASM (administrative staff member) #2, the director of nursing, presented a documented titled, "Acknowledgement and Consent for the Use of a Transfer Assistive Device." This form had Resident #74's name and the date of 8/10/2021.

An interview was conducted with ASM #1, the administrator, on 8/11/2021 at 11:33 a.m. When asked about bed rails, ASM #1 stated all beds don't have side rails. If someone needs one, that is initiated by therapy. Therapy does the evaluation and assessment. Then they write an order for them [bed rails]. The nursing department then calls engineering department and the engineering department would put them on.

An interview was conducted with LPN (licensed practical nurse) #2 on 8/11/2021 at 2:37 p.m., regarding the role a nurse plays in doing an assessment or obtaining a consent for the use of bed rails. LPN #2 stated, "The residents don't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 700	Continued From page 6	F 700		

have bedrails unless necessary. We need a physician order for them for residents who are high risk for falls." When asked how the nurse knows the resident needs the rails, LPN #2 stated, "We do an assessment, a side rail assessment." When asked where that assessment is located, LPN #2 stated it's in the computer. LPN #2 stated, "When an admission comes in, the nurse does a bed rail or bar assessment and if at that time they don't need it then the nurses don't bring it up to the doctor. If at a later time, the nurse feels the resident would need them, then we get an order from the doctor." When asked if they get consent from the resident or the responsible party for the use of the rails, LPN #2 stated, "When we get the order, if the resident is not alert or cannot give consent we get consent." LPN #2 was asked if staff fill in a consent form at that time, LPN #2 stated, "I'm sure there is a consent form." When asked where the assessment is located, LPN #2 stated, "it's on the admission assessment as one of the 12 sections to complete."

An interview was conducted with OSM (other staff member) #3, the physical therapist, on 8/11/2021 at 3:52 p.m. When asked if therapy has a role in obtaining the consent for the use of the bed rails, OSM #3 stated no.

ASM #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concerns on 8/11/2021 at 5:06 p.m.

No further information was obtained prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 700	Continued From page 7 Chapman, page 138. 4. The facility staff failed to obtain a consent for the use of bed rails, halo rails, for Resident #13. Resident #13 was admitted to the facility on 6/25/2021 with a readmission on 7/9/2021, with diagnoses that included but were not limited to: fractures of thoracic vertebra (bones in the spine), diabetes, and high blood pressure. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 7/16/2021, coded the resident as scoring a "10" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one or more staff members for moving in the bed. Observation was made of Resident #13 in bed, with halo rails on each side, on 8/10/2021 at 4:12 p.m. Review of Resident #13's clinical record revealed a therapy communication form dated 7/13/2021 that documented Resident #13's needed halo bars (bed rails) to help with bed mobility and transfers. A therapy note dated 7/30/2021 documented in part, "Max (maximum) A (assist) for log rolling R (right) and L (left) with BUE (bilateral upper extremities) supported on halo bars." Further review of Resident #13's clinical record failed to evidence a consent for the use of side rails/halo rails.	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 700	Continued From page 8	F 700		

The "Service Evaluation and Health Assessment" form dated 6/25/2021, documented, "Bed Mobility assistive devices needed, a "No" was checked.

Resident #8 had a physician order dated 8/11/2021 that documented, "Resident to use bilateral halo bars for safe bed mobility and transfers."

The comprehensive care plan dated, 6/26/2021, documented in part, "Focus: Bed mobility." The "Interventions" dated, 7/9/2021, documented in part, "Remind and encourage me to use my enabler/device when repositioning in bed, has halo bars."

On 8/11/2021 at 10:54 a.m., ASM (administrative staff member) #2, the director of nursing, presented a document titled, "Acknowledgement and Consent for the Use of a Transfer Assistive Device." This form had Resident #74's name and the date of 8/10/2021.

An interview was conducted with ASM #1, the administrator, on 8/11/2021 at 11:33 a.m. When asked about bed rails, ASM #1 stated all beds don't have side rails. If someone needs one, that is initiated by therapy. Therapy does the evaluation and assessment. Then they write an order for them. The nursing department then calls the engineering department and the engineering department would put them on.

An interview was conducted with LPN (licensed practical nurse) #2 on 8/11/2021 at 2:37 p.m., regarding the role a nurse plays in doing an assessment or obtaining a consent for the use of bed rails. LPN #2 stated, "The residents don't have bedrails unless necessary. We need a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE JEFFERSON	900 NORTH TAYLOR STREET ARLINGTON, VA 22203

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F 700	Continued From page 9	F 700		

physician order for them for residents who are high risk for falls." When asked how the nurse knows the resident needs the rails, LPN #2 stated, "We do an assessment, a side rail assessment." When asked where that assessment is located, LPN #2 stated it's in the computer. LPN #2 stated, "When an admission comes in, the nurse does a bed rail or bar assessment and if at that time they don't need it then the nurses don't bring it up to the doctor. If at a later time, the nurse feels the resident would need them, then we get an order from the doctor." When asked if they get consent from the resident or the responsible party for the use of the rails, LPN #2 stated, "When we get the order, if the resident is not alert or cannot give consent we get consent." LPN #2 was asked if staff fill in a consent form at that time, LPN #2 stated, "I'm sure there is a consent form. When asked where the assessment is located, LPN #2 stated it's on the admission assessment as one of the 12 sections to complete."

An interview was conducted with OSM (other staff member) #3, the physical therapist, on 8/11/2021 at 3:52 p.m. When asked if therapy has a role in obtaining the consent for the use of the bed rails, OSM #3 stated no.

ASM #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concerns on 8/11/2021 at 5:06 p.m.

No further information was obtained prior to exit.

5. The facility staff failed to obtain a consent for the use of bed rails, halo rails, for Resident #8.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	08/12/2021

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THE JEFFERSON	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 700	Continued From page 10	F 700		

Resident #8 was admitted to the facility on 6/28/2021 with diagnoses that included but were not limited to: dementia (- a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation.) (1), high blood pressure and fracture of right femur (thighbone).

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 7/5/2021, coded the resident as scoring a "7" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for moving in the bed.

Observation was made of Resident #8 in bed, with halo bars up on each side of the bed, on 8/10/2021 at 1:30 p.m. and 4:13 p.m.

Review of Resident #8's clinical record revealed a therapy communication form dated 6/29/2021 that documented Resident #8's needed halo bars (bed rails) to help with bed mobility and transfers. A therapy note dated 7/7/2021 documented in part, "bed mob (mobility) training, rolling with min A (minimum assist) using halo bar." Further review of Resident #8's clinical record failed to evidence a consent for the use of side rails/halo rails.

The "Service Evaluation and Health Assessment" form dated 6/28/2021, documented, "Bed Mobility assistive devices needed, a "No" was checked.

Resident #13 had a physician order dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JEFFERSON	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 700	Continued From page 11	F 700		

7/9/2021 that documented," Halo bar for enhanced bed mobility."

The comprehensive care plan dated, 6/29/2021, documented in part, "Focus: Bed mobility." The "Interventions" dated, 8/10/2021, documented in part, "Halo bar for enhanced bed mobility." The "Intervention" dated 8/10/2021, documented, "Resident requires one person physical assist for bed mobility."

On 8/11/2021 at 10:54 a.m., ASM (administrative staff member) #2, the director of nursing, presented a documented entitled, "Acknowledgement and Consent for the Use of a Transfer Assistive Device." This form had Resident #8's name and the date of 8/10/2021.

An interview was conducted with ASM #1, the administrator, on 8/11/2021 at 11:33 a.m. When asked about bed rails, ASM #1 stated all beds don't have side rails. If someone needs one, that is initiated by therapy. Therapy does the evaluation and assessment. Then they write an order for them. The nursing department then calls the engineering department and the engineering department would put them on.

An interview was conducted with LPN (licensed practical nurse) #2 on 8/11/2021 at 2:37 p.m., regarding the role a nurse plays in doing an assessment or obtaining a consent for the use of bed rails. LPN #2 stated, "The residents don't have bedrails unless necessary. We need a physician order for them for residents who are high risk for falls." When asked how the nurse knows the resident needs the rails, LPN #2 stated, "We do an assessment, a side rail assessment." When asked where that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495269	A. BUILDING _____ B. WING _____	08/12/2021

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(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 700	Continued From page 12 assessment is located, LPN #2 stated it's in the computer. LPN #2 stated, "When an admission comes in, the nurse does a bed rail or bar assessment and if at that time they don't need it then the nurses don't bring it up to the doctor. If at a later time, the nurse feels the resident would need them, then we get an order from the doctor." When asked if they get consent from the resident or the responsible party for the use of the rails, LPN #2 stated, "When we get the order, if the resident is not alert or cannot give consent we get consent." LPN #2 was asked if staff fill in a consent form at that time, LPN #2 stated, "I'm sure there is a consent form." When asked where the assessment is located, LPN #2 stated, "it's on the admission assessment as one of the 12 sections to complete." An interview was conducted with OSM (other staff member) #3, the physical therapist, on 8/11/2021 at 3:52 p.m. When asked if therapy has a role in obtaining the consent for the use of the bed rails, OSM #3 stated no. ASM #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concerns on 8/11/2021 at 5:06 p.m. No further information was obtained prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 700		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information.	F 732		

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	495269	A. BUILDING _____ B. WING _____	08/12/2021

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F 732	Continued From page 13 §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the	F 732	F 732 **A. With respect to the specific resident/situation cited:** 08/10/2021 Nursing Staffing was posted on the evening of 08/10/2021. **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** On 08/10/2021 evening, Director of Nursing Services (DNS)and Administrator printed out 11th, 12th of 2021 Nursing Staffing ready to be posted. On 08/11/2021 morning, the Nursing Staffing was confirmed and posted accordingly. The DNS and Administrator reviewed the record of daily staffing information to confirm that records are maintained accordingly. **C. With respect to what systemic measures have been put into place to address the stated concern:** Moving forward, the posting of the daily staffing will occur before the morning meeting and will be confirmed by a member of the leadership team in attendance or designee immediately post meeting.	09/14/2021

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F 732	Continued From page 14 facility staff failed to post current nurse staffing information. Nurse staffing information for 8/10/21 was not posted on 8/10/21. Instead, nurse staffing information for 8/8/21 was posted. The findings include: On 8/10/21 at 11:55 a.m. and 4:09 p.m., observation of the nurse staffing information posted across from the unit nurse's station was conducted. The nurse staffing information was dated 8/8/21 and contained staffing information for that date. On 8/10/21 at 4:59 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 stated she and the director of nursing were responsible for posting the daily nurse staffing information. ASM #1 stated she had printed out a copy of the daily nurse staffing information and discussed the information at the morning meeting but she and the director of nursing had been busy and the nurse staffing information for 8/10/21 was not posted. On 8/11/21 at 5:06 p.m., ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Posting of Daily Nurse Staffing Data" documented, "It is the community's policy to post daily staffing of direct care nursing personnel per CMS (Centers for Medicare and Medicaid Services) requirements, and to maintain a record of the daily posted staffing." No further information was presented prior to exit.	F 732	**D. With respect to how the plan of correction will be monitored:** Over the next three months, the findings from Posted Nursing Staffing Information audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Skilled Nursing Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Skilled Nursing Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.	

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F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store medications according to professional standards for one of one medication room. Two expired vials of Aplisol PPD (purified protein derivative) solution (1) was stored in the medication room refrigerator available for resident use.	F 761	F 761 **A. With respect to the specific resident/situation cited:** Two expired vials of Aplisol PPD solution Were disposed of upon identification on 8/10/2021 **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** The DNS or designee will audit all med rooms, medication carts, and medication refrigerators for expired medications to confirm appropriate storage and use of medications and biologicals within date. **C. With respect to what systemic measures have been put into place to address the stated concern:** DNS or designee will re-educate the nurses regarding requirement and policy/procedure on: label/store drugs and biologicals. The DNS or designees will conduct a weekly audit on label/store drugs and biologicals for the next 3 months	09/14/2021

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F 761	Continued From page 16 The findings include: On 8/10/21 at 3:59 p.m., observation of the medication room refrigerator was conducted with LPN.(licensed practical nurse) #1. A plastic bottle containing one vial of opened PPD solution that was approximately one eighth full had a hand written date of 6/10/21 on in. Another plastic bottle containing one vial of opened PPD solution that was approximately half full had a hand written date of 6/10/21 on it. LPN #1 stated she would ask the director of nursing what the hand written date meant. LPN #1 stated PPD solution is good for 30 days after being opened. LPN #1 stated PPD vials that are open for more than 30 days should not be used and should be returned to the pharmacy. On 8/10/21 at 4:21 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was shown the vials of PPD solution and stated the hand written date of 6/10/21 was the date the vials were opened. ASM #2 stated she would check to see how long PPD solution is good for after being opened. On 8/10/21 at 4:36 p.m., ASM #2 stated she called the pharmacy and PPD solution is good for 30 days once opened. ASM #2 stated the two vials of PPD solution had been open for more than 30 days and the vials would be discarded. The Aplisol PPD solution manufacturer's instructions documented, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..."	F 761	**D. With respect to how the plan of correction will be monitored:** Over the next three months, the findings from DN label/store drugs and biologicals audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Skilled Nursing Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Skilled Nursing Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.	

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F 761	Continued From page 17 On 8/11/21 at 5:06 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility pharmacy medication storage guidance documented the following regarding Aplisol PPD solution, "Date when opened and discard unused portion after 30 days." No further information was presented prior to exit. Reference: (1) Aplisol PPD solution is used in the diagnosis of tuberculosis (a lung disease). This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1e91a67c-1694-4523-9548-58f7a8871134	F 761		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. 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 dispose of garbage in a sanitary manner. On 8/10/21, the facility staff failed to ensure trash in the garbage compactor was covered. Multiple flies were observed flying above the trash. The findings include: On 8/10/21 at 1:25 p.m., observation of the	F 814	F 814 **A. With respect to the specific resident/situation cited:** The area around the trash compactor was cleaned at the time of survey and trash was covered to the extent possible. **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** There is no other trash compactor for the facility. The Director of Housekeeping reviewed all trash areas within the community and grounds to verify that all trash was covered	09/14/2021

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F 814	Continued From page 18 garbage compactor was conducted with OSM (other staff member) #1 (the director of dining services). The covered portion of the garbage compactor was full and multiple trash bags in the compactor were not covered. Multiple flies were observed flying above the exposed trash bags. OSM #1 stated the facility staff was not able to keep all trash covered when the compactor was full and the housekeeping department would have to call the trash compactor company to empty the compactor. On 8/11/21 at 12:47 p.m., an interview was conducted with OSM #2 (the housekeeping director). OSM #2 stated the housekeeping staff is supposed to compact the trash every time trash is placed into the compactor so the trash moves into the covered portion of the compactor. OSM #2 was made aware of the above observation and stated this was not the proper way to maintain the trash compactor. OSM #2 stated someone probably did not press the button to compact the trash and he needed to educate his staff. On 8/11/21 at 5:06 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Trash Disposal" documented, "Employees will understand the importance of proper trash disposal. Proper trash removal aids in pest control & maintaining sanitary conditions. Outdoor Garbage Dumpsters: Keep doors closed when not in use..." The policy did not document specific instructions for the trash compactor.	F 814	**C. With respect to what systemic measures have been put into place to address the stated concern:** Refresher training will be conducted for utility staff by the Dining Services Coordinator on regarding the need for the area around the trash compactor to be free from debris with trash covered. The cleaning process / schedule was revised so that the area is checked and cleaned daily by housekeeping and two times each day by dining utility staff. Dining Services Coordinator/designee will conduct random weekly for the next three months by the to verify that the area around the trash compactor is free from debris and trash is covered. If an issue is identified, the area will be cleaned and the cleaning schedule will be re-evaluated. **D. With respect to how the plan of correction will be monitored:** Over the next three months, the findings from periodic rounds will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Administrator are responsible for ensuring implementation and ongoing compliance	

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F 814	Continued From page 19 No further information was presented prior to exit.	F 814	with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 842		

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F 842	Continued From page 20 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for six of 17 residents in the survey sample, Residents #18, #20, #22, #74, #13 and #8.	F 842	F 842 **A. With respect to the specific resident/situation cited:** Resident #18: progress notes of the wound care physician's assessments were obtained during survey. Resident #20 was discharged to home as planned on 08/20/2021. Resident #22, #74: The complete assessment of resident # 22, #74 need for bed rails and risk for entrapment were completed on 08/25/2021. The documentations of these assessments were obtained on 08/25/2021. Resident #13 was transferred to hospital on 08/24/2021. Resident #8 was discharged to ALF as planned on 08/12/2021. **B. With respect to how the facility will identify residents/situations with the potential for the identified concerns:** DNS or designee will audit records of residents that are under wound physician's care to verify the wound assessment progress notes are obtained and maintained in residents medical records timely. DNS or designee will conduct the audit of the residents that have bed rail usages to verify the documentations of residents' need for bed rails and risk for entrapment are in place.	09/14/2021

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F 842	Continued From page 21 The findings include: 1. The facility staff failed maintain wound care physician notes in Resident #18's clinical record. Resident #18 was admitted to the facility on 3/11/19. Resident #18's diagnoses included but were not limited to diabetes, major depressive disorder and history of stroke with paralysis. Resident #18's significant change in status minimum data set assessment with an assessment reference date of 6/28/21, coded the resident's cognition as moderately impaired. Review of a facility pressure injury document revealed Resident #18 presented with a facility acquired left heel pressure injury on 6/21/21, a facility acquired right heel pressure injury on 6/21/21, a facility acquired right first toe pressure injury on 7/26/21 and a facility acquired left first toe pressure injury on 8/2/21. Further review of Resident #18's clinical record, including the paper record and electronic record, revealed nursing assessments of the pressure injuries but failed to reveal any of the wound care physician's assessments. On 8/11/21 at 3:35 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated the wound physician sends wound care assessments to the facility secretary (health information coordinator) and the facility secretary is supposed to upload the assessments into the computer each week. On 8/11/21 at 3:40 p.m., ASM #2 presented wound care physician assessments for all of	F 842	**C. With respect to what systemic measures have been put into place to address the stated concern:** Wound care physician will forward the progress notes to DNS and designees timely; Health Information Coordinator will place the progress notes to resident's medical record timely. Skilled Nursing Administrator or her designees will re-educate the rehab staff and nurses on bed rails usage Policy and Procedures. Moving forward, documentation of wound notes will be confirmed each week as part of the weekly At Risk Meeting. For next three month, the Director of Nursing Services (DNS) or designees will audit the residents that need bed rails to assure the documentation of assessment	

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F 842	Continued From page 22 Resident #18's pressure injuries. The assessments were dated 6/28/21, 7/5/21, 7/12/21, 7/19/21, 7/26/21, 8/2/21 and 8/9/21. On 8/11/21 at 4:41 p.m., an interview was conducted with OSM (other staff member) #4 (the health information coordinator). OSM #4 stated she files every document that is placed in her filing bin and she files wound care physician assessments into the paper clinical record. OSM #4 stated the wound care physician assessments for Resident #18 were never placed in her filing bin. On 8/11/21 at 5:06 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. ASM #2 stated the wound care physician was previously sending his notes to the former assistant director who was no longer employed but he will now be sending his notes to her (ASM #2). On 8/12/21 at 7:42 a.m., ASM #1 stated she could not find a policy for maintaining a complete and accurate clinical record. On 8/12/21 at 7:49 a.m., ASM #2 stated she obtained the wound care physician notes presented on 8/11/21 from the wound care physician's office on 8/11/21. No further information was presented prior to exit. 2. The facility staff failed to document a complete assessment of Resident #20's need for bed rails and the risk for entrapment. Resident #20 was admitted to the facility on 7/21/21. Resident #20's diagnoses included but	F 842	**D. With respect to how the plan of correction will be monitored:** Over the next three months, the findings from DNS/designees on wound care physician's progress notes and documentation for bed rails usages audits will be reviewed at Quality Assurance / Performance Improvement (QAPI) meetings. During and at the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period. The Executive Director and/or Skilled Nursing Administrator are responsible for ensuring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur. The Executive Director and/or Skilled Nursing Administrator are responsible for ensuring the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated if required.	

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(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 23 were not limited to diabetes, chronic kidney disease and muscle weakness. Resident #20's admission minimum data set assessment with an assessment reference date of 7/28/21, coded the 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. A therapy note dated 7/29/21 documented Resident #20 was able to reposition self in bed with the use of halo bars. Further review of Resident #20's clinical record, including nursing assessments and therapy documentation, failed to reveal a complete assessment that documented how the facility staff determined the resident's need for bed rails such as consideration of diagnoses, cognition and functional abilities/limitations and failed to reveal assessment of the risk for entrapment. On 8/10/21 at 1:37 p.m., Resident #20 was observed lying in bed with bilateral bed rails. On 8/11/21 at 3:52 p.m., an interview was conducted with OSM (other staff member) #3, the physical therapist and person who determined Resident #20's need for bed rails. OSM #3 stated residents' beds do not have bed rails when they are first admitted. OSM #3 stated after admission, the therapy staff complete an evaluation to determine if bed rails are needed to assist with bed mobility and transfers. OSM #3 stated that during his evaluation, he considers the necessity for bed rails, residents' diagnoses, current functional level, functional restrictions, cognitive level and risk for entrapment. OSM #3	F 842		

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	495269	A. BUILDING _____ B. WING _____	08/12/2021

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F 842	Continued From page 24 stated his documentation did not reflect this assessment but he could include this information in his documentation going forward. On 8/11/21 at 5:06 p.m., ASM (administrative staff member) #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. 3. The facility staff failed to document a complete assessment of Resident #22's need for bed rails and the risk for entrapment. Resident #22 was admitted to the facility on 7/27/21. Resident #22's diagnoses included but were not limited to osteoporosis, muscle weakness and heart disease. Resident #22's admission minimum data set assessment with an assessment reference date of 8/3/21, coded the resident's cognition as moderately impaired. Review of Resident #22's clinical record revealed a therapy communication form dated 7/29/21 that documented Resident #22 needed halo bars (bed rails) for safe mobility. A therapy note dated 7/29/21 documented Resident #22 utilized bed rails for upper extremity support. Further review of Resident #22's clinical record including nursing assessments and therapy documentation, failed to reveal a complete assessment that documented how the facility staff determined the resident's need for bed rails such as consideration of diagnoses, cognition and functional abilities/limitations and failed to reveal assessment of the risk for entrapment.	F 842		

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	495269	A. BUILDING _____ B. WING _____	08/12/2021

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F 842	Continued From page 25 On 8/10/21 at 1:52 p.m., Resident #22 was observed lying in bed with bilateral bed rails. On 8/11/21 at 3:52 p.m., an interview was conducted with OSM (other staff member) #3, the physical therapist and person who determined Resident #22's need for bed rails. OSM #3 stated residents' beds do not have bed rails when they are first admitted. OSM #3 stated after admission, the therapy staff complete an evaluation to determine if bed rails are needed to assist with bed mobility and transfers. OSM #3 stated that during his evaluation, he considers the necessity for bed rails, residents' diagnoses, current functional level, functional restrictions, cognitive level and risk for entrapment. OSM #3 stated his documentation did not reflect this assessment but he could include this information in his documentation going forward. On 8/11/21 at 5:06 p.m., ASM (administrative staff member) #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. 4. The facility staff failed to document a complete assessment of Resident #74's need for bed rails and the risk for entrapment. Resident #74 was admitted to the facility on 8/9/2021. Resident #74's diagnoses included but were not limited to diabetes, congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) (1), high blood pressure, and low back pain.	F 842		

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F 842	Continued From page 26 A MDS (minimum data set) assessments had not yet been completed as the resident was newly admitted to the facility. The "Service Evaluation and Health Assessment" dated 8/9/2021 documented the resident had no difficulty with short or long term memory. Resident #74 was documented as being independent in making decisions regarding tasks of daily living. Observation was made on 8/10/2021 at 4:11 p.m. of Resident #74 in her bed with halo rails up on the bed. Review of Resident #74's clinical record revealed a therapy communication form dated 8/10/2021 that documented Resident #74's needed halo bars (bed rails) to help with bed mobility and transfers. A therapy note dated 8/11/2021 documented in part, "Resident #74 is up at EOB (edge of bed) with use of hallo bars to increase pt's (patient's) independence/safety in bed mobility." Further review of Resident #74's clinical record including nursing assessments and therapy documentation, failed to reveal a complete assessment that documented how the facility staff determined the resident's need for bed rails, such as consideration of diagnoses, cognition and functional abilities/limitations and failed to reveal assessment of the risk for entrapment. The comprehensive care plan dated, 8/10/2021, documented in part, "Focus: Bed mobility." The "Interventions" dated, 8/11/2021, documented in part, "Halo bar for enhanced bed mobility." On 8/11/21 at 3:52 p.m., an interview was conducted with OSM (other staff member) #3, the	F 842		

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F 842	Continued From page 27 physical therapist and person who determined Resident #74's need for bed rails. OSM #3 stated residents' beds do not have bed rails when they are first admitted. OSM #3 stated after admission, the therapy staff complete an evaluation to determine if bed rails are needed to assist with bed mobility and transfers. OSM #3 stated that during his evaluation, he considers the necessity for bed rails, residents' diagnoses, current functional level, functional restrictions, cognitive level and risk for entrapment. OSM #3 stated his documentation did not reflect this assessment but he could include this information in his documentation going forward. On 8/11/21 at 5:06 p.m., ASM (administrative staff member) #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) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138. 5. The facility staff failed to document a complete assessment of Resident #13's need for bed rails and the risk for entrapment. Resident #13 was admitted to the facility on 6/25/2021 with a readmission on 7/9/2021, with diagnoses that included but were not limited to: fractures of thoracic vertebra (bones in the spine), diabetes, and high blood pressure. The most recent MDS (minimum data set) assessment, an admission assessment, with an	F 842		

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F 842	Continued From page 28 assessment reference date of 7/16/2021, coded the resident as scoring a "10" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one or more staff members for moving in the bed. Observation was made of Resident #13 in bed, with halo rails up on each side, on 8/10/2021 at 4:12 p.m. Review of Resident #13's clinical record revealed a therapy communication form dated 7/13/2021 that documented Resident #13's needed halo bars (bed rails) to help with bed mobility and transfers. A therapy note dated 7/30/2021 documented in part, "Max (maximum) A (assist) for log rolling R (right) and L (left) with BUE (bilateral upper extremities) supported on halo bars." Further review of Resident #13's clinical record including nursing assessments and therapy documentation failed to reveal a complete assessment that documented how the facility staff determined the resident's need for bed rails, such as consideration of diagnoses, cognition and functional abilities/limitations and failed to reveal assessment of the risk for entrapment. The comprehensive care plan dated, 6/26/2021, documented in part, "Focus: Bed mobility." The "Interventions" dated, 7/9/2021, documented in part, "Remind and encourage me to use my enabler/device when repositioning in bed, had halo bars."	F 842		

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F 842	Continued From page 29 On 8/11/21 at 3:52 p.m., an interview was conducted with OSM (other staff member) #3, the physical therapist and person who determined Resident #13's need for bed rails. OSM #3 stated residents' beds do not have bed rails when they are first admitted. OSM #3 stated after admission, the therapy staff complete an evaluation to determine if bed rails are needed to assist with bed mobility and transfers. OSM #3 stated that during his evaluation, he considers the necessity for bed rails, residents' diagnoses, current functional level, functional restrictions, cognitive level and risk for entrapment. OSM #3 stated his documentation did not reflect this assessment but he could include this information in his documentation going forward. On 8/11/21 at 5:06 p.m., ASM (administrative staff member) #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. 6. The facility staff failed to document a complete assessment of Resident #8's need for bed rails and the risk for entrapment. Resident #8 was admitted to the facility on 6/28/2021 with diagnoses that included but were not limited to: dementia (- a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation.) (1), high blood pressure and fracture of right femur (thigh bone). The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 7/5/2021, coded	F 842		

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F 842	Continued From page 30	F 842		

the resident as scoring a "7" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for moving in the bed.

Observation was made of Resident #8 in bed, with halo bars on each side of the bed, on 8/10/2021 at 1:30 p.m. and 4:13 p.m.

Review of Resident #8's clinical record revealed a therapy communication form dated 6/29/2021 that documented Resident #8's needed halo bars (bed rails) to help with bed mobility and transfers. A therapy note dated 7/7/2021 documented in part, "bed mob (mobility) training, rolling with min A (minimum assist) using halo bar."

Further review of Resident #8's clinical record including nursing assessments and therapy documentation failed to reveal a complete assessment that documented how the facility staff determined the resident's need for bed rails, such as consideration of diagnoses, cognition and functional abilities/limitations and failed to reveal assessment of the risk for entrapment.

The comprehensive care plan dated, 6/29/2021, documented in part, "Focus: Bed mobility." The "Interventions" dated, 8/10/2021, documented in part, "Halo bar for enhanced bed mobility." The "Intervention" dated 8/10/2021, documented, "Resident requires one person physical assist for bed mobility."

On 8/11/21 at 3:52 p.m., an interview was conducted with OSM (other staff member) #3 the

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F 842	Continued From page 31 physical therapist and person who determined Resident #13's need for bed rails. OSM #3 stated residents' beds do not have bed rails when they are first admitted. OSM #3 stated after admission, the therapy staff complete an evaluation to determine if bed rails are needed to assist with bed mobility and transfers. OSM #3 stated that during his evaluation, he considers the necessity for bed rails, residents' diagnoses, current functional level, functional restrictions, cognitive level and risk for entrapment. OSM #3 stated his documentation did not reflect this assessment but he could include this information in his documentation going forward. On 8/11/21 at 5:06 p.m., ASM (administrative staff member) #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) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 842		