STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/10/20 through 3/12/20. The facility was in substantial compliance with 42 CFR Part 483.73, (emergency preparedness) Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/10/2020 through 03/12/2020. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 68 certified bed facility was 42 at the time of the survey. The survey sample consisted of 18 resident reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to uphold the resident right to self-administer medication for one resident (Resident #28) in a sample size of 18 residents. The findings included: For Resident #28, the facility staff failed to honor	F 554		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/31/2021

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
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 554	Continued From page 1 her right to self-administer her combivent inhaler and keep it at her bedside. Resident #28, an 89-year old female, was admitted to the facility on 02/11/2020. Diagnoses included but not limited to unspecified displaced fracture of surgical neck of left humerus, chronic obstructive pulmonary disease, and congestive heart failure. Resident #28's Minimum Data Set with an Assessment Reference Date of 02/18/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition. Functional status for dressing and personal hygiene were coded as requiring extensive assistance from staff. Eating was coded as requiring supervision - oversight, encouragement or cueing from staff. On 03/10/2020 at approximately 3:15 PM, Resident #28 was observed in her room, seated in her wheelchair. When asked if she had any concerns about the care she receives at the facility, Resident #28 stated that she wants to keep her inhaler with her. Resident #28 also stated that she "told the nurses" but they won't let her keep it with her. There was no inhaler observed on her bedside table or tray table. On 03/11/2020, the physician's orders were reviewed. An order dated 03/05/2020 at 11:00AM documented, "Combivent Inh [inhaler] - allow pt. [patient] to keep at bedside for self admin." On 03/12/2020 at 9:20 AM, Resident #28 was observed in her room seated in her wheelchair. When asked if she had her inhaler, Resident #28	F 554		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 554	Continued From page 2	F 554		

stated that she still didn't have her inhaler and stated that "the nurses keep it out there (motioning toward the hall)." There was no inhaler observed on tray table or bedside table in the room.

On 03/12/2020 at 9:25 AM, an interview with the nurse caring for Resident #28, Licensed Practical Nurse C (LPN C), was conducted. When asked if Resident #28 was allowed to keep her inhaler at her bedside, LPN C stated the [Resident #28] would not be able to do that "unless we have an order." When asked if Resident #28 had a self-administration assessment completed, LPN C stated, "not that I know of." LPN C then obtained the hard chart to review the physician orders. LPN C also reviewed Resident #28's Medication Administration Record (MAR). LPN C stated that the order to allow her to keep her inhaler at bedside is not listed on the MAR. LPN C then stated she would "look into it."

On 03/12/2020 at approximately 9:45 AM, the DON was notified of findings and a copy of their self-administration policy and a copy of [Resident #28]'s self-administration assessment were requested.

The facility staff provided a copy of their policy entitled, "Self Administration of Medications." Under the header, "Policy Statement", it was documented, "It is the policy of this [corporate name] and its affiliates that a resident has the right to administer his or her own medications." Under the header, "Procedure", in Section I, it was documented, "Residents' rights regarding self-administration of medications are reviewed on admission." An excerpt of Section II documented, "An assessment for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 554	Continued From page 3 self-administration of medications is completed by a licensed nurse utilizing [form name], if appropriate." In Section III, it was documented, "An interdisciplinary team meeting is held to review cases and to issue approval or denial." In Section IV, it was documented, "A physician's order is required for self-administration." On 03/12/2020 at approximately 6:30 PM, the administrator was notified of findings. The administrator stated that a self-administration of medications assessment was not completed and also stated, "We'll make sure it gets there."	F 554		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 578	Continued From page 4	F 578		

Continued From page 4

(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to communicate advanced directive preference for one resident (Resident #28) in a sample size of 18 residents.

The findings included:

For Resident #28, the facility staff caring for her were unable to determine her advanced directive preference.

Resident #28, an 89-year old female, was admitted to the facility on 02/11/2020. Diagnoses included but not limited to unspecified displaced fracture of surgical neck of left humerus, chronic obstructive pulmonary disease, and congestive heart failure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	**5100 FILLMORE AVENUE ALEXANDRIA, VA 22311**

(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 578	Continued From page 5	F 578		

Resident #28's Minimum Data Set with an Assessment Reference Date of 02/18/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition.

One 03/11/2020, a review of the clinical record was conducted. The following conflicting information was observed:

On a document entitled, "Admission Record" in the section "Code Status", it was documented, "Full Code."

On a document entitled, "Physician's Admission Orders", an entry dated 02/11/2020, documented, "Code Status Full Code."

On a document entitled, "Medications/Treatments", undated, it was documented, "Code Status Full Code."

On a document entitled, "Durable Do Not Resuscitate Order" dated 02/18/2020, it was documented, "The patient is capable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient is required)" "I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 578	Continued From page 6 or other therapies deemed necessary to provide comfort care or alleviate pain." The document was signed by [Resident #28] and the provider. On a document entitled, "Physician's Order Data Record", an entry dated 02/11/2020 documented, "Code Status: Full Code." It was signed by the provider on 02/28/2020 (ten days after the 'Durable Do Not Resuscitate Order' was signed). The care plan was reviewed. A focus initiated on 02/13/2020 and revised on 02/18/2020 entitled, "Code Status: DNR Code Status." Situated below the revision date, it was documented, "Full code." In a section above this focus entry entitled, "Special Instructions", it was documented, "Full Code." On 03/12/2020 at approximately 9:30 AM, the nurse caring for Resident #28, Licensed Practical Nurse C (LPN C) was interviewed. When asked about the code status for Resident #28, LPN C stated, "I think she's a full code." LPN C then walked to the med cart nearby and looked at the Medication Administration Record for Resident #28. LPN C then pointed to the entry and stated that [Resident #28] is a full code. When asked where she would find code status information in an actual emergency, LPN C stated that she would check the chart. LPN C and this surveyor went to look at the hard chart and observed the Durable Do Not Resuscitate Order. LPN C looked at the date on the Do Not Resuscitate Order and flipped through the chart to look for a physician's order. LPN C and this surveyor looked at the physician's order for full code dated on 02/11/2020. When asked what should be done in an emergency, LPN C stated she thinks since the Do Not	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	**5100 FILLMORE AVENUE ALEXANDRIA, VA 22311**

(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 578	Continued From page 7 Resuscitate Order was most recent and dated on 02/18/2020, she would go with the Do Not Resuscitate." LPN C and this surveyor then looked at the physician's order for full code on 02/11/2020 and signed by the provider on 02/28/2020. When asked what should be done in an emergency, LPN C didn't answer. On 03/12/2020 at approximately 9:45 AM, the DON was notified of concern that staff were uncertain of Resident #28's code status and conflicting information in the clinical record. The DON stated she would find out what Resident #28 wants pertaining to advanced directives. On 03/12/2020 at 12:00 PM, Resident #28 was observed in her room seated in a wheelchair. When asked about her preference for advanced directives, Resident #28 stated that she signed a "Do not Resuscitate" and stated that "that's still the way I want it." The facility staff provided a copy of their policy entitled, "DNR status." in Section IV under the header, "Procedure", it was documented, "A DNR will remain in effect until the resident or resident's responsible party notifies the community in writing that the DNR is no longer in effect. The physician must be informed of the request to cease the DNR order." On 03/12/2020 at approximately 6:35 PM, the administrator and DON were notified of findings and they offered no further information or documentation.	F 578		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 607	Continued From page 8	F 607		

§483.12(b) The facility must develop and implement written policies and procedures that:

§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and

§483.12(b)(3) Include training as required at paragraph §483.95,
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review, and employee record review, the facility failed to implement their abuse policy for 4 Staff (LPN D, RN B, RN C, and LPN E) in a survey sample of 25 Staff Record Reviews.

The findings included:

1. The facility failed to verify nursing license was active and in good standing prior to employment for LPN D.

On 3/11/20 a review of the facility's employee files was conducted with Employee D, the Human Resources Representative/Assistant Executive Director.

Review of LPN D's file revealed that she was hired on 9/19/18. The facility staff did not verify that she held a current and unencumbered license to practice as a Licensed Practical Nurse (LPN) until 9/25/18, which was after she had been working in the role of LPN.

On 3/11/20 at 6:36 PM, Employee D returned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	**5100 FILLMORE AVENUE ALEXANDRIA, VA 22311**

(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 607	Continued From page 9 the conference room with the requested copy of the license verification for LPN D. Employee D stated, "this was after the fact, there is no disputing that". When Employee D was asked why verification of professional licensure is important and the purpose, Employee D stated, "we want to make sure they are in good standing with their credentials. We don't want to put the Resident's at risk." 2. The facility staff failed to check references for RN B prior to employment/hire. On 3/11/20 a review of a sample of 25 of the facility's employee files was conducted with Employee D (Human Resources/ Assistant Executive Director). The review revealed the following: RN B was hired 12/4/19. In RN B's employee file there was two emails to Employee D on behalf of RN B dated 12/13/19, recommending her for employment. RN B had already been hired, had completed orientation, and was working with Residents, prior to the references being received. 3. The facility staff failed to check references for RN C prior to employment/hire. On 3/11/20 a review of a sample of 25 of the facility's employee files was conducted with Employee D (Human Resources/ Assistant Executive Director). The review revealed the following: RN C was hired 2/26/20. RN C's	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 607	Continued From page 10	F 607		

employee file revealed a document titled "Reference Assessment Report". Employee D indicated these were the references for RN C. The date the references were completed were: 3/1/20, 3/2/20, 3/3/20. RN C had already been hired, had completed orientation, and was working with Residents, prior to the references being received.

4. The facility staff failed to check references for LPN E prior to employment/hire.

On 3/11/20 a review of a sample of the facility's employee files was conducted with Employee D (Human Resources/ Assistant Executive Director). The review revealed the following: LPN E was hired 4/17/19. LPN E's file revealed an email that was sent to Employee D, on behalf of LPN E, on 4/26/19 providing a reference and recommending LPN E for employment. A typed letter of recommendation was also in the file with a date of 4/26/19. LPN E had already been hired, had completed orientation, and was working with Residents, prior to the references being received.

On 3/11/20 at 6:36 PM, Employee D returned to the conference room with the requested copies. When Employee D was asked why checking references is important and the purpose of it, Employee D stated, "to make sue they are in good standing, get an idea of their work ethic and character. We don't want to put the Resident's at risk. They could present a negative outcome especially for those Residents that can't report abuse, negligence or anything of that nature".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 607	Continued From page 11 Review of the facility policy titled, "Risk Management Abuse, Neglect, Injuries of Unknown Source and Misappropriation of Property: Screening" was reviewed. This policy read, "All potential associates shall be screened prior to employment for the following: background criminal check, professional license/registration verification, at least two reference checks". The Administrator and Director of Nursing (DON) were made aware of the findings on 3/11/20 during the end of day meeting. No further information was received.	F 607		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by	F 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 640	Continued From page 12 CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review the facility staff failed to transmit a Resident assessment to the CMS system for one Resident (Resident #1) in a survey sample of 18 Residents. The findings included: Resident #1 was admitted to the facility on 9/16/19. Resident #1's diagnoses included but were not limited to: spinal stenosis, hyperlipidemia, schizophrenia, and major	F 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	**5100 FILLMORE AVENUE ALEXANDRIA, VA 22311**

(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 640	Continued From page 13	F 640		

depressive disorder.

Resident #1's most recent completed OMRA (other Medicare Required Assessment) MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 9/23/19 was coded as an admission assessment. Resident #1 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated no cognitive impairment. Resident #1 was coded as having required extensive assistance of facility staff for transfers, bathing, and bed mobility. Resident #1 required limited assistance of facility staff for ambulation, dressing, personal hygiene, and toileting.

Review of Resident #1's MDS (Minimum Data Set) assessment history revealed a MDS with an ARD (assessment reference date) of 10/7/19, which was coded as a Medicare 5 day assessment and another MDS with an ARD of 10/11/19 which was coded as a discharge return not anticipated/end of PPS (prospective payment system) Part A stay.

Both of these above referenced MDS were noted as being "in-progress" status and had not been transmitted to CMS.

On 3/12/20 at approximately 3:45 PM an interview was conducted with Employee F, the MDS Coordinator and she indicated they use the RAI (resident assessment instrument) manual as their policy and directive on when they complete MDS and transmit them to the CMS. She was shown the MDS for Resident #1 and asked what in-progress means, Employee F stated, "it means everyone is working on it, it isn't complete'. She was asked how often she transmits assessments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 640	Continued From page 14	F 640		

to CMS and what the requirement is, Employee F stated, "I transmit every week, we have up to 1 month per the RAI manual". She was asked if the assessments for Resident #1 had been transmitted to CMS and Employee F stated, "No, it has not been transmitted". When asked if this was acceptable, Employee F stated, "no, it's not ok. it's a missed one. We can lock it and it would be a default rate".

The CMS RAI manual Version 1.16 effective October 2018 on page 5-1 read, "All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS ' Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS." Page 5-2 read, "For all non-Admission OBRA and PPS assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD) (A2300).

Page 5-3 read, "Within 7 days after completing a resident ' s MDS assessment or tracking record, the provider must encode the MDS data (i.e., enter the information into the facility MDS software). For a Quarterly, Significant Correction to Prior Quarterly, Discharge, or PPS assessment, encoding must occur within 7 days after the MDS Completion Date.

On 3/12/20 during the end of day meeting the facility Administrator and Director of Nursing were made aware of the concern that Resident #1 had incomplete and untransmitted MDS. The facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	**5100 FILLMORE AVENUE ALEXANDRIA, VA 22311**

(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 640	Continued From page 15 Administrator confirmed they go by the RAI manual and do not have a written policy. No further information was provided.	F 640		
F 642 SS=D	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review the facility staff	F 642		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 642	Continued From page 16 failed to complete a Resident assessment for one Resident (Resident #1) in a survey sample of 18 Residents. The findings included: Resident #1 was admitted to the facility on 9/16/19. Resident #1's diagnoses included but were not limited to: spinal stenosis, hyperlipidemia, schizophrenia, and major depressive disorder. Resident #1's most recent completed OMRA (other Medicare Required Assessment) MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 9/23/19 was coded as an admission assessment. Resident #1 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated no cognitive impairment. Resident #1 was coded as having required extensive assistance of facility staff for transfers, bathing, and bed mobility. Resident #1 required limited assistance of facility staff for ambulation, dressing, personal hygiene, and toileting. Review of Resident #1's MDS (Minimum Data Set) assessment history revealed an MDS with an ARD (assessment reference date) of 10/7/19, which was coded as a Medicare 5 day assessment and another MDS with an ARD of 10/11/19 which was coded as a discharge return not anticipated/end of PPS (prospective payment system) Part A stay. Both of these above referenced MDS were noted as being "in-progress" status and had not been signed as being completed.	F 642		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 642	Continued From page 17	F 642		

On 3/12/20 at approximately 3:45 PM an interview was conducted with Employee F, the MDS Coordinator and she indicated they use the RAI (resident assessment instrument) manual as their policy and directive on when they complete MDS. She was shown the MDS for Resident #1 and asked what in-progress means, Employee F stated, "it means everyone is working on it, it isn't complete'. When asked if this was acceptable, Employee F stated, "No, it's not ok. It's a missed one. We can lock it and it would be a default rate."

The CMS RAI manual Version 1.16 effective October 2018 on page 2-50 read, "Medicare-required 5-Day Scheduled Assessment must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days)."

Page 2-36 & 2-37 of the CMS RAI manual references the discharge assessment and stated, "Discharge Assessment-Return Not Anticipated
· Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days.
· Must be completed (Item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days)."

On 3/12/20 the facility Administrator confirmed they go by the RAI manual and do not have a written policy. He stated that he reviewed the record for Resident #1 and Employee F had completed it. The facility Administrator provided the survey team a copy of the MDS screen shot for Resident #1 which indicated the MDS with an ARD of 10/7/19 was completed 3/11/20. The MDS with an ARD of 10/11/19 was completed 3/11/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 642	Continued From page 18 On 3/12/20 during the end of day meeting the facility Administrator and Director of Nursing were made aware of the concern that Resident #1 had incomplete MDS'. No further information was provided by the facility staff.	F 642		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 656	Continued From page 19	F 656		

resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one resident (Resident #28) in a sample size of 18 residents.

The findings included:

For Resident #28, the facility staff failed to develop a comprehensive care plan to include her diagnosis of congestive heart failure.

Resident #28, was admitted to the facility on 02/11/2020. Diagnoses included but not limited to, unspecified displaced fracture of surgical neck of left humerus, chronic obstructive pulmonary disease, and congestive heart failure.

Resident #28's Minimum Data Set with an Assessment Reference Date of 02/18/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition. Functional status for dressing and personal hygiene were coded as requiring extensive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 656	Continued From page 20	F 656		

assistance from staff. Eating was coded as requiring supervision - oversight, encouragement or cueing from staff.

On 03/10/2020 at approximately 3:15 PM, Resident #28 was observed in her room, seated in her wheelchair. When asked if she had any concerns about the care she receives at the facility, Resident #28 stated that prior to coming to the facility, she would take her Lasix every day but the facility changed it to just Monday, Wednesday, and Friday each week. Resident #28 also stated that the facility staff did not tell her they changed her Lasix dose but she has noticed her feet and legs are swollen "like an elephant." Resident #28 lifted her pant legs to reveal her feet and ankles which appeared edematous.

The physician's orders were reviewed. A document entitled, "Physician's Admission Orders" had an entry dated 02/11/2020 which documented, "Lasix 20 mg [milligram] tab [tablet] Take one tab po Q MON, WED, FRI [one tablet by mouth every Monday, Wednesday, Friday] DX: CHF [diagnosis congestive heart failure]." A telephone order dated 03/08/2020 at 12:50 PM documented, "Lasix 20 mg now po x 1 dose [by mouth now for one dose] BLE edema [bilateral lower extremity edema]." A telephone order dated 03/10/2020 at 10:00 PM documented, "Lasix 20 mg po 1 tab QD [20 milligrams by mouth 1 tablet daily]." Also, on the document entitled, "Physician's Admission Orders" dated 02/11/2020, it was documented, "Weight on admission, QDx3DAYS [every day for 3 days], QWKx4 [every week for four weeks], QMONTHLY [every month]."

On 03/11/2020, the care plan was reviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 656	Continued From page 21	F 656		

There was no focus associated with the diagnosis of congestive heart failure.

On 03/12/2020 at approximately 10:15 AM, the facility was asked for a copy of all weights for Resident #28 and the DON provided a document entitled, "Weight Summary." There was one weight recorded on 02/12/2020 at 1:36 PM which documented, "148.8 lbs [pounds]." There were no other weights recorded.

On 03/12/2020 at 2:25 PM, an interview with Employee F, a full time MDS coordinator, and Employee H, a part time MDS coordinator. When asked if someone had a diagnosis of congestive heart failure, would the expectation be to see it on the care plan, Employee F answered yes. When asked what would be on the care plan, Employee H stated there would be goals set and measures in place. When asked what interventions would be on the care plan associated with congestive heart failure, Employee H stated that they would monitor vital signs, assess for complaints of chest pain or shortness of breath or coughing. Employee H stated that if the physician ordered blood work, they would obtain and monitor labs. Employee H also stated they would obtain weights as ordered.

According to an Elsevier (Mosby) publication, Fundamentals of Nursing by Potter & Perry, 2013, in Chapter 18 entitled, "Planning Nursing Care" on p. 237 it was documented, "Priority setting begins at a holistic level when you identify and prioritize a patient's main diagnoses or problems. However, you also need to prioritize the specific interventions or strategies that you will use to help a patient achieve desired goals and outcomes."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 656	Continued From page 22 On 03/12/2020 at approximately 6:30 PM, the Administrator and Director of Nursing were notified that the congestive heart failure goals and measures were not on the care plan. They offered no further documentation or information prior to exit.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 657	Continued From page 23	F 657		

Based on observation, staff interview and clinical record review the facility staff failed to review and revise the careplan for 1 Resident (Resident #241) in a survey sample of 18 residents.

The findings included:

For Resident #241 the facility staff failed to review and revise the careplan to address a fluid restriction due to heart failure.

Resident #241 was admitted to the facility on 3/3/20 and remained an active Resident of the facility at the time of survey. Resident #241's diagnoses included but were not limited to: hypertensive heart disease with heart failure, chronic atrial fibrillation, chronic embolism and cellulitis.

Resident #241's most recent MDS (minimum data set; an assessment tool) with an ARD (assessment reference date) of 3/10/20 was coded as an admission assessment. Resident #241 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated no cognitive impairment. Resident #241 was coded as having required extensive assistance of facility staff for transfers, dressing, personal hygiene, bathing, bed mobility and toileting.

Review of the clinical record for Resident #241 revealed a telephone order written 3/4/20 that read, "daily weights, fluid restriction 2,000 ml/24 hr." Review of the entire careplan for Resident #241 was conducted and revealed no mention of daily weights or a fluid restriction. The careplan did state "at risk for complications from CHF [congestive heart failure], edema and bronchus

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 657 Continued From page 24 F 657

[sic] date initiated: 3/4/20." The interventions for this focus area were:
"obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated" date initiated: 3/4/20.
"provide, serve diet as ordered. Monitor intake and record q [every] meal. Date initiated: 3/4/20"
"weigh at same time of day and record per order. date initiated: 3/4/20".

Review of the diet meal ticket for Resident #241 read, "diet type: NAS [no added salt], Allergies: grapefruit, Diet Texture: Regular, Liquids: thin, portions: fruit at breakfast."

On 3/12/20 at 2:42 PM an interview was conducted with Employee F, the RN care plan coordinator. Employee F was asked if a Resident has an order for a fluid restriction and daily weights would you expect this to be noted in the careplan, Employee F stated, "It should be."

On 3/12/20 during an end of day meeting the facility Administrator and Director of Nursing were made aware that Resident #241 had orders for daily weights and a fluid restriction which were not noted in the careplan. No further information was provided by the facility staff.

F 658 SS=E Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) F 658

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 658	Continued From page 25	F 658		

Based on observation, Resident interview, staff interview, facility documentation review, and clinical record review the facility staff failed to follow professional standards of care for 4 Residents (Resident #241, #28, #193, #191) in a survey sample of 18 Residents.

The findings included:

1. For Resident #241 the facility staff failed to follow physician orders for a fluid restriction and daily weights.

Resident #241 was admitted to the facility on 3/3/20 and remained an active Resident of the facility at the time of survey. Resident #241's diagnoses included but were not limited to: hypertensive heart disease with heart failure, chronic atrial fibrillation, chronic embolism and cellulitis.

Resident #241's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/10/20 was coded as an admission assessment. Resident #241 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated no cognitive impairment.

Review of the clinical record for Resident #241 revealed a telephone order written 3/4/20 that read, "daily weights, fluid restriction 2,000 ml/24 hr."

On 3/10/20 during the evening meal the tray for Resident #241 was observed when it was delivered to the resident. The tray contained 2 glasses of juice and a cup of water.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 658	Continued From page 26	F 658		

On 03/11/20 at 08:47 AM, the breakfast tray was delivered to the room of Resident #241 and it had 2 juices (orange) and 1 cup of water. The surveyor observed the Resident to already have a cup of water on over-bed table. On the round table in the middle of the room was also 2 bottles of cola.

On 3/11/20 the clinical record for Resident #241 was reviewed. The electronic record revealed a weight on 3/3/20 of 160 lbs. The TAR (treatment administration record) revealed an entry that read, "3/3/20 weight on admission" with a recorded entry on 3/3/20 that read "160.0." Below that entry was the following: "3/3/20 daily wt [weight] x 3 days" with the dates of 3/4/20, 3/5/20, 3/6/20 blocked off but empty. Another entry read, "3/3/2020 weekly wt x 4 on Tuesday" and all entries were blank. Lastly, another entry read, "3/3/2020 monthly wt" and again, all entries for the month were empty.

On the morning of 3/12/20 the facility Administrator was made aware that Resident #241 had an order for daily weights and the only weight the surveyor could find was on 3/3/20. The Administrator was asked to see if he could find any additional weights as this was concerning since Resident #241 had an order for daily weights. On 3/12/20 at 9:55 AM the Administrator returned with a printed copy of the weight in the electronic record dated 3/3/20 at 160 lbs and stated "This is the only weight I was able to find."

On 3/12/20 during a later review of the clinical record, Surveyor C was able to see on another TAR page a daily weight recorded on 3/7, 3/8, 3/9, 3/10, 3/11. The fluid restriction was also noted on this same TAR for each shift to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 658	Continued From page 27	F 658		

document and had only been signed off on 3 of the 21 shifts.

On 3/12/20 at 2:12 PM an interview was conducted with Resident #241. The Resident was asked if he/she is on fluid restriction and the Resident replied "Yes, I'm supposed to have no more than 50 oz a day. I talked to the people in the nutrition area and they said their experience is a glass of water with each meals and 1 in-between is sufficient." Resident #241 was advised that the surveyor had observed 2 of the meal trays and each tray had a glass of water and 2 glasses of juice and the Resident already had several cups of ice chips on the over-bed tray table, throughout the observations on 3/10/20 and 3/11/20. Resident #241 said "I love the OJ and I order 2. I use ice chips and I was told they are equivalent to only 1/2 of the fluid." Resident #241 stated he/she was not aware of any staff monitoring of intake but that he/she monitors it.

On 3/12/20 at 2:25 PM an interview was conducted with Employee P, a kitchen server. Employee P was asked what they do when someone is on a fluid restriction, Employee P stated, "We only send 1 cup of water on the meal tray." Employee P was asked how they know when someone is on a fluid restriction and she directed the surveyor to a listing of diets in the kitchenette. Employee P was asked who is on a fluid restriction and Employee P looked at the listing of diets and said Resident #28. The surveyor reviewed the diet listing and Resident #241 was not listed as being on a fluid restriction.

On 3/12/20 at 2:27 PM Employee P provided the surveyor with the diet meal ticket for Resident #241, it read, "diet type: NAS [no added salt],

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 658	Continued From page 28	F 658		

Allergies: grapefruit, Diet Texture: Regular, Liquids: thin, portions: fruit at breakfast".

On 3/12/20 at approximately 2:30 PM an interview was conducted with certified nursing assistant (CNA) A. CNA A was asked how they know when someone is on a fluid restriction. CNA A stated, "We have a sign on the door & a picture." CNA A and this writer walked the halls and observed no Resident's, including Resident #28 and Resident #241 to have the sign to alert staff they were on fluid restrictions.

On 3/12/20 at 2:35 PM an interview was conducted with CNA B. CNA B was asked how she knows when someone is on a fluid restriction and she stated, "they have a slip that they put on the door, a yellow cup". She was asked if they have anyone on a fluid restriction and CNA B stated, "no, not yet".

Review of the careplan for Resident #241 did not address the fluid restriction.

Review of the facility policy related to "Monitoring Intake & Output" was reviewed and read, "documentation is required to be done in Point of Care by both CNA's and licensed nurses. Include fluids consumed during meals, between meals, and with medication pass."

During an end of day meeting with the Administrator and Director of Nursing held on 3/12/20 they were made aware that there was no evidence that the facility staff is monitoring the fluid intake of Resident #241 who has a known diagnoses of heart failure and underwent diuresis while hospitalized prior to admission to the facility and had failed to obtain daily weights on 3/5/20,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 658	Continued From page 29 3/6/20. The DON was asked if she expected to find documentation within the record and for staff to be aware of these orders, she stated "Yes." No further information was provided. 2. For Resident #28, the facility staff failed to carry out/clarify physician's orders for obtaining weights and providing showers. Resident #28 was admitted to the facility on 02/11/2020. Diagnoses included but not limited to unspecified displaced fracture of surgical neck of left humerus, chronic obstructive pulmonary disease, and congestive heart failure. Resident #28's Minimum Data Set with an Assessment Reference Date of 02/18/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition. Functional status for dressing and personal hygiene were coded as requiring extensive assistance from staff. Bathing was coded as total dependence on staff with one-person physical assist for support. On 03/10/2020 at approximately 3:15 PM, Resident #28 was observed in her room, seated in her wheelchair. When asked if she had any concerns about the care she receives at the facility, Resident #28 stated that she received a shower when she first arrived to the facility but that was the only shower she has had since arriving to the facility (one month ago). Resident #28 stated that the staff does not offer a shower and that maybe she needs to ask. On 03/11/2020, the clinical record was reviewed. A physician's order dated 02/11/2020 documented, "Shower resident twice a week on	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 658	Continued From page 30	F 658		

Wed/Sat 3-11 [Wednesday/Saturday on the 3 PM-11 PM shift."].

On the document entitled, "Physician's Admission Orders" dated 02/11/2020, it was documented, "Weight on admission, QDx3DAYS [every day for 3 days], QWKx4 [every week for four weeks], QMONTHLY [every month]."

On a document entitled, "Physician's Order Data Record" dated 02/14/2020, it was documented, "Weight every week x 4 [for 4 weeks] then monthly."

On the document entitled, "Physician's Order Data Record" dated 02/24/2020, it was documented, "Record pt [patient] weights on Mon + Friday 7-3 [Monday and Friday on the 7 AM-3 PM shift]."

A document entitled, "Medications/Treatments" undated, with columns numbered 1 through 31. An entry documented, "Shower resident twice a week on Wed + Sat 3-11 [Wednesday and Saturday on the 3-11 shift]." Boxes associated with this entry were outlined in black to highlight column 12, 15, 19, 22, and 26 meaning 02/12 [Wednesday], 02/15 [Saturday], 02/19 [Wednesday], 02/22 [Saturday], and 02/26 [Wednesday]. The shower was signed off as administered on 02/12/2020 but all the other blocks were blank.

On 03/12/2020 at approximately 10:15 AM, the facility was asked for a copy of all weights for Resident #28 and the Director of Nursing (DON) provided a document entitled, "Weight Summary." There was one weight recorded on 02/12/2020 at 1:36 PM which documented, "148.8 lbs [pounds]."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 658	Continued From page 31	F 658		

There were no other weights recorded.

On 03/12/2020 at approximately 10:15 AM, the DON was notified of concerns that showers were not being given and weights were not being done as ordered. The DON stated that she would look into it. This surveyor and the DON reviewed the conflicting orders for weights. When asked about the expectation, the DON agreed that it was confusing and would expect the nurse to call the physician to clarify the order for frequency of obtaining weights.

According to the Lippincott Manual of Nursing Practice, 10th edition, 2014, an excerpt of a passage under the section entitled, "Common Departures from the Standards of Nursing Care" it was documented, "Failure to implement a physician's, advanced practice nurse's, or physician assistant's order properly or in a timely fashion." "Failure to act as a patient advocate, such as not questioning illegible or incomplete medical orders ..."

On 03/12/2020 at approximately 6:30 PM, the administrator and DON were notified that showers were not being given and the orders for weights were not clarified/completed. They offered no further documentation or information.

3. For Resident #193, the facility staff failed to follow physician orders for lidocaine patch removal according to professional standards of nursing care.

Resident #193, was admitted to the facility on 03/09/2020. Diagnoses included but not limited to severe osteoarthritis of the knee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 658	Continued From page 32 Resident #193 was a new admission so no Minimum Data Set (MDS) was completed. On 03/11/2020 at approximately 8:50 AM in the course of a medication pass observation, Licensed Practical Nurse H (LPN H) entered Resident #193's room to apply a lidocaine patch to her left knee as ordered. When LPN H exposed Resident #193's left knee, LPN H and this surveyor observed an unlabeled patch to the left knee. The patch was not initialed, timed, or dated. LPN H removed the patch and inspected the skin. There was no redness or irritation noted. LPN H stated that this patch was supposed to be removed "9 PM last night." LPN H also stated that she will wait about 5 minutes before applying the new lidocaine patch "so the skin won't get irritated." LPN H and this surveyor waited approximately 5 minutes by the medication cart. This surveyor and LPN H observed the Medication Administration Record for removing the lidocaine on 03/10/2020 at 9 PM, was signed off as completed. LPN H initialed, timed, and dated the new lidocaine patch and then re-entered Resident #193's room. LPN H then applied the new lidocaine patch to Resident #193's left knee. LPN H did not notify the provider the old lidocaine patch remained on her left knee for approximately 24 hours (not 12 hours as ordered) before applying the new lidocaine patch. After leaving Resident #193's room, this surveyor asked LPN H what her next task was. LPN H stated she was going to call and notify the physician the old lidocaine patch was not removed as ordered. On 03/11/2020 at approximately 10:00 AM, the Director of Nursing (DON) was notified of findings. When asked about the expectation of	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 658	Continued From page 33	F 658		

Continued From page 33
nurses, the DON stated she expects the patch to be removed as ordered and to notify the physician before putting on another patch.

On 03/11/2020, the physician's orders were reviewed. An order entry on a document entitled, "Physician's Admission Orders" dated 03/09/2020 documented, "Lidocaine 5% patch. Place 1 patch to left knee QD [every day] Remove and discard after 12 hours. DX [diagnosis]: pain." Under the column labeled "Hour", it was documented, "9 AM on, 9 pm off."

The facility staff provided a copy of their policy entitled, "Medication Pass Policy." In Section VII, part C, subpart (a), it was documented, "Medication managers must check the following "rights" of medication administration each time they assist with administration or administer medications to a resident: right resident, right drug, right dosage, right time, right route, right record/right documentation." The policy does not specifically address the timing of application and removal of patches. On page 8 of their Medication Pass Policy under the header, "What Should Happen When a Medication Error Occurs", in Parts 1-5, it was documented, "1. Do not panic; stay calm, and stop whatever you are doing. 2. Report to the nurse the med error. 3. Never try to cover up an error. 4. The following steps will be taken regardless of the severity of the error: 5. Contact the physician."

On 03/12/2020 at approximately 6:30 PM, the Administrator and DON were notified of findings and they offered no further information or documentation.

4. For Resident #191, the facility staff failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 658	Continued From page 34	F 658		

secure his prescriptions for controlled substances.

Resident #191, an 88-year old male, was admitted to the facility on 05/31/2019. Diagnoses included but not limited to idiopathic progressive neuropathy.

Resident #191's most recent Minimum Data Set with an Assessment Reference Date of 02/26/2020 was coded as a discharge assessment. The Brief Interview for Mental Status was coded as 12 out of possible 15 indicative of moderate cognitive impairment.

On 03/11/2020 at approximately 3:15 PM while conducting a review of the clinical record (hard chart form), two original, active prescriptions were observed in Resident #191's chart under the Physician's Orders tab. Both prescriptions were computer-generated prescriptions with a header from [hospital name] and signed by the physician. One prescription was dated 02/19/2020 and documented, "Oxycodone [an opioid analgesic] 5 mg [milligram] immediate release tablet. Sig: Take 1 tablet (5 mg total). Sig: Take 1 tablet (5 mg total) every 6 (six) hours as needed for pain. Qty [quantity]: 14 (fourteen) tablet. Refill: 0 (zero)." The other prescription was also dated 02/19/2020 and documented, "Gabapentin [an anticonvulsant] 100 mg [milligram] capsule. Sig: Take 1 capsule (100 mg total) by mouth every 8 (eight) hours. Qty [quantity]: 30 (thirty) capsule. Refill: 0 (zero)."

On 03/11/2020 at approximately 5:45 PM, an interview with Licensed Practical Nurse G (LPN G) was conducted. When asked about the process for handling scripts (prescriptions) when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 658	Continued From page 35	F 658		

residents arrive from the hospital, LPN G stated that staff will review the scripts with the admitted physician and then fax it to the pharmacy with a cover sheet. LPN G then stated that sometimes the original script is copied and placed in chart. When asked why the original script is copied, LPN G stated "because sometimes the pharmacy says they didn't see it [the faxed script] so we have to re-fax it." LPN G stated that the original "Goes to a place where the pharmacy picks it up." LPN G stated that it's in a bag at the nurse's station and that pharmacy staff come daily to pick it up. LPN G stated that they always void out the original and the copy. When shown the active prescriptions in Resident #191's hard chart, LPN G stated they should have been voided out. When asked why it's important they be voided out, LPN G stated that it shouldn't be that way because people could refill it somewhere else.

On 03/11/2020 at approximately 5:55 PM, the DON was notified of concerns and stated that it is the expectation that scripts would be voided out after faxing to the pharmacy. When asked if these prescriptions were the originals or copies, the DON stated that they appeared to be the originals.

A copy of the facility policy on handling prescriptions of controlled substances was requested and the facility staff provided a copy of their policy entitled, "Ordering and Receiving Controlled Medications." The policy did not address the processing of prescriptions of controlled substances.

According to a publication entitled, "ASHP [American Society of Health-System Pharmacists] Guidelines on Preventing Diversion of Controlled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 658	Continued From page 36 Substances", 2016, on page 87, under the header, "Special Considerations", it was documented, "Although it is not possible to predict all scenarios, and procedures need to be customized for unique circumstances and settings, these guidelines present core principles applicable to all settings. Examples of areas with special considerations include both high and low-volume areas, such as ...long-term care facilities, and retail pharmacies. Over 30% of hospitals and health systems operate retail pharmacies. It is important to also understand and address controls unique to these operations ...Retail pharmacies within health systems pose a significant risk to the organization's CS [controlled substance] supply chain because of theft and the possibility of receiving fraudulent prescriptions." "Other areas providing CS prescriptions or drugs to patients (e.g., emergency departments, emergency medical services, discharge prescriptions, home infusion) should ensure the chain of custody from preparation to delivery or administration to the patient and wasting, if applicable, including procedures that validate that the chain of custody has been maintained." On 03/12/2020 at approximately 6:30 PM, the administrator and DON were notified of findings and they offered no further documentation or information.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 677	Continued From page 37 by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide services to maintain personal hygiene for one resident (Resident #28) in a sample size of 18 residents. The findings included: The facility staff failed to assist or offer showers to Resident #28. Resident #28, was admitted to the facility on 02/11/2020. Diagnoses included but not limited to unspecified displaced fracture of surgical neck of left humerus, chronic obstructive pulmonary disease, and congestive heart failure. Resident #28's Minimum Data Set with an Assessment Reference Date of 02/18/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition. Functional status for dressing and personal hygiene were coded as requiring extensive assistance from staff. Bathing was coded as total dependence on staff with one-person physical assist for support. On 03/10/2020 at approximately 3:15 PM, Resident #28 was observed in her room, seated in her wheelchair. When asked if she had any concerns about the care she receives at the facility, Resident #28 stated that she received a shower when she first arrived to the facility but that was the only shower she has had since arriving to the facility (last month). Resident #28 stated that the staff does not offer a shower and	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 677	Continued From page 38	F 677		

that maybe she needs to ask.

On 03/11/2020, the clinical record was reviewed. A physician's order dated 02/11/2020 documented, "Ambulation/mobility: bed to chair, with 1 assist, wheelchair." An order dated 02/11/2020 documented, "Shower resident twice a week on Wed/Sat 3-11 [Wednesday/Saturday on the 3-11 shift."]. A document entitled, "Medications/Treatments" undated, with columns numbered 1 through 31. An entry documented, "Shower resident twice a week on Wed + Sat 3-11 [Wednesday and Saturday on the 3-11 shift]." Boxes associated with this entry were outlined in black to highlight column 12, 15, 19, 22, and 26 meaning 02/12 [Wednesday], 02/15 [Saturday], 02/19 [Wednesday], 02/22 [Saturday], and 02/26 [Wednesday]. The shower was signed off as administered on 02/12/2020 but all the other blocks were blank.

On 03/12/2020 at approximately 10:15 AM, the Director of Nursing (DON) was notified of concerns that showers were not being given and the DON stated that she would look into it.

On 03/12/2020 at approximately 10:30 AM, an interview with Certified Nursing Assistant C (CNA C), was conducted. When asked about how she knows when her residents are scheduled for a shower, CNA C stated that she looks at the shower book. This surveyor and CNA C observed the shower book. A document entitled, "(Name) Bath/Shower Schedule" was reviewed. CNA C explained that room numbers were listed on the days the showers were scheduled. Resident #28's room was listed on Wednesday and Saturday for the 3 PM-11 PM shift to receive a shower.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 677	Continued From page 39	F 677		

On 03/12/2020 at approximately 10:40 AM, an interview with Employee G, the Rehab Director, was conducted. Employee G verified he was familiar with Resident #28. When asked about her functional status on admission, Employee G referred to Resident #28's electronic clinical record. Employee G then stated that [Resident #28] was evaluated by therapy on 02/12/2020. When asked if there was any reason why she would be prohibited from getting up and taking showers, Employee G stated "No." Employee G also stated that [Resident #28] was a "mod assist for standing and a min assist for stand and pivot." When asked to define these terms, Employee G stated that mod assist means the therapist does about 50% of the work and min assist means the therapist does about 25% of the work. Employee G stated that from a therapy standpoint, there was no reason why [Resident #28] couldn't get a shower.

On 03/12/2020 at approximately 11:45 AM, the DON presented a copy of a document entitled, "Notes." On Line 1, it was handwritten, "Refused shower, offer." On line 2, it was documented, "Bed bath, notify nurse." Under the header "Resident" Resident #28's name was listed. Under the header "Reported by" the name was illegible. Under the header "Date/Time" it was documented, "3/11/20."

On 03/12/2020 at approximately 12:00 PM, Resident #28 was observed in her room seated in her wheelchair. When asked if she ever refused a shower, Resident #28 stated, "Yesterday I didn't feel well so I refused yesterday." Resident #28 also stated that she worked it out with staff and she will get a shower tonight.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 677	Continued From page 40 The facility staff provided a copy of their policy entitled, "Bathing-Hygiene." Under the header "Policy Statement", it was documented, "It is the policy of [corporate name] and its affiliates to provide assistance to all residents with hygiene and bathing to assure maintenance of appropriate levels of hygiene, to promote socialization, to preserve dignity, stimulate circulation, promote relaxation, and observe the resident skin condition." Under the header, "Procedure" in Section B, Part I, it was documented, "Baths (shower, tub, bed bath) will be given or assisted on a regular basis or as needed." In Part II, it was documented, "Residents will be consulted for his/her preferences in bathing." In Part III, it was documented, "When resident's bath is not given for any reason the nurse in charge will be notified and an alternative bath schedule will be implemented." On 03/12/2020 at approximately 6:30 PM, the Administrator and DON were notified that Resident #28 had not received her showers as scheduled. They offered no further information or documentation.	F 677		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review,	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 759	Continued From page 41	F 759		

the facility staff had 2 medication errors out of 30 opportunities which resulted in a medication error rate of 6.67% for one resident (Resident #193) in a sample size of 18 residents.

The finding included:

For Resident #193, the facility staff failed to apply/reapply her lidocaine patch according to professional standards of nursing care resulting in a medication error rate greater than 5%.

Resident #193 was admitted to the facility on 03/09/2020. Diagnoses included but not limited to severe osteoarthritis of the knee. Resident #193 was a new admission so no Minimum Data Set was completed.

On 03/11/2020 at approximately 8:50 AM in the course of a medication pass observation, Licensed Practical Nurse H (LPN H) entered Resident #193's room to apply a lidocaine patch to her left knee as ordered. When LPN H exposed Resident #193's left knee, LPN H and this surveyor observed an unlabeled patch to the left knee. The patch was not initialed, timed, or dated. LPN H removed the patch and inspected the skin. There was no redness or irritation noted. LPN H stated that this patch was supposed to be removed "9 PM last night." LPN H also stated that she will wait about 5 minutes before applying the new lidocaine patch "So the skin won't get irritated." LPN H and this surveyor waited approximately 5 minutes by the medication cart. This surveyor and LPN H observed on the Medication Administration Record for removing the lidocaine on 03/10/2020 at 9 PM was signed off as completed. LPN H initialed, timed, and dated the new lidocaine patch and then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 759	Continued From page 42	F 759		

re-entered Resident #193's room. LPN H then applied the new lidocaine patch to Resident #193's left knee. LPN H did not notify the provider the old lidocaine patch remained on her left knee for approximately 24 hours (not 12 hours as ordered) before applying the new lidocaine patch. After leaving Resident #193's room, this surveyor asked LPN H what her next task was. LPN H stated she was going to call and notify the physician the old lidocaine patch was not removed as ordered.

On 03/11/2020 at approximately 10:00 AM, the Director of Nursing was notified of findings. When asked about the expectation of nurses, the DON stated she expects the patch to be removed as ordered and to notify the physician before putting on another patch.

On 03/11/2020, the physician's orders were reviewed. An order entry on a document entitled, "Physician's Admission Orders" dated 03/09/2020 documented, "Lidocaine 5% patch. Place 1 patch to left knee QD [every day] Remove and discard after 12 hours. DX [diagnosis]: pain." Under the column labeled "Hour", it was documented, "9 AM on, 9 pm off."

The facility staff provided a copy of their policy entitled, "Medication Pass Policy." In Section VII, part C, subpart (a), it was documented, "Medication managers must check the following "rights" of medication administration each time they assist with administration or administer medications to a resident: right resident, right drug, right dosage, right time, right route, right record/right documentation." The policy does not specifically address the timing of application and removal of patches. On page 8 of their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 759	Continued From page 43 Medication Pass Policy under the header, "What Should Happen When a Medication Error Occurs", in Parts 1-5, it was documented, "1. Do not panic; stay calm, and stop whatever you are doing. 2. Report to the nurse the med error. 3. Never try to cover up an error. 4. The following steps will be taken regardless of the severity of the error: 5. Contact the physician." On 03/12/2020 at approximately 6:30 PM, the Administrator and DON were notified of findings and they offered no further information or documentation.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ____ B. WING ____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 761	Continued From page 44	F 761		

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 documentation review, the facility staff failed to ensure drugs and biologicals were labeled in accordance with professional principles and in locked compartments on 1 of 2 nursing units.

The findings included:

1. On 03/11/20 at 02:46 PM Surveyor C went to the nursing station on the George unit. The nursing station door was pulled, but not latched/locked. Surveyor C was able to open the door and enter the nursing station. No staff were observed around or in line of sight. A treatment cart was observed directly inside the nursing station and was observed to be unlocked. The following contents were observed and accessible: lancets, santyl [a debriding wound agent], iodosorb & santyl- in a zip lock bag which contained no resident name. Another Ziploc bag which contained 2, 1.5 oz containers of therahoney gel with no name, and also a tube of silasorb gel with a pharmacy label with a Resident name. The Resident was discharged 9/1/17, the prescription had a fill date of 7/7/17.

On 3/11/20 at approximately 2:55 PM LPN C entered the medication room and was made aware that Surveyor C was able to gain entrance without any staff assistance and the treatment cart was unlocked. LPN C was shown the items that were accessible. LPN C was asked about the Resident who the tube of Silasorb gel was dispensed for and she stated "She isn't here, I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	**5100 FILLMORE AVENUE ALEXANDRIA, VA 22311**

(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 761	Continued From page 45	F 761		

have to discard it".

On 03/11/20 at 03:28 PM LPN B, the evening supervisor came into the nursing station. LPN B was asked, what is the process when a Resident is discharged, what happens to their medications? LPN B stated, "We take them out and send back to pharmacy." LPN B and LPN C looked in the computer at the electronic record and confirmed that the Resident had discharged from the facility 9/1/2017. They were also asked about the other items in the cart that were not tabled, LPN C stated, "It is house stock." Surveyor C asked, "So if it is house stock, it has been opened, do you use the same tube for multiple Residents? How do you know who to use it on?" LPN C stated, "It should have the Resident's name and not be used for multiple Residents."

2. On 3/11/20 at 5:46 PM Surveyor C walked down the hall on the George unit and observed the medication cart in the hall, outside of room 57. The medication cart was observed to be unlocked/unsecured. RN A came out of an unoccupied Resident room, approximately 3 minutes after the Surveyor arrived at the medication cart. Immediately upon approach, RN A locked the medication cart. RN A was asked if he should have locked/secured the cart before walking away and RN A stated, "Yes."

The cart was approximately 4 feet tall, 2 feet deep and 3 feet wide, with multiple drawers that held blister packs of 30 days worth of medication in each blister pack. Blister packs were filed by dividers for each of 10 residents residing on the unit. Which revealed hundreds of medications accessible to anyone walking by.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 761 Continued From page 46 F 761

On 3/11/20 at 6:02 PM the facility Director of Nursing (DON) was made aware of the treatment cart and medication cart on one unit being left open and unsecured, therefore leaving medications accessible to anyone walking by. The DON was asked if this was acceptable. The DON stated it was not acceptable.

Review of the facility policy titled "Medication Storage" read, "Medications shall be stored in an orderly manner in cabinets, drawers of sufficient size to prevent crowding. All medications including treatment items, shall be stored in a locked cabinet, inaccessible to residents and visitors. All medications on hand for residents who expire and those medications not sent home with residents at the time of their move-out shall be immediately withdrawn from storage and either locked away separately, or immediately destroyed."

On 3/11/20 and again on 3/12/20 during end of day meetings the facility Administrator and DON were made aware of the facility staff's failure to ensure medications were stored under lock and secured. No further information was provided.

F 842 SS=E Resident Records - Identifiable Information F 842
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 47	F 842		

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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 48 (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, Resident interview, staff interview, facility documentation review, clinical record review the facility staff failed to ensure Resident identifiable information was not open for public viewing and ensure an accurate clinical record for 3 Residents (Resident #33, #242, #28) in a survey sample of 18 Residents. The findings included: 1. For Resident #33 the facility staff failed to ensure the Resident's code status regarding DNR was accurately reflected in the clinical record. Resident #33 was admitted to the facility on 2/3/20 with a recent readmission on 2/13/20. Diagnoses for Resident #33 included but were not limited to: fracture of upper and lower end of left fibula, osteoarthritis, idiopathic neuropathy, obesity, and hypertension.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	**5100 FILLMORE AVENUE ALEXANDRIA, VA 22311**

(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 49	F 842		

Resident #33's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 2/20/20 was coded as a Medicare 5-day assessment. Resident #33 was coded on this assessment as having had a BIMS (brief interview for mental status) score of 15, which indicated no cognitive impairment.

On 3/11/20 a review of the clinical record for Resident #33 was performed and revealed the following:
The Admission Record/Facesheet in the front of the clinical record,with a print date of 3/2/20 revealed a code status of "FULL CODE;"
Behind the Advance Directives tab of the clinical chart was a "Durable Do Not Resuscitate Order" dated 2/9/20 signed by Resident #33 and the attending physician;
The electronic clinical record revealed a code status of "Full Code;"
The careplan for Resident #33 had a focus dated 2/13/20 that read, "Code Status: DNR Code." At the top of the careplan was a "Special Instructions" bar that read, "FULL CODE;"
The "Physician's Order Data Record" for March 2020 read, "Code Status: DNR."

On 3/11/20 at 5:43 PM an interview was conducted with Licensed Practical Nurse (LPN) B, the evening supervisor. When LPN B was asked how he knows the code status of a Resident he said there is a colored page in the front of the chart that has it and showed the surveyor in a chart the colored page. LPN B was asked what he would do if there was no colored page in the chart, LPN B stated, "Look at the face sheet, if they have a DNR it is under Advance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 50	F 842		

Directive tab."

On 3/11/20 at 5:46 PM an interview was conducted with Registered Nurse (RN) A who was responsible for the care of Resident #33 during that shift. RN A was asked what the code status of Resident #33 was. RN A said he would look at the MAR (Medication Administration Record), "Every resident has code status in the MAR;" he then looked at the MAR for Resident #33. He was not able to find the code status for Resident #33 on the MAR so he then stated, "If you look in the computer it will show code status." RN A proceeded to the nursing station and pulled the chart of Resident #33 and said the face sheet says "Full code, normally there is a full page that says code status;" but he wasn't able to find that document in the clinical record for Resident #33. RN A then turned to the Advance Directives section of the chart which revealed a DNR. RN A was asked what he would do in this case. RN A stated, "In this case I would take a risk and do CPR until it is clarified. I would chance being sued for resuscitating versus not resuscitating. Wow, that's a big one." RN A stated the code status for Resident #33 would be clarified.

On 3/11/20 at 6:02 PM an interview was conducted with the facility DON (Director of Nursing) in the conference room. She was asked how she knows if a Resident is a DNR. The DON stated, "I would look for the Golden Rod" [referring to the Durable Do Not Resuscitate Order]. She was asked what if the chart is inconsistent, the DON said "I would look at the date." The surveyor showed the DON that Resident #33's facesheet had a print date of 3/2/20 and the Durable Do Not Resuscitate Order was dated 2/9/20. The DON stated she would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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		F 842		

Continued From page 51
expect it to be documented consistently in the chart.

On 3/12/20 the facility Administrator provided the survey team facility policies with regard to CPR and DNR orders. Review of the facility policy titled "Cardiopulmonary Resuscitation- CPR" read, "CPR is to be initiated on any Resident that does not have a "No Code" or a "DNR" order from the Resident's physician."

Review of the facility polity titled "DNR Status" read, "It is the policy of [facility company name redacted] and its affiliates that we will not use cardopulmonary resuscitation to maintain life functions on a resident when there is a DO NOT RESUSCITATE ORDER in effect."

The facility Administrator and DON were made aware of the inaccurate clinical record with regard to code status for Resident #33 during an end of day meeting held on 3/11/20 and again on 3/12/20. No further information was provided.

2. For Resident #242 the facility staff failed to ensure Resident identifiable information was not open and available for public viewing.

Resident #242 was admitted to the facility on 2/26/20. Diagnoses for Resident #242 included but were not limited to: right rib fracture, hypertension, chronic kidney disease, and anemia.

Resident #242's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 3/4/20 was coded as an admission assessment. Resident #242

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 52	F 842		

was coded on this assessment as having had a BIMS (brief interview for mental status) score of 15, which indicated no cognitive impairment.

On 3/11/20 at 5:46 PM Surveyor C walked down the hall on the George unit and observed the medication cart in the hall, outside of room 57. On top of the medication cart the MAR (medication administration record) book was observed to be open, Resident #242's MAR page was visible. Surveyor C did not observe any staff within line of sight of the cart. Surveyor C was able to observe that the MAR for Resident #242 which had the following information visible: date of birth, name, Code Status, Medications with diagnoses listed. RN A came out of an unoccupied Resident room, approximately 3 minutes after the Surveyor arrived at the medication cart. RN A was asked if he saw any problems with his medication cart and RN A stated, "I should have covered it [referring to the MAR]."

On 3/11/20 at 6:02 PM the facility Director of Nursing (DON) was made aware of the MAR for Resident #242 being left open and visible for anyone walking by. The DON was also made aware that private health information was visible and she was asked if this was acceptable. The DON stated it was not acceptable.

On 3/11/20 and again on 3/12/20 during the end of day meetings the facility Administrator and DON were made aware of the facility staff's failure to ensure Resident identifiable information was not open and available for public viewing for Resident #242. No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 53	F 842		

Continued From page 53

3. For Resident #28, the facility staff failed to accurately document:

A) Advanced directive preference;
B) Physician's order for frequency of weights;
C) Treatment administration of showers.

A) Resident #28 was admitted to the facility on 02/11/2020. Diagnoses included but not limited to unspecified displaced fracture of surgical neck of left humerus, chronic obstructive pulmonary disease, and congestive heart failure.

Resident #28's Minimum Data Set with an Assessment Reference Date of 02/18/2020 was coded as an admission assessment. The Brief Interview for Mental Status was coded as 15 out of possible 15 indicative of intact cognition.

One 03/11/2020, a review of the clinical record was conducted. The following conflicting information was observed:

On a document entitled, "Admission Record" in the section "Code Status", it was documented, "Full Code."
On a document entitled, "Physician's Admission Orders", an entry dated 02/11/2020, documented, "Code Status Full Code."
On a document entitled, "Medications/Treatments," undated, it was documented, "Code Status Full Code."

On a document entitled, "Durable Do Not Resuscitate Order" dated 02/18/2020, it was documented, "The patient is capable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 54	F 842		

(Signature of patient is required)" "I hereby direct any and all qualified health care personnel, commencing on the effective date noted above, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions, such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain." The document was signed by [Resident #28] and the provider.

On a document entitled, "Physician's Order Data Record," an entry dated 02/11/2020 documented, "Code Status: Full Code." It was signed by the provider on 02/28/2020 (ten days after the 'Durable Do Not Resuscitate Order' was signed). The care plan was reviewed. A focus initiated on 02/13/2020 and revised on 02/18/2020 entitled, "Code Status: DNR Code Status." Situated below the revision date, it was documented, "Full code." In a section above this focus entry entitled, "Special Instructions", it was documented, "Full Code."

On 03/12/2020 at approximately 9:30 AM, the nurse caring for Resident #28, Licensed Practical Nurse C (LPN C) was interviewed. When asked about the code status for Resident #28, LPN C stated, "I think she's a full code." LPN C then walked to the med cart nearby and looked at the Medication Administration Record for Resident #28. LPN C then pointed to the entry and stated that [Resident #28] is a full code. When asked where she would find code status information in an actual emergency, LPN C stated that she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 55	F 842		

would check the chart. LPN C and this surveyor went to look at the hard chart and observed the Durable Do Not Resuscitate Order. LPN C looked at the date on the Do Not Resuscitate Order and flipped through the chart to look for a physician's order. LPN C and this surveyor looked at the physician's order for full code dated on 02/11/2020. When asked what should be done in an emergency, LPN C stated she thinks since the Do Not Resuscitate Order was most recent and dated on 02/18/2020, she would go with the Do Not Resuscitate." LPN C and this surveyor then looked at the physician's order for full code on 02/11/2020 and signed by the provider on 02/28/2020. When asked what should be done in an emergency, LPN C didn't answer.

On 03/12/2020 at approximately 9:45 AM, the Director of Nursing (DON) was notified of concern that staff were uncertain of [Resident #28]'s code status and conflicting information in the clinical record. The DON stated she would find out what [Resident #28] wants pertaining to advanced directives.

On 03/12/2020 at 12:00 PM, Resident #28 was observed in her room seated in a wheelchair. When asked about her preference for advanced directives, Resident #28 stated that she signed a "Do not Resuscitate" and stated that "That's still the way I want it." Resident #28 then stated, "Who wants to die twice?"

B) On the document entitled, "Physician's Admission Orders" dated 02/11/2020, it was documented, "Weight on admission, QDx3DAYS [every day for 3 days], QWKx4 [every week for four weeks], QMONTHLY [every month]."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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 56	F 842		

On a document entitled, "Physician's Order Data Record" dated 02/14/2020, it was documented, "Weight every week x 4 [for 4 weeks] then monthly."

On the document entitled, "Physician's Order Data Record" dated 02/24/2020, it was documented, "Record pt [patient] weights on Mon + Friday 7-3 [Monday and Friday on the 7-3 shift]."

A document entitled, "Medications/Treatments" undated, with columns numbered 1 through 31. An entry documented, "Shower resident twice a week on Wed + Sat 3-11 [Wednesday and Saturday on the 3-11 shift]." Boxes associated with this entry were outlined in black to highlight column 12, 15, 19, 22, and 26 meaning 02/12 [Wednesday], 02/15 [Saturday], 02/19 [Wednesday], 02/22 [Saturday], and 02/26 [Wednesday]. The shower was signed off as administered on 02/12/2020 but all the other blocks were blank.

On 03/12/2020 at approximately 10:15 AM, the facility was asked for a copy of all weights for Resident #28 and the DON provided a document entitled, "Weight Summary." There was one weight recorded on 02/12/2020 at 1:36 PM which documented, "148.8 lbs [pounds]." There were no other weights recorded.

On 03/12/2020 at approximately 10:15 AM, the Director of Nursing (DON) was notified of concerns that weights were not being done as ordered. This surveyor and the DON reviewed the conflicting orders for weights. When asked about the expectation, the DON agreed that it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	5100 FILLMORE AVENUE ALEXANDRIA, VA 22311

(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		F 842		

Continued From page 57

confusing and would expect the nurse to call the physician to clarify the order for frequency of obtaining weights.

C) On 03/10/2020 at approximately 3:15 PM, Resident #28 was observed in her room, seated in her wheelchair. When asked if she had any concerns about the care she receives at the facility, Resident #28 stated that she received a shower when she first arrived to the facility but that was the only shower she has had since arriving to the facility (one month ago). Resident #28 stated that the staff does not offer a shower and that maybe she needs to ask.

On 03/11/2020, the clinical record was reviewed. A physician's order dated 02/11/2020 documented, "Ambulation/mobility: bed to chair, with 1 assist, wheelchair." An order dated 02/11/2020 documented, "Shower resident twice a week on Wed/Sat 3-11 [Wednesday/Saturday on the 3 PM-11 PM shift."]. A document entitled, "Medications/Treatments" undated, with columns numbered 1 through 31. An entry documented, "Shower resident twice a week on Wed + Sat 3-11 [Wednesday and Saturday on the 3-11 shift]." Boxes associated with this entry were outlined in black to highlight column 12, 15, 19, 22, and 26 meaning 02/12 [Wednesday], 02/15 [Saturday], 02/19 [Wednesday], 02/22 [Saturday], and 02/26 [Wednesday]. The shower was signed off as administered on 02/12/2020 but all the other blocks were blank.

On 03/12/2020 at approximately 10:15 AM, the Director of Nursing (DON) was notified of concerns that showers were not being given and the DON stated that she would look into it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495288	A. BUILDING ______ B. WING ______	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT WASHINGTON HOUSE	**5100 FILLMORE AVENUE ALEXANDRIA, VA 22311**

(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 58	F 842		

Continued From page 58

On 03/12/2020 at approximately 11:45 AM, the DON presented a copy of a document entitled, "Notes." On Line 1, it was handwritten, "Refused shower, offer." On line 2, it was documented, "Bed bath, notify nurse." Under the header "Resident", Resident #28's name was listed. Under the header "Reported by" the name was illegible. Under the header "Date/Time" it was documented, "3/11/20."

On 03/12/2020 at approximately 12:00 PM, Resident #28 was observed in her room seated in her wheelchair. When asked if she ever refused a shower, Resident #28 stated, "Yesterday I didn't feel well so I refused yesterday." Resident #28 also stated that she worked it out with staff and she will get a shower tonight.

On 03/12/2020 at approximately 6:30 PM, the Administrator and DON were notified of findings. The administrator was asked if this reflected an inaccurate clinical record and he stated, "Yes." They offered no further information or documentation.