PRINTED: 03/25/2022 FORM APPROVED OMB NO. 0938-0391

1	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495011	B. WING			01/20/2022	
	ROVIDER OR SUPPLIER	AND REHAB (ALEXANDRIA)		15	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	survey was conducte The facility was in sul	nergency Preparedness d 1/19/22 through 1/20/22. ostantial compliance with 42 quirement for Long-Term	F	000			
	survey was conducte Corrections are requi CFR Part 483 Federa requirements.	-					
F 558	at the time of the survicensisted of 28 curre closed record reviews Reasonable Accomm	certified bed facility was 72 vey. The survey sample ent resident reviews and six s. odations Needs/Preferences	F	558			2/3/22
SS=D	services in the facility accommodation of re preferences except we endanger the health other residents. This REQUIREMENT by:	sident needs and			The statements made on this plan of		
	interview, facility doct record review, it was staff failed to ensure resident reach for one survey sample, Resid	ument review, and clinical determined that the facility call bell placement within e of 34 residents in the			correction are not an admission to and not constitute an agreement with the alleged deficiencies herein. To remain compliance with all Federal and State regulations, the center has taken or wil take the actions set forth in the followin plan of correction. The following POC	in I	
LABORATORY	call bell was out of re				constitutes the center s allegation of		(X6) DATE

Electronically Signed 02/03/2022

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.

Facility ID: VA0177

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495011	B. WING _			01/	20/2022
	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)	•	151	REET ADDRESS, CITY, STATE, ZIP CODE 10 COLLINGWOOD ROAD LEXANDRIA, VA 22308	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558	12/28/21 with diagnosclerosis (1) and hist recent MDS (minimulassessment with an adate) of 1/1/22, Resimoderately impaired She was coded as restaff for bed mobility On 1/19/22 at 1:17 p #60 was observed ly was visible. When in Resident #60 stated and had not seen it at A review of Resident plan dated 12/28/21 related to the resident On 1/19/22 at 3:50 p nurse) #1 was asked bell. She looked on the not initially find the comoved the privacy of bell lying on the floor bedside table. She coplaced it within the restated every staff med bell every time they admitted she had no call bell at all during #1 stated a resident.	dmitted to the facility on uses including multiple cory of a stroke. On the most m data set), an admission ARD (assessment reference dent #60 was coded as being for making daily decisions. Equiring the assistance of and transfers. Im. and 3:49 p.m., Resident ing in bed. No call bell cord terviewed about the call bell, she did not know where it is,	F 5	558	compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Corrective Action: Upon notification, resident #60 call bell/ light was placed within reach immediately. Identification: 100 percent audit completed to ensure that all residents bell/ light were within reach. System Change: Staff will be re-educa on ensuring resident call bell/ light are within reach. Monitoring: Facility Administrator and/ designee will round rooms to ensure the residents call bell/ lights are within reach residents daily x5, weekly x4, and mon x2 to ensure compliance. Date of Compliance: 2/24/2022 Per request of state agency, this POC been resubmitted.	or eat ch 5 thly	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	1, ,	E SURVEY PLETED	
		495011	B. WING _		01	/20/2022	
	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)	STREET ADDRESS, CITY, STATE, ZIP CO 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 558	assistant) #1 was in resident's call bell sl to the resident's bed accessibility is impo contact the staff quid. On 1/20/22 at 4:06 p staff member) #1, th director of nursing, a assurance consultar concerns. A review of the facili revealed, in part: "A conveniently for use be used to secure the	p.m., CNA (certified nursing terviewed. She stated the nould always be located next, within reach. CNA #1 stated rtant so the resident can ckly. b.m., ASM (administrative e administrator, ASM #2, the and ASM #3, the quality of, the were informed of these ty policy, "Call Light," ways position call light and within reach. A clip may	F 5	58			
F 583 SS=D	central nervous syst immune system atta nerve cells. Sympton weakness (often in the and burning sensation coordination and basis vision problems, and control. People with and have trouble the information is taken https://nccih.nih.gov	from the website /health/multiple-sclerosis. onfidentiality of Records)-(3)(i)(ii)	F 5	33		2/3/22	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495011	B. WING		0	1/20/2022	
	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 583	confidentiality of his records. §483.10(h)(l) Persor accommodations, m telephone communic and meetings of family this does not require private room for each successful success	ight to personal privacy and or her personal and medical mal privacy includes edical treatment, written and cations, personal care, visits, illy and resident groups, but the facility to provide a h resident. acility must respect the resonal privacy, including the sor her oral (that is, spoken), ic communications, including I promptly receive unopened is, packages and other to the facility for the resident, the red through a means other established. Desident has a right to secure sonal and medical records. the right to refuse the release lical records except as (i)(2) or other applicable	F 58	· · ·			
	by: Based on observatirecord review, it was failed to provide curl Resident # 21's roor	T is not met as evidenced on, staff interview and clinical s determined that facility staff ains, shades or blinds on n window to promote one of 34 residents in the		The statements made on this p correction are not an admission not constitute an agreement with alleged deficiencies herein. To rompliance with all Federal and	to and do h the emain in		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	510 COLLINGWOOD ROAD		
PROMEDI	CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		Α	LEXANDRIA, VA 22308		
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F 583	Continued From page	e 4	F 5	583			
	survey sample.				regulations, the center has taken or wi	I	
					take the actions set forth in the followir	ıg	
	The findings include:				plan of correction. The following POC		
					constitutes the center□s allegation of		
		admitted to the facility with			compliance such that all alleged		
	•	led but were not limited to:			deficiencies cited have been or will be		
		wing difficulties and muscle			corrected by the date indicated.		
	weakness.				Corrective Action: Upon notification,		
	Resident # 21's most	recent MDS (minimum data			facility immediately provided blinds in		
	set), a quarterly asse	,			resident #21 room in order to promote		
		ce date) of 11/14/2021,			personal privacy.		
	,	as scoring a 14 on the brief					
		status (BIMS) of a score of 0			Identification: 100 percent audit		
	- 15, 14 - being cogni	itively intact for making daily			completed to ensure that all resident		
		t 14 was coded as requiring			rooms contained curtain, shades, or		
	supervision of one sta				blinds to promote personal privacy.		
	[activities of daily living	ng].					
	0= 04/40/22 =+ 4:02 :	h			System Change: Staff will be re-educa		
	-	o.m. an observation of			on promoting personal privacy to inclu		
		ed they were sitting on the ident # 21 stated that they			curtains, shades, or blinds on the wind	OW.	
		dow curtains. Observation of			 Monitoring: Maintenance Director and/	or	
		window reveal that there			designee will round on 5 resident room		
		ades or blinds on the window.			for blinds daily x5, weekly x4 and month		
		indow revealed a view to the			x2 to ensure compliance.	-	
	neighboring commun	ity center.					
					Date of Compliance: 2/24/2022		
		o.m., an observation of					
		window reveal that there					
		ades or blinds on the window.					
	neighboring commun	indow revealed a view to the					
	neignboning commun	ny center.					
	On 01/19/22 at 4:12 t	o.m., an observation of					
		window reveal that there					
		ades or blinds on the window.					
		indow revealed a view to the					
	neighboring commun	ity center.					

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F 583	Continued From pa	ge 5	F 583				
	Resident # 21's roo were no curtains, shouservation of the veneral community of the veneral curtains. The should be shown to the conducted with Resident should be shown to the curtains. The should be should	7 a.m., an observation of m window reveal that there nades or blinds on the window. window revealed a view to the unity center. 9 a.m., an interview was sident # 21, regarding not es or curtains for their # 21 stated, "It's a violation of I feel more private if I had # 21 further stated that they has for the past 2 years. have privacy while changing, d, "I have to go into the					
	interview and obser room window was onurse] #1, unit man window RN # 1 stat that Resident # 21 or blinds on Reside asked how privacy Resident # 21, RN asked if Resident # her room from the company of the room window was on staff member] # 1, on observing the window were broke	pproximately 10:35 a.m., an evation of Resident # 21's conducted with RN [registered ager. After observing the ed that they were not aware did not have curtains, shades int # 21's room window. When was being provided for # 1 stated, "It can't be." When 21 was entitled to privacy in outside RN # 1 stated yes. pproximately 10:45 a.m., an evation of Resident # 21's conducted with OSM [other director of maintenance. After ow OSM # 1 stated that the dis that were installed on the and removed and that om measured and cut blinds					

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F 584 SS=D	did not have a covering 1 stated, "A couple of facility could have procovering to promote F # 1 stated that they w [Name of Store] to gethem that afternoon. On 01/20/2022 at apduring the end of the [administrative staff m ASM # 2, director of cought of the above findings. could have provided scovering to promote F the blinds that were on ASM # 3 stated yes. No further information Safe/Clean/Comfortation CFR(s): 483.10(i)(1)-(1)-(2)(483.10(i)) Safe Environmental CFR (s): 483.10(i) (1)-(2)(483.10(i)) A safe, homelike environmental couples in the person possible. (i) This includes ensureceive care and servered to promote of the person possible. (ii) This includes ensureceive care and servered that they was a couple of the person possible. (iii) This includes ensureceive care and servered that they was a couple of the person possible. (iii) This includes ensureceive care and servered that they was a couple of the person possible. (iiii) This includes ensureceive care and servered that they was a couple of the person possible. (iiii) This includes ensureceive care and servered that they was a couple of the person possible. (iiiiii) The facility must prove the person possible. (iiii) This includes ensureceive care and servered that they was a couple of the person possible.	g Resident # 21's window ng to provide privacy, OSM # weeks." When asked if the ovided some sort of window Resident # 21's privacy OSM were going to go out now to t a set of blinds and install proximately 4:06 p.m., day meeting, ASM member] # 1, administrator, clinical services, ASM # 3, consultant, were made aware When asked if the facility some sort of window Resident # 21's privacy until ordered arrived at the facility on was provided prior to exit. ble/Homelike Environment (7) conment. ght to a safe, clean, elike environment, including diving treatment and org safely.		584			2/3/22

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND REHAB (ALEXANDRIA)	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	,	
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F 584	(ii) The facility shall ethe protection of the ror theft. §483.10(i)(2) Housek services necessary to and comfortable inter §483.10(i)(3) Clean bin good condition; §483.10(i)(4) Private resident room, as specified in all areas; §483.10(i)(5) Adequate levels in all areas; §483.10(i)(6) Comford levels. Facilities initiated 1990 must maintain at 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observation	ees not pose a safety risk. Exercise reasonable care for esident's property from loss eeping and maintenance or maintain a sanitary, orderly, ior; ed and bath linens that are	F 58	·	do	
	was determined that the maintain a clean, hone of 34 residents in the #73 and Resident #2 change the resident's 1/19/22 and 1/20/22,	the facility staff failed to ne like environment for two survey sample, Resident 16. The facility staff failed to bloody draw sheet on and failed to ensure window had curtains or a		not constitute an agreement with the alleged deficiencies herein. To remain compliance with all Federal and State regulations, the center has taken or wi take the actions set forth in the following plan of correction. The following POC constitutes the center sallegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated.	in II	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		E SURVEY IPLETED
		495011	B. WING		0.	1/20/2022
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				1510 COLLINGWOOD ROAD		
PROMEDI	CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		ALEXANDRIA, VA 22308		
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F 584	12/21/21 with diagno		F 58	(a) Corrective Action: Upon notific facility changed resident #73 d with blood stain in order to pro	raw sheet	
	data set), an admiss (assessment referent Resident #73 was compairment for making scored 15 out of 15 of for mental status). The requiring the extension members for bed more dependent on two states from bed to chair. On the following data p.m.; 1/19/22 at 3:5. Resident #73 was of Underneath him was observed to have a series of the seri	ion assessment with an ARD ace date) of 12/27/21, oded as having no cognitive and daily decisions, having on the BIMS (brief interview the resident was coded as we assistance of two staff obility, and as being aff members for transfers and times, 1/19/22 at 1:27 4 p.m.; 1/20/22 at 8:16 a.m., oserved lying in bed.		comfortable, and homelike environment to include changing sheet if blood stains on draw sheet identified. System Change: Staff will be runner on ensuring each resident has clean, comfortable, and homel environment to include changing sheet if blood stain identified. Monitoring: Administrator and/will round 5 resident rooms for stains on draw sheet daily x5, and monthly x2 to ensure com	vironment. it ns to ensure were e-educated a safe, ike ng draw or designee blood weekly x4 pliance	
	the survey. A review of Resident plan dated 12/22/21 related to maintainin like environment. On 1/22/22 at 11:38 nurse) #1 was intervishe had checked Reflected with the stated she could she took care of Residay shift, and she was took care.	a.m., LPN (licensed practical iewed regarding the last time esident #73's bed linens. LPN not remember. She stated sident #73 on the previous as taking care of him on the e stated if a draw sheet has		(b) Corrective Action: Upon notific facility immediately provided by resident #21 room in order to phomelike environment. Identification: 100 percent aud completed on all resident room blinds were provided System Change: Staff will be non Safe, clean, comfortable, and environment to include blinds of window.	ation, linds in bromote it ns to ensure e-educated and homelike	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD ILEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	where the blood cam sure the sheet was chasked if a bloody bed like environment for a is not. On 1/20/22 at 12:21 passistant) #1 was into was currently taking of stated she had not not draw sheet until a few stated if she had not in rounds earlier in the schanged it immediated linen does not provid for a resident. On 1/20/22 at 4:06 p. staff member) #1, the director of nursing, at assurance consultant concerns. A review of the facility 584," revealed, in parany environment in the by residents, including rooms The concept includespractices the decrease the institution.	should be changed stated she did not know e from, and she could make hanged immediately. When a linen is a part of a home a resident, LPN #1 stated it o.m., CNA (certified nursing erviewed. She stated she care of Resident #73. She oticed the bloody spot on his or minutes ago. CNA #1 ced it when she made shift, she would have ely. She stated a bloody bed the a home like environment when the man and the shift, she would have ely. She stated a bloody bed the a home like environment when the man and the shift is the were informed of these administrator, ASM #2, the man and ASM #3, the quality is, the were informed of these when the facility that is frequented gower than the residents of creating a home setting that can be eliminated to conal character of the rethat does not reflect a	F	584	Monitoring: Maintenance Director, Administrator, and/or designee will rou 5 resident rooms for blinds on the wind daily x5, weekly x4 and monthly x2 to ensure compliance. Date of Compliance: 2/24/2022		
	2. Resident # 216 wa	n was provided prior to exit. s admitted to the facility with ed but were not limited to:					

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	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP COL 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	•	1120/2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 584	weakness. Resident # 21's mos set), a quarterly asse (assessment referenceded Resident # 21 interview for mental - 15, 14 - being cogr decisions. Resident supervision of one s [activities of daily living On 01/19/22 at 1:03 Resident # 21 reveaside of the bed. Resident # 21's roor were no curtains, shobservation of the wineighboring community. On 01/19/22 at 2:27 Resident # 21's roor were no curtains, shobservation of the wineighboring community.	trecent MDS (minimum data essment with an ARD ace date) of 11/14/2021, as scoring a 14 on the brief status (BIMS) of a score of onitively intact for making daily # 14 was coded as requiring taff member for ADLs angl. p.m. an observation of led they were sitting on the sident # 21 stated that they adow curtains. Observation of an window reveal that there ades or blinds on the window. Vindow revealed a view to the adds or blinds on the window. Vindow revealed a view to the adds or blinds on the window. Vindow revealed a view to the adds or blinds on the window. Vindow revealed a view to the adds or blinds on the window. Vindow revealed a view to the vindow revealed a view to the	F 5				
	Resident # 21's roor were no curtains, sh Observation of the w neighboring commun On 01/20/22 at 8:17 Resident # 21's roor were no curtains, sh	p.m., an observation of my window reveal that there ades or blinds on the window. vindow revealed a view to the mity center. a.m., an observation of my window reveal that there ades or blinds on the window. vindow revealed a view to the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 584	conducted with Reshaving blinds, shad window. Resident amy privacy. I would curtains." Resident have not had curtain When asked if they Resident # 21 state bathroom to have portion of the provided and the provided asked if the lack of homelike environment of the lack of the lack of homelike environment of the lack of the lack of homelike environment of	a.m., an interview was sident # 21, regarding not es or curtains for their # 21 stated, "It's a violation of I feel more private if I had # 21 further stated that they ns for the past 2 years. have privacy while changing, d, "I have to go into the	F 584	4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	VIDER OR SUPPLIER A SKILLED NURSING A	AND REHAB (ALEXANDRIA)		STREET ADDRE 1510 COLLING ALEXANDRIA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD E SS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
dd [a A C O C C C C C C C C C C C C C C C C C	during the end of the administrative staff madministrative succession of the above findings. The facility's policy "Factor of the staff o	proximately 4:06 p.m., day meeting, ASM nember] # 1, administrator, dinical services, ASM # 3, ansultant, were made aware. When asked if the facility some sort of window # 21's room window until redered arrived at the facility. This concept of creating a the elimination of dipractices to the extent ces that can be eliminated ational character of the but are not limited to, the at does not reflect a not or is uncomfortable; the eatments or drapes; the lack ence of bedspreads or ms or on walls." In was provided prior to exit. comprehensive Care Plans callity must develop and densive person-centered sident, consistent with the chat §483.10(c)(2) and	F				2/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		495011	B. WING		,	01/20/2022		
	ROVIDER OR SUPPLIER	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 656	describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the re under §483.10, include treatment under §483 (iii) Any specialized sere a result of recommendations. If findings of the PASAI rationale in the reside (iv) In consultation wite resident's representa (A) The resident's goodesired outcomes. (B) The resident's prefuture discharge. Fact whether the resident' community was assee local contact agencie entities, for this purpor (C) Discharge plans in plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on staff interview, and clinical redetermined the facility and/or implement the	are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized as the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-als for admission and efference and potential for illities must document as desire to return to the essed and any referrals to a sand/or other appropriate ose. In the comprehensive care in accordance with the in in paragraph (c) of this is not met as evidenced iew, facility document cord review, it was a systaff failed to develop comprehensive care plan in the survey sample,	F 68	The statements made on this correction are not an admissi not constitute an agreement alleged deficiencies herein. Tompliance with all Federal a regulations, the center has ta	on to and do with the To remain in and State			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495011	B. WING _				01/20/2022		
	ROVIDER OR SUPPLIER	AND REHAB (ALEXANDRIA)	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		•			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	CTION SHOULD BE O THE APPROPRIATE			
F 656	#69's comprehensive non-pharmacological management prior to medication on 1/12 develop a compreher things are the develop a compreher things are placed at a set) with and A date) of 11/2/2021 resimplement Resident plan intervention for [1], and failed to de	ed to implement Resident te care plan intervention to for al intervention for pain to administering pain and 1/16/2022; failed to tensive care plan for Resident andering as assessed and tenning on the MDS (minimum RD (assessment reference tesident assessment; failed to # 45's comprehensive care the checking the thrill and bruit to the checking the checking the thrill and bruit to the checking the ch	F	pll ccc ccc de ccc (a Cc in de im in or er ncc m	ke the actions set forth in the followan of correction. The following PO onstitutes the center's allegation of ompliance such that all alleged eficiencies cited have been or will borrected by the date indicated. Orrective Action: Upon notification, terdisciplinary team reviewed and eveloped #69 care plan regarding aplementation of non-pharmacological tervention for pain management and even one in-service completed with mployee regarding implementing a con-pharmacological intervention for anagement prior to administering edication.	pC f be be gical nd th i			
	5/17/2018 with diagrant limited to: stroke hemorrhage or block the brain leads to ox symptoms - sudden part [as an arm or paralysis weakness diabetes, and high but the most recent ME assessment, a quartassessment referent the resident as scori interview for mental resident was capable decisions. In Section coded as receiving stroke.	s admitted to the facility on moses that included but were to (abnormal condition in which kage of the blood vessels of exygen lack and resulting loss of ability to move a body earts of the face], or to speak, or if severe, death) (1), blood pressure. OS (minimum data set) terly assessment with an ce date of 12/28/2021, coded ing a "15" on the BIMS (brief status) score, indicating the e of making daily cognitive in J0100, the resident was scheduled pain regimen. The as stating she had no pain at		Sylvarian or state of the state	entification: 100 percent audit ompleted all residents with care placen-pharmacological interventions. System Change: Staff will be re-educed following and implementing a pon-pharmacological intervention for an agement prior to administering edication. Onitoring: DON and/or designee we onitor 5 residents with care plans on-pharmacological interventions of the complete plans and the comp	ucated or pain pain vill for daily sure			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495011	B. WING			01/	20/2022
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	510 COLLINGWOOD ROAD		
PROMEDI	CA SKILLED NURSING A	AND REHAB (ALEXANDRIA)	ALEXANDRIA, VA 22308		LEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
F 656	6 Continued From page 15		F	656			
	the time of the assess	sment.					
					Date of Compliance: 2/24/2022		
		are plan dated, 5/17/2018,					
		2021, documented in part,			(b)		
	_	alized." The "Interventions"			Corrective Action: Upon notification,		
		Administer pain medication			interdisciplinary team reviewed and		
	per physician orders.				developed #16 care plan to a patient		
	non-pharmacological				specific comprehensive care plan		
		other activities of choice to nonitor for effectiveness."			regarding behavior of wandering.		
	The physician and an a	1-1-1 10/10/2021			Identification: 100 percent audit		
	The physician order of	en (used to treat pain) (2)			completed of all residents assessed and triggered for wandering on MDS for care		
		Give 1 tablet orally every 12			plan development.	-	
	hours as needed for r				pian development.		
					System Change: Staff who complete M	DS	
	The January 2022 MA	AR (medication			will be re-educated on developing a		
	_) documented the above			patient specific care plan on behavior o	f	
	order for Ibuprofen. T	he Ibuprofen was			wandering when behavior triggers on		
	documented as given				MDS.		
		022 at 5:30 p.m. the MAR					
	entry documented the	•			Monitoring: DON and/or designee will		
	1/16/2022 at 6:37 a.m	•			monitor 5 residents assessed and	_	
	documented the pain	level of "3."			triggered for wandering on MDS daily x		
	Davious of the pureo's	notes and the aMAP			weekly x4 and monthly x2 to ensure that	ala	
		notes and the eMAR administration record) for			comprehensive care plan has been developed regarding wandering behavior	ors	
	the above two doses	•			to ensure compliance.	013	
	evidence documentat	•			to chaire compliance.		
		and failed to document any			Date of Compliance: 2/24/2022		
		interventions provided prior			'		
	to the administration	·			(c)		
					Corrective Action: Upon notification,		
	An interview was con-	ducted with LPN (licensed			interdisciplinary team reviewed and		
		n 1/20/2022 at 10:35 a.m.,			developed #45 care plan to ensure		
		s staff follows for resident		implementation regarding checking the			
		PN #3 stated the nurse first			thrill and bruit.		
		ate the pain, and then check					
	the physician orders f	or medication. If the			Identification: 100 percent audit		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
		495011	B. WING			01	/20/2022	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				1	510 COLLINGWOOD ROAD			
PROMEDI	CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		А	LEXANDRIA, VA 22308			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D BE COMPLÉTION		
F 656	Continued From page	<u>-</u> 16	F	656				
	resident does not have		'	000	completed all regidents care plans with			
		contact the doctor to see if			completed all residents care plans with interventions of monitoring bruit and th			
	-	mething. When asked if the			checks for bruit and thrill check	1111		
	nurse should ask the	resident where the pain is			interventions.			
		ed, yes, that's part of the When asked if the nurse			System Change: Staff will be re-educa	tod		
		giving the medication, LPN			on implementation of care plan regardi			
	, , ,	ck on them, if any pain, I then			monitoring thrill and bruit.	''9		
		n asked if the staff offers						
		interventions, LPN #3			Monitoring: DON and/or designee will			
		in pain, we can change			monitor residents with care plans with			
	position. When asked	where the location and the			interventions of monitoring bruit and th	rill		
	offering of non-pharm	nacological interventions is			checks daily x5, weekly x4 and monthly	y x2		
		stated, if we offered those			to ensure compliance			
	_	cumented in the MARS or						
	nurses notes.				Date of Compliance: 2/24/2022			
		ducted with RN (registered			(d)			
		022 at 10:45 a.m., regarding			Corrective Action: Upon notification,			
	the process the staff				interdisciplinary team reviewed and			
		N #1 stated, the nurse			developed #60 care plan and develope	:d		
		in, its location, and intensity,			an anticoagulant use care plan.			
		relieve the pain. If the pain is the physician orders and			Identification: 100 percent audit			
		rder for pain. If they don't			completed of all residents on			
		ordered we contact the			anticoagulant medications to ensure th	at		
	· ·	where the assessment, with			a comprehensive care plan has been	u.		
		nd the non-pharmacological			developed.			
	_ ·	was documented, RN #1			'			
		ocumented in the pain			System Change: Staff will be re-educa	ted		
	assessment or in the	nurse's notes.			on developing an anticoagulant use ca	re		
					plan.			
	An interview was con							
		nember) #2, the director of			Monitoring: DON and/or designee will			
	_	2 at 11:00 a.m., regarding			monitor 5 residents with anticoagulant			
		ws for resident complaints			medications daily x5, weekly x4 and			
	-	ed, the nurse will assess the			monthly x2 to ensure that a			
		on of pain, the intensity of			comprehensive care plan has been			
	i the Dain, rate the Dail	n on a pain scale of 0 -10.	1		developed regarding anticoagulant use	; LO	1	

OLIVILIV	O T OIT MEDIO, TILE &	- INLEDIO (ID OLIVIOLO				CIVID ITC	7. 0000 000 I
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495011	B. WING			01/	20/2022
	ROVIDER OR SUPPLIER	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	We try diversional act reposition the patient resident after the diversional act reposition the patient resident after the diversion of relieved; the nursion orders to see if they immedication. If no order the physician for an of the assessment with and non-pharmacological provided be documented the nurse's notes. The documentation of the pain and no document non-pharmacological provided prior to the amedication was shared. On 01/20/2022 at apprinterview was conduct nurse) # 1 regarding. When asked to describe resident's care plan in the patient's care plan in the patient's care plan in the patient's care and follow. When asked a implemented if there evidence the care plan on-pharmacological or provided, RN # 1 strength of the patient's care including interdisciplinary team information about the the patient's care including including which is care including the patient's c	tivities, talk to the patient, or You follow up with the ersional activity, if the pain is e checks the physician have an order for a pain er, the nurse should contact order. When asked where the pain intensity, location gical (diversional) ocumented, ASM #2 stated it ed in the pain assessment or e above concern of no location of Resident #69's intation evidencing interventions were offered/administration of the pain ed with ASM #2. Proximately 4:30 p.m. an exted with RN (registered comprehensive care plans ibe the purpose of a RN # 1 stated, it's based on it tells the staff what to about if the care plan was was no documented inned interventions was attempted in part, Assessment: nembers of the	F	656	ensure compliance. Date of Compliance: 2/24/2022 (e) Corrective Action: Upon notification, interdisciplinary team reviewed and developed resident #73 care plan and implemented care plan regarding use of Foley catheter. Identification: 100 percent audit completed on all residents with Foley catheter to ensure that a comprehensicare plan has been developed regarding Foley catheter. System Change: Staff will be re-education on developing and implementing a carplan regarding use of Foley catheter. Monitoring: DON and/ or designee will monitor 5 residents with Foley catheter daily x5, weekly x4 and monthly x2 to ensure that a comprehensive care plan has been developed regarding Foley catheter to ensure compliance. Date of Compliance: 2/24/2022	ve ng ted e	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND REHAB (ALEXANDRIA)	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD ILEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	enable the patient to factors to focus on ar interventions are goin and help the patient risk versus benefits or clarifying how the interteatments and other for effectiveness and consequences, identifying interventions. Implements and seveloped. The statinterventions identified may include, but not be treatments and medicate therapies, and participatient." According to Fundam Williams and Wilkins documented, "A writte communication tool as members that helps escareThe nursing cas information about the and goals. It contains achieving the goals eand is used to direct crevise and update the there are changes in with new orders" (3	meet their goals. Key e: evaluating how current ng to address the risk factors reach their goals, identifying if the current interventions, reventions regarding services will be evaluated monitored for negative fying members of the (in the center or outside, ponsible for implementing mentation: Once the care plan off must implement the d in the care plan. These limited to: administering mentations, performing mentals of Nursing Lippincott 2007 pages 65-77 en care plan serves as a mong health care team mensure continuity of me plan is a vital source of mentals of repatient's problems, needs, so detailed instructions for mentals dinstructions for mentals of repatient to review, mentals of repatient to review, mentals of repatient to review, mentals of repatient, and mentals of repatient, when mentals of repatient, and mentals of repatient mentals of repatient mentals of repatient mentals of	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495011	B. WING _			01/20/2022	
	ROVIDER OR SUPPLIER CA SKILLED NURSING	G AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
F 656	References: (1) Barron's Dictions Non-Medical Reade Chapman, page 114 (2) This information following website: https://medlineplus. tml (3) Fundamentals o & Wilkins 2007 Lipp pages 65-77. 2. Resident #16 wa diagnoses that inclu Alzheimer's disease depressive disorder Resident #16's mos set), an annual asse (assessment refere Resident #16 as so assessment for mer of 0 - 15, 7- being s daily decisions. Se displaying wanderin triggered behaviora care planned. On 1/19/2022 at ap observation was ma	ary of Medical Terms for the er, 5th edition, Rothenberg and 4. was obtained from the gov/druginfo/meds/a682159.h f Nursing Lippincott Williams sincott Company Philadelphia as admitted to the facility with aded but were not limited to e (1), dementia (2) and major (3). It recent MDS (minimum data essment with an ARD nce date) of 11/2/2021, coded oring a 7 (seven) on the staff ntal status (BIMS) of a score everely impaired for making cition E coded Resident #16 as an area to be proximately 12:30 p.m., an ade of Resident #16 in their 6 was observed sitting on the	F 6	,			
	1/19/2022 at approx 1/20/2022 at approx	ions of Resident #16 on kimately 3:15 p.m. and kimately 10:45 a.m. revealed ng in the hallways of the unit					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 656	failed to evidence a and triggered wands. On 1/20/2022 at 1:2 conducted with LPN LPN #2 stated that r behaviors every shift care plan was a protocare for the resident resident were docum #2 stated that reside have care plans dev. On 1/20/2022 at apprinterview was condunurse) #1. RN #1 st guideline for the care asked about behaviors stated that she wand #1 stated that Resid plan addressing spedocumentation of being processing to the care asked about behaviors at the care asked about asked about behaviors at the care asked about behaviors at the care asked about behaviors at the care asked about asked about behaviors at the care asked about asked about behaviors at the care asked about asked about asked about behaviors at the care asked about asked	care plan for Resident #16 care plan for the assessed ering behaviors. O p.m., an interview was (licensed practical nurse) #2. esidents were monitored for t. LPN #2 stated that the cocol for the staff to follow to and behaviors specific to the nented on the care plan. LPN ents who wandered should eloped for the behavior. Oroximately 3:00 p.m., an cted with RN (registered ated that the care plan was a se of the resident. When ors for Resident #16, RN #1 dered and did not sleep. RN ent #16 should have a care cific behaviors and shavior monitoring.	F 6			
	member) #2, the dire asked about behavior stated that Resident wandering, pacing be sleeping. ASM #2 sepond have a care predications, side efficient medications, side efficient medications. On 1/20/2022 at apprequest was made to	ack and forth and not tated that Resident #16				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
		495011	B. WING _			1/20/2022	
	ROVIDER OR SUPPLIER	NG AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CO 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	•		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 656	Continued From p	page 21	F 6	256			
	email, "Interdiscip 11/2016 which do "Assessment all interdisciplinary to information about includes completic (MDS), Care Area facility-specific aspatient's care incluand/or risks (poteneeds; evaluating or chronic; setting frames; and deterenable the patient On 1/20/2022 at a #1, the administranursing and ASM consultant were n further information References: 1. Alzheimer's disan irreversible, preslowly destroys meventually, the abtasks. It is the moin older adults." The website https://www.nia.ni 2. Dementia: A lowith certain diseasalanguage, judgment interdisciplinary in the size and in the certain diseasalanguage, judgment interdisciplinary in the size and interdisciplinary in the size and interdisciplinary in the size and interdisciplinary interdisciplinary in the size and interdisciplinary interdisciplinary to the size and interdisciplinary interdiscipli	linary Care Planning" dated cumented in part, lows members of the sam to gather essential the patient. Assessment on of the Minimum Data Set a Assessments (CAAs), and sessments. Planning the udes identifying problems intial or actual), strengths, and whether the problem is acute in measurable goals with time mining the interventions that will it to meet their goals" Approximately 4:00 p.m., ASM attor, ASM #2, the director of #3, the quality assurance of the findings. No in was provided prior to exit. Sease: "Alzheimer's disease is orgessive brain disorder that the mory and thinking skills and, illity to carry out the simplest st common cause of dementia this information is taken from the h.gov/health/alzheimers/basics. Sess of brain function that occurs ses. It affects memory, thinking, and, and behavior. This btained from the website:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED		
		495011	B. WING _			01/20/2022		
	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308					
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 656	3. Major depressive disorder. It occurs we loss, anger, or frustrilife over a long period how your body work obtained from the we https://medlineplus.g. 3. Resident # 45 was diagnoses included stage renal disease recent MDS (minimulassessment with an date) of 12/11/2021, scoring a 15 on the status (BIMS) of a severely impaired of decisions. Section Procedures and Profor "Dialysis" while a The physician's order "Check AV [arterial/ores]	e disorder: is a mood when feelings of sadness, ation get in the way of your and of time. It also changes s. This information was ebsite: gov/ency/article/000945.htm. as admitted to the facility with but were not limited to: end [2]. Resident # 45's most um data set), a quarterly ARD (assessment reference coded Resident # 45 as brief interview for mental core of 0 - 15, 15 - being fecognition for making daily O Special Treatments, grams" coded Resident # 45	F 6	556				
	dated 11/18/2021 do Renal insufficiencies failure. Date Initiate "Interventions" it do access site for lack infection, swelling, of facility guidelines. F physician. Date Init	care plan for Resident # 45 ocumented in part, "Focus: s related to: chronic renal d: 06/24/2021." Under cumented in part, "Check of thrill/bruit, evidence of or excessive bleeding per Report abnormalities to stated: 06/24/2021."						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495011	B. WING _			01/	20/2022		
	ROVIDER OR SUPPLIER CA SKILLED NURSING A	AND REHAB (ALEXANDRIA)	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	REFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE		
F 656	documented in part, "fistula (R-[right] Uppe shift." Further review blanks on the 7:00 a. 12/12/2021, 12/27/20 The eTAR [electronic Resident # 45 dated in part, "Check AV [ar [right] Upper Arm) thr Further review of the the 7:00 a.m. to 3:00 On 01/20/2022 at aprinterview was conductively and the dates listed about interpret the blanks. signed off then it's not describe the purpose # 1 stated, "It's based tells the staff what to intervention on the reimplemented can the being implemented R reviewing the eTAR for December 2021 and # 45's comprehensive	Check AV [arterial/venous] or Arm) thrill/bruit every day of the eTAR revealed m. to 3:00 p.m. shift on 21 and on 12/30/2021. treatment record] for January 2022 documented terial/venous] fistula (R-ill/bruit every day shift." eTAR revealed blanks on p.m. shift on 01/07/2022. broximately 10:24 a.m., an eted with RN [registered ger. After reviewing the ber 2021 and January 2022 bove, RN # 1 was asked to RN # 1 stated, "If it's not at done." When asked to of a resident's care plan RN I on the patient's care and it follow." When asked if an sident's care plan is not y say that the care plan is N # 1 stated no. After or Resident # 45 dated January 2022 and Resident e care plan, RN # 1 was 5's care plan was being	F	356	BEHOLIKOT)				
	[administrative staff n ASM # 2, director of of Quality Assurance Co of the above findings.	proximately 4:06 p.m., ASM nember] # 1, administrator, clinical services, ASM # 3, possultant, were made aware a was provided prior to exit.							

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495011	B. WING		01/20/2022	
	ROVIDER OR SUPPLIER	G AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	1 0.120.2022	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 656	you should feel a gra "thrill." Another sist stethoscope a loud called a "bruit." If be and normal, the gra This information was https://www.vasculavisions/vascular-sucess/#:~:text=Wher Ofingertips,is%20stives. [2] The last stage of is when your kidney body's needs. This from the website: https://medlineplus. 4. Resident #60 was 12/28/21 with diagr sclerosis (1) and his recent MDS (minimassessment with an date) of 1/1/22, the moderately impaire She was coded as during the look back. A review of Resider revealed the following Rivaroxaban (2) Tastablet by mouth of fibrillation) (3). Give A review of Resider plan dated 12/28/27	your fingertips over the site entle vibration, which is called gn is when listening with a swishing noise will be heard oth of these signs are present aft is still in good condition. It is obtained from the website: arhealthclinics.org/institutes-diargery-and-medicine/dialysis-ac an%20you%20slide%20your%2 ill%20in%20good%20condition of the chronic kidney disease. This is can no longer support your information was obtained gov/ency/article/000500.htm. Is admitted to the facility on loses including multiple story of a stroke. On the most um data set), an admission an ARD (assessment reference resident was coded as being d for making daily decisions. The receiving an anticoagulant and the proof. In the control of the c	F 656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILI		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495011	B. WING		01/	20/2022		
	ROVIDER OR SUPPLIER CA SKILLED NURSING	G AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	1 2 1/20/2022			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 656	staff member) #2, t interviewed. She st is responsible for d care plan. She state the daily morning memoral coordinator focus of medications. ASM is should be included because the care president, and instructure for the resident of the resident of the resident needs. On 1/22/22 at 11:38 nurse) #1 was interested and in order for all of the resident needs. On 1/20/22 at 4:06 staff member) #1, the director of nursing, assurance consultation concerns. No further information for the resident needs. REFERENCES (1) "Multiple sclerost central nervous system attainerve cells. Symptoweakness (often in	9 a.m., ASM (administrative he director of nursing, was ated the interdisciplinary team eveloping the comprehensive ed residents are reviewed in neetings. Nursing and the MDS in the clinical items like #2 stated an anticoagulant in a resident's care plan lan is a snapshot of the cts the staff on how best to	F 65	6				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495011	B. WING _			01/	20/2022
	ROVIDER OR SUPPLIER CA SKILLED NURSING A	AND REHAB (ALEXANDRIA)		1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 656	Continued From page	e 26	F	356			
	vein thrombosis (DVT leg) and pulmonary e the lung). Rivaroxaba DVT and PE from hap	; a blood clot, usually in the mbolism (PE; a blood clot in n is also used to prevent opening again after initial					
	treatment is completed. It is also used to help prevent strokes or serious blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body, and possibly causing strokes) that is not caused by heart valve						
	website	ation is taken from the					
	types of arrhythmias, rhythms. Atrial fibrillat beat much faster thar upper and lower chan as they should. When	s one of the most common which are irregular heart tion causes your heart to n normal. Also, your heart's nbers do not work together n this happens, the lower ompletely or pump enough					
	feel tired or dizzy, or y palpitations or chest p your heart, which incr clots and can leads to	pain. Blood also pools in eases your risk of forming					
	taken from the websit	serious and even lications." This information is					

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495011	B. WING		01/20/2022		
	ROVIDER OR SUPPLIER	G AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	·		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION		
F 656	Continued From pa	age 27	F 65	56			
	12/21/21 with diagrand diabetes. On the data set), an admis (assessment references Resident #73 was a impairment for makes scored 15 out of 15 for mental status). indwelling catheter back period. On the following dap.m. and 1/19/22 a observed lying in b collection bag was floor.	as admitted to the facility on moses including heart failure me most recent MDS (minimum asion assessment with an ARD ence date) of 12/27/21, coded as having no cognitive king daily decisions, having on the BIMS (brief interview He was coded as having an in his bladder during the look ates and times, 1/19/22 at 1:27 t 3:54 p.m., Resident #73 was ed, and the Foley catheter lying in direct contact with the					
	the survey. A review of Reside revealed, in part: "catheter 16 FR (Fresize) with 10cc (cul Neurogenic Bladde for obstruction." A review of Reside plan dated 12/22/2 related to an indwer On 1/20/22 at 11:0 staff member) #2, 1 interviewed. She stis responsible for deside revealed to the staff member of the staff member) #2, 1 interviewed. She stis responsible for deside revealed to the staff member of t	nt #73's physician's orders 12/21/21 Maintain Foley ench - designates catheter bic centimeter) balloon for er. Change PRN (as needed) nt #73's comprehensive care 1 revealed no information					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	1, ,	E SURVEY PLETED
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	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	the daily morning mecoordinator focus on catheters. She stated included in a resident care plan is a snapsh instructs the staff on livesident. On 1/22/22 at 11:38 a nurse) #1 was intervice catheter should be incorder for all of the car to monitor the catheter. On 1/20/22 at 4:06 p. staff member) #1, the director of nursing, an	etings. Nursing and the MDS the clinical items like Foley I a Foley catheter should be I's care plan because the not of the resident, and how best to care for the a.m., LPN (licensed practical ewed. She stated a Foley cluded in the care plan in regivers to know they need	F 6	56		
F 657 SS=D	References (1) "A urinary cathete tube placed in the borfrom the bladder." The the website https://medlineplus.gc Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Comprehe §483.21(b)(2) A complete (i) Developed within 7 the comprehensive at	ensive Care Plans brehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that	F 6	57		2/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	NG AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CO 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	•	1720/2022	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 657	resident. (C) A nurse aide versident. (D) A member of the resident and the resident and the resident and their resident not practicable for resident's care plater or as requested become as requested become and team after each a comprehensive and assessments. This REQUIREMING. Based on observer record review, facting interview, it was dereview and/or review and/or	physician. urse with responsibility for the with responsibility for the good and nutrition services staff. practicable, the participation of the resident's representative(s). ust be included in a resident's the participation of the resident representative is determined the development of the the development of the the development of the the participation of the resident representative is determined the development of the the development of the the development of the the participation of the resident representative is determined the development of the the development of the the development of the the resident. The revised by the interdisciplinary the resident. The revised by the interdisciplinary the resident including both the the development review and staff the termined facility staff failed to the termined facility staff failed to the termined to revise the the replan of Resident #65 to the termined rails.	F 6	The statements made on the correction are not an admiss not constitute an agreement alleged deficiencies herein. compliance with all Federal regulations, the center has take the actions set forth in plan of correction. The following constitutes the center all compliance such that all alleged deficiencies cited have been corrected by the date indicated actions. Upon not care plan was revised for use the deficiencies of the date indicated action of the deficiencies cited have been corrected by the date indicated actions. Upon not care plan was revised for use the deficiencies of the deficiencies cited have been corrected by the date indicated actions.	sion to and do t with the To remain in and State taken or will the following wing POC egation of eged n or will be sted. iffication, #65 se of side rails.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			X3) DATE SURVEY COMPLETED			
		495011	B. WING		0.	1/20/2022
	ROVIDER OR SUPPLIER	AND REHAB (ALEXANDRIA)	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 657	coded Resident #65 assessment for ment of 0 - 15, 15- being or daily decisions. Sect as requiring extensive member for bed mobin personal hygiene. On 1/19/2022 at approbservation was mader oom. Resident #65 with one quarter bed upper right side of the interview was conducted Resident #65 stated grab onto for position Resident #65 stated they had signed a conthey used it. Additional observation 1/19/2022 at 2:45 p.r. 1/20/2022 at 9:15 a.r. bed with the quarter side of the bed. The physician orders evidence an order for the comprehensive of dated 10/01/2018 do complications due to r/t (related to) musculunavoidable. Date In	ressment with an ARD ce date) of 12/26/2021, as scoring a 15 on the staff al status (BIMS) of a score ognitively intact for making cion G coded Resident #65 e assistance from one staff ility, eating, toilet use and roximately 1:15 p.m., an de of Resident #65 in their was observed in their bed rail in the up position on the de bed. At that time an ced with Resident #65. that they used the bed rail to hing and during care. that they were not sure if insent for the bed rail but ans of Resident #65 on m. and 4:15 p.m. and m. revealed Resident #65 in bed rail up on the upper right for Resident #65 failed to r bed rails. care plan for Resident #65 cumented in part, "At risk for musculoskeletal problems lar dystrophy, loss may be hitiated: 10/01/2018, Revision de care plan failed to evidence	F 65	completed on residents with care plan revision. System Change: Staff will be on care plan revisions with urails. Monitoring: Administrator and will monitor residents with side x5, weekly x4 and monthly x that residents with side rails plan revision to ensure complete of Compliance: 2/24/20	e re-educated use of side d/or designee derails daily 2 to ensure have a care oliance.	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CO 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	NGWOOD ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 657	conducted with LPN LPN #2 stated that the were responsible for LPN #2 stated that the when there was a chanew. LPN #2 stated plan was to provide a in caring for the resident caring for the resident was to provide a conducted with RN # stated that the purposprovide guidelines for RN #1 stated that up conducted by the un coordinator. RN #1 required bed rails we ensure they were ap when a resident was rails they obtained a documented them on stated that they were for Resident #65 bed care resident who have ago. RN #1 stated that they were ap when a resident who have ago. RN #1 stated that they were for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident who have ago. RN #1 stated that they were appropriate for Resident #65 bed care resident #65 bed care resident #65 bed care resident #65 bed care resident #65 bed	Opp.m., an interview was (licensed practical nurse) #2. The RN's (registered nurses) updating the care plans. The care plan was updated ange in status or anything that the purpose of the care a protocol for them to follow dent. Opp.m., an interview was the care plan was to refer the care plan was to refer the care plan were at manager and the MDS stated that residents who are assessed for them to propriate. RN #1 stated that assessed as needing bed physician's order and the care plan. RN #1 and sure what was in place the care plan. RN #1 and send the care plan. RN #1 and send the care plan. RN #1 and the care plan assessed a few years that there should be a current mine if the bed rails were still dent #65. Toximately 4:00 p.m., a passing the care plan. ASM (administrative staff ininistrator for the facility and revising the care plan.	F 6	57		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		E SURVEY PLETED
		495011	B. WING _		01	/20/2022
	ROVIDER OR SUPPLIER	AND REHAB (ALEXANDRIA)	•	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 657	plan is a communical members of the intermeter each individual identifies the types a patient should receil Rail Guidelines" data part, "The individual plan addresses the for the use of the besinterventions and the elimination of the besinterventions. 1. Atrial fibrillation: rhythm of the hearth obtained from the went obtained from the went obtained from the went of the elimination of the part of the elimination of the besinterventions. 2. Muscular dystropis a group of more to the elimination of the part of the elimination of the besinterventions. This information website: https://vsearch.nlm.meta?v%3Aproject=	In part, "The patient's care ation tool that guides redisciplinary team in how to all patient's needs. It also and methods of care that the ve" The facility policy "Bed ed 4/20214 documented in alized comprehensive care medication symptom, the goal ed rail, individualized e plan for reduction or ed rail" 100 p.m., ASM #1, the #2, the director of nursing ality assurance consultant f the findings. 21	F 6	57		
F 690 SS=D	Bowel/Bladder Inco CFR(s): 483.25(e)(1	ntinence, Catheter, UTI)-(3)	F6	90		2/3/22

		(3) DATE SURVEY COMPLETED					
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	ROVIDER OR SUPPLIER	AND REHAB (ALEXANDRIA)	•	STREET ADDRESS, CITY, STATE, ZIP CO 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	DE	,	
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F 690	Continued From page		F6	590			
	resident who is continuadmission receives simaintain continence of condition is or become not possible to maintain \$483.25(e)(2)For a resincontinence, based of comprehensive assessed in the comprehensive assessed in the continuation of the continence of the cont	cility must ensure that hent of bladder and bowel on ervices and assistance to unless his or her clinical hes such that continence is ain. esident with urinary on the resident's asment, the facility must heres the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an asubsequently receives one wal of the catheter as soon the resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible. esident with fecal on the resident's asment, the facility must the two is incontinent of bowel treatment and services to hall bowel function as is not met as evidenced					
		n, staff interview, facility d clinical record review, it		The statements made on the correction are not an admiss	•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495011	B. WING _			01/20/2022	
NAME OF PR	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COL	•		
PROMEDI	CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		1510 COLLINGWOOD ROAD			
				ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 690	was determined that the facility staff failed to provide care and services for a Foley catheter for one of 34 residents in the survey sample, Resident #73. The facility staff failed to evidence regular care of Resident #73's Foley catheter, and failed to position the catheter in a manner to prevent infection. On 1/19/22 and 1/20/22 observation revealed Resident #73's Foley catheter collection bag was lying in direct contact with the floor.		F 6	not constitute an agreement alleged deficiencies herein. I compliance with all Federal a regulations, the center has take the actions set forth in the plan of correction. The follow	To remain in and State aken or will ne following ing POC		
				constitutes the center's allegated compliance such that all allegated deficiencies cited have been corrected by the date indicated	ged or will be		
	12/21/21 with diagnand diabetes. On the data set), an admiss (assessment references Resident #73 was compairment for making scored 15 out of 15 for mental status).	dmitted to the facility on oses including heart failure e most recent MDS (minimum sion assessment with an ARD noce date) of 12/27/21, oded as having no cognitive ng daily decisions, having on the BIMS (brief interview desident #73 was coded as greatheter in his bladder		Corrective Action: Upon notifing resident #73 immediately recorded for Foley catheter and propositioning, off the floor, was prevent infection. Identification: 100 percent authorized on all residents with Catheter for evidence of regulator positioning in a manner to infection such as, not in containing the containing in the containin	eived regular roper ensured to dit fth Foley ular care and prevent		
	On the following dat p.m. and 1/19/22 at observed lying in be collection bag was if floor. Resident #73 decline the survey. A review of Resident revealed, in part: "1: catheter 16 FR (Fre size) with 10cc (cub	es and times, 1/19/22 at 1:27 3:54 p.m., Resident #73 was d, and the Foley catheter ying in direct contact with the ed to be interviewed during t #73's physician's orders 2/21/21 Maintain Foley nch - designates catheter ic centimeter) balloon for . Change PRN (as needed)		System Change: Staff will be on Foley catheter regular car catheter positioning in a man prevent infection, such as, no with the floor. Monitoring: DON and/ or des monitor 5 residents with Fole daily x5, weekly x4, monthly evidence of regular care and a manner to prevent infection not in contact with the floor. Date of Compliance: 2/24/20.	e and Foley ner to ot in contact ignee will y catheter x2, to ensure positioning in n, such as,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495011	B. WING _			01/2	20/2022
NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSING A	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CO 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	ODE		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIA	I .	(X5) COMPLETION DATE
administration record administration record for the dates of his acrevealed no evidence received any care for A review of Resident plan dated 12/22/21 related to an indwelling on 1/22/22 at 11:38 anurse) #1 was interviewed to the interviewed for catheter. LPN #1 state every shift, at least. Included the insertion tubing. LPN #1 state assistants) provide the document it in the colif she could verify the if there is no docume not. LPN #1 stated, Innot done. Period. Which will will will will be could contain items the catheter bag, resulting on 1/20/22 at 12:21 passistant) #1 was interviewed for the floor of th	#73's MARs (medication s), TARs (treatment s), and point of care records dmission to the facility that Resident #73 had his Foley catheter. #73's comprehensive care revealed no information in gratheter. a.m., LPN (licensed practical ewed regarding the care that or a resident with a Foley ited, "It should be cleaned She stated the cleaning is site as well as the catheter is the CNAs (certified nursing ite catheter care, and imputer record. When asked ite catheter care is being done intation, she stated she could if it is not documented, it is then asked how a catheter be positioned in relation to ited the bag should never be or. She stated the floor intat could contaminate the	F	690			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495011	B. WING		01.	/20/2022
	ROVIDER OR SUPPLIER CA SKILLED NURSING A	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	·	
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F 690	her care on the comp a collection bag on th #1 stated the floor ha She states she charts has completed Foley On 1/20/22 at 4:06 p. staff member) #1, the director of nursing, ar assurance consultant concerns. The manag asked to provide infor Resident #73 had rec since his admission to A review of the facility Indwelling Catheter," information regarding	uter. She stated if she sees e floor, she picks it up. CNA s a risk of contamination. s on the computer when she catheter care for a resident. m., ASM (administrative administrator, ASM #2, the ad ASM #3, the quality , the were informed of these gement staff members were mation to evidence that eived Foley catheter care to the facility.	F 69	90		
F 697 SS=D	References (1) "A urinary cathete tube placed in the bod from the bladder." The the website https://medlineplus.go Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mana The facility must ensure provided to residents consistent with profess the comprehensive paind the residents' goal of the second second in the second in t	ure that pain management is who require such services, esional standards of practice, erson-centered care plan,	F 69	97		2/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		((X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE		
DDOMEDI	CA SKILLED MUDSING	AND DELIAD (ALEVANDDIA)		1510 COLLINGWOOD ROAD			
PROMEDI	CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIAT		
F 697	and clinical record refacility staff failed to refacility staff failed to remanagement programment by sample, Resident #69's pain a non-pharmacological administering pain mentagement. The findings include: Resident #69 was ad 5/17/2018 with diagned in the findings include: Resident #69 was ad 5/17/2018 with diagned in the part leads to oxysymptoms - sudden I part [as an arm or part [as an	riew, facility document review view, it was determined the maintain a complete pain in for one of 34 residents in desident #69. If to document the location of and failed to attempt/offer interventions prior to edication to Resident #69. In mitted to the facility on coses that included but were (abnormal condition in which age of the blood vessels of regen lack and resulting coss of ability to move a body rts of the face], or to speak, or if severe, death) (1), cood pressure. In mitted to the facility on coses that included but were (abnormal condition in which age of the blood vessels of regen lack and resulting cos of ability to move a body rts of the face], or to speak, or if severe, death) (1), cood pressure. In mitted to the facility on coses that included but were (abnormal condition in which age of the blood vessels of regen lack and resulting cos of ability to move a body rts of the face], or to speak, or if severe, death) (1), cood pressure. In mitted to the facility on coses that included but were (abnormal condition in which age of the blood vessels of regen lack and resulting cost of the face), or to speak, or if severe, death) (1), cood pressure. In mitted to the facility on coses that included but were (abnormal condition in which age of the blood vessels of regen lack and resulting cost of the face).	F	The statements made or correction are not an admost constitute an agreem alleged deficiencies here compliance with all Federegulations, the center has take the actions set forth plan of correction. The foconstitutes the center's a compliance such that all deficiencies cited have becorrected by the date ind. Corrective Action: Upon resident #69 was assessed denied pain at the time. Freviewed and revised to a document the location of and attempt/ offer a non-intervention for pain man administering pain medical light of pain and for attempting non-pharmacological intervention for document of pain and for attempting non-pharmacological intervention for pain manage to include documentation pain and attempting/ offer non-pharmacological intervention: Monitoring: DON and/or of manitor Execution to an administration of the pain and attempting offer non-pharmacological intervention:	nission to and dent with the in. To remain in ral and State as taken or will in the following llowing POC llegation of alleged een or will be icated. Inotification, ed for pain and 69 care plan wensure staff resident's pain pharmacological agement prior thation. It audit is on PRN pain ation of location of location of ring erventions. If the re-educate ement guideline of location of ring erventions.	ras al co	
	-	en (used to treat pain) (2) Give 1 tablet orally every 12 mild pain.		monitor 5 residents receimedications for documen of resident's pain and atte	itation of location		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		•	
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F 697	Ibuprofen. The Ibupr given on 1/12/2022, 1/12/2022 at 5:30 p. documented the pair 6:37 a.m., the MAR level of "3." On 1/17, entry documented the Review of the nurse (electronic medication the above dated and failed to evidence do of Resident #69's par non-pharmacologica attempted/provided the medication. The comprehensive and revised on 4/16/ "Focus: Pain - gener documented in part, per physician orders non-pharmacologica music, positioning or assist with pain and An interview was compractical nurse) #3, regarding the process complaints of pain. Lasks the resident to the physician orders resident does not hamedication, then you	JAR (medication d) for Resident #69 ove physician order for rofen was documented as 1/16/2022 and 1/17/2022. On m. the MAR entry in level of "4." On 1/16/2022 at tentry documented the pain 1/2022 at 5:27 p.m., the MAR are pain level of "0." Is notes and the eMAR on administration record) for a three doses of Ibuprofen, ocumentation of the location in and failed to document all interventions were prior to the administration of care plan dated, 5/17/2018, 1/2021, documented in part, 1/2021, documented in part, 1/2021, documented in part, 1/2021, documented in part, 1/2018 in The "Interventions" "Administer pain medication. Implement I interventions such as 1/2040 to the administration of complement and the pain interventions such as 1/20/2022 at 10:35 a.m., as staff follows for resident LPN #3 stated the nurse first 1/2040 to 1/20/2022 at 10:35 a.m., as staff follows for resident	F 6	non-pharmacological inte x5, weekly x4 and month compliance. Date of Compliance: 2/24	ly x2 to ensure		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRE 1510 COLLING ALEXANDRIA				
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F 697	of the pain is, LPN #3 the assessment for p try's anything prior to #3 stated, Yes, I che give medication. Wh offers/attempts non-p interventions, LPN #3 can change position. location and the offer interventions is docur offered those things, the MAR or nurses n An interview was con nurse) #1, on 1/20/20 the process staff follo of pain. RN #1 stated the pain, its location, done to relieve the pain we go to the physicial have an order for pain medication ordered w asked where the ass pain and attempted / interventions is docur should be documente in the nurse's notes. An interview was con (administrative staff r nursing, on 1/20/202: the process staff follo of pain. ASM #2 state resident for the locati the pain, rate the pain We try diversional ac reposition the patient	resident where the location 3 stated, yes, that's part of ain. When asked if the nurse giving the medication, LPN ck on them, if any pain, I then asked if the staff charmacological 3 if a resident is in pain, we When asked where the ring of non-pharmacological mented, LPN #3 stated, if we it would be documented in ootes. Inducted with RN (registered 222 at 10:45 a.m., regarding ows for resident complaints 14, the nurse should assess and intensity, what can be ain. If the pain is not relieved, an orders and see if they not if they don't have any we contact the doctor. When the essment, with location of the offered non-pharmacological mented, RN #1 stated it and in the pain assessment or	F	697				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION IG	1, ,	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	'		
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F 697	orders to see if they medication. If no ord the physician for an the assessment with and attempted/offere (diversional) interver ASM #2 stated it sho pain assessment or concern of no docun Resident #69's pain evidencing attempte non-pharmacological administration of the with ASM #2. The facility policy, "Find documented in part, documented in	se checks the physician have an order for a pain er, the nurse should contact order. When asked where the pain intensity, location ed non-pharmacological nitions were documented, buld be documented in the the nurse's notes. The above nentation of the location of and no documentation d/offered I interventions prior to the pain medication was shared e and after the administration pain harmacological interventions first. These include: patient or therapy intervention, s, positioning, counseling, sedback, massage, hypnosis, anscutaneous electrical nerve ultrasound, imagery, nerve thermal therapy, meditation, mentals of Nursing, Fifth cott Williams & Wilkins, page, one of the most complex is an invisible phenomenon eraction of affective	F6	97			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
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F 697	doesTypically peolocation, intensity, questions subjective but can be standardized tools assessment focusing for determining proper assessment also is in effective pain manage assessment informate. Even the best pain as one nurse is of limite shares the information professionals respons Subjective Data: In a client's pain, obtain a questions: Where is the magnitude or intervent what level of pain would be with the work of pain change with restemporal pattern)?I assessment is a lead controlObjective dato pain are the result autonomic nervous seneral responses of elevated blood press rate, diaphoresis, and persistent chronic parmodified or absent additional clues about vomiting, fatigue, and common with pain expressions and bod	enever the person says it ple describe pain by its ple describe pain by its pality, and temporal pattern. It is of the pain experience are expenses may be an accurate good particular therapy. Ongoing proportant for implementing an ement planDocument pain a comment planDocument pain an ement planDocument pain a comment planDocument pain a comment planDocument pain a comment plan accessible location. It is sessment conducted by the divalue unless he or she can attempt to assess the enswers to the following the pain located? What is ensity (level) of the pain? Could the client like to have? Could the client be willing to the pain feel to the client; the quality)? How does the transport of the activity, or time (its landequate or poor pain ataPhysiologic responses of the activation of the pystem. With acute pain, the beserved include tachycardia, ture, increased respiratory digastric distress. With in, these responses may be a contract of the property of the pain of the pain of the pain, the poserved include tachycardia, ture, increased respiratory of the pain of the property of the pain o	F	697			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
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decrease the pain. B rubbing, splinting, gui elevating the painful of positions frequently in On 1/20/2022 at 4:07 administrator, ASM # assurance consultant above concern. No further information References: (1) Barron's Dictionar Non-Medical Reader, Chapman, page 114. (2) This information of following website: https://medlineplus.gottml. F 698 SS=E CFR(s): 483.25(I) §483.25(I) Dialysis. The facility must ensurequire dialysis receiv with professional star comprehensive perso the residents' goals a This REQUIREMENT by: Based on staff interv and clinical record ret the facility staff failed for a complete dialysis	resent protective actions to Body movements such as arding, immobilizing, extremity, or changing may increase with pain" 7 p.m., ASM #1, the E2, and ASM #3, the quality the extrement of the	F 69		in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				15	10 COLLINGWOOD ROAD		
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F 698	Continued From pag	e 43	F	698			
F 698	The facility staff faile communication with treatment center and monitoring for potent evidenced by the staff #45's AV [arterial/veresident right upper physician orders on and 1/07/22. The findings include Resident # 45 was a diagnoses included stage renal disease recent MDS (minimulassessment with an date) of 12/11/2021, scoring a 15 on the status (BIMS) of a severely impaired of decisions. Section Procedures and Profor "Dialysis" while a The physician's order "Check AV [arterial/vupper Arm) thrill/bru 10/13/2021. Start D Days one time a day [Monday, Wednesdaff evidence of the staff page of the st	d to have ongoing Resident #45's dialysis I failed to ensure ongoing tial complications as If failure to assess Resident hous] dialysis fistula in the farm for a thrill/bruit per the 1/12/21, 12/27/21, 12/30/21 I dmitted to the facility with fout were not limited to: end [2]. Resident # 45's most find data set), a quarterly ARD (assessment reference coded Resident # 45 as forief interview for mental fore of 0 - 15, 15 - being cognition for making daily O Special Treatments, grams" coded Resident # 45	F	698	take the actions set forth in the following plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date indicated. Corrective Action: Upon notification, #4 dialysis care plan reviewed and revised ensure implementation of ongoing communication with resident dialysis treatment centers with a Hemodialysis Communication Form and ongoing monitoring for potential complications such as bruit and thrill assessment. Identification: 100 percent audit completed of all residents receiving dialysis services to ensure ongoing communication with residents dialysis treatment centers with Hemodialysis Communication form and ongoing monitoring for potential complications such as bruit and thrill assessment. System Change: Staff will be re-educa on communication with residents dialyst treatment centers with Hemodialysis Communication form and ongoing monitoring for potential complications such as bruit and thrill assessment Monitoring: DON and/or designee will	l5 d to	
	"Hemodialysis [Nam Wednesday, Friday Wed, Fri for dialysis.	e of Dialysis Center] Monday, every day shift every Mon, Order Date: 11/02/2021. 21. End Date: 12/08/2021."			monitor residents receiving dialysis services to ensure ongoing communication with residents dialysis treatment centers with Hemodialysis Communication Form and ongoing monitoring for potential complications		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		•		
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F 698	The comprehensive of dated 11/18/2021 dor Renal insufficiencies failure. Date Initiated "Interventions" it door Days of the week: 3 x [Monday/Wednesday 06/24/2021; Check at thrill/bruit, evidence of excessive bleeding properties abnormalities to phys 06/24/2021." On 01/20/2022 at appreview of Resident # book was conducted. Communication Form dialysis communication "Section 1: Complete Company] staff (send center). Significant of dialysis treatment: Fall risk: No YeTime Obtained: Tem Tympanic Temperent, describe: Pain/Burnit Thrill/Bruit, if absent, dry/intact: Patient Stathree] Confused Sedated/lethargic. [short ness of breath] Congestion Eden N/V [nausea/vomit (explain): Lab [latif needed): Result/Date Result/Date	care plan for Resident # 45 cumented in part, "Focus: related to: chronic renal l: 06/24/2021." Under umented in part, "Dialysis: a [three times] a week M/W/F b/Friday]. Date initiated: ccess site for lack of of infection, swelling, or er facility guidelines. Report dician. Date Initiated: croximately 9:30 a.m. a 45's dialysis communication The "Hemodialysis as" in Resident # 45's on book documented in part, d by [Name of Healthcare d with patient to dialysis hange/decline since last NoYes (explain): es (explain): Vital signs: perature: Axillary foral. B/P [blood pressure]: tion]: Weight:lbs ccess Site: Redness, if forainage, if present, ng, if present, describe: describe: Dressing atus:Orientated x3 [times	F	698	such as bruit and thrill assessment dai x5 weekly x4 and monthly x2 to ensure compliance. Date of Compliance: 2/24/2022	•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER CA SKILLED NURSING	G AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	DE		
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F 698	Continued From page	ge 45	F 69	8			
	Medications (attach medication regime s Nurse Signature: D Further review of th "Hemodialysis Com the following: - The form dated 01 documentation in al - The form dated 01 documentation und since last dialysis tr Lab Tests (attach co Received; Diet Orde patient compliance monitoring); Curren needed); Changes in the signature of the signature o	e Resident # 45's munication Form" revealed /05/2022 failed to evidence					
	evidence document change/decline sinc Dialysis Access Site needed); Result/Da Fluid Restrictions (il I&O [input and outp Medications (attach Changes in medicatreatment." - The form date 01/documentation under since last dialysis trust Lab Tests (attach con Received; Diet Order	m dated 01/10/2022 failed to ation under "Significant ce last dialysis treatment; e; Lab Tests (attach copy if ate Received; Diet Order / include patient compliance and ut] monitoring); Current copy if needed); and tion regime since last dialysis /12/2022 failed to evidence er "Significant change/decline eatment; Dialysis Access Site; opy if needed); Result/Date er / Fluid Restrictions (include and I&O [input and output]					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	•		
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F 698		Continued From page 46		98			
	needed); Changes i	Medications (attach copy if n medication regime since nt; Nurse Signature; and					
	documentation under since last dialysis treatly Lab Tests (attach conceived; Diet Order patient compliance a monitoring); Current needed); Changes in	/14/2022 failed to evidence er "Significant change/decline eatment; Dialysis Access Site; py if needed); Result/Date er / Fluid Restrictions (include and I&O [input and output] Medications (attach copy if medication regime since nt; Nurse Signature; and					
	documentation under since last dialysis treatles (attach conceived; Diet Order patient compliance amonitoring); Current needed); Changes in	1/16/2022 failed to evidence er "Significant change/decline eatment; Dialysis Access Site; py if needed); Result/Date er / Fluid Restrictions (include and I&O [input and output] Medications (attach copy if n medication regime since nt; Nurse Signature; and					
	- The form 01/19/2022 failed to evidence documentation under "Significant change/decline since last dialysis treatment; Dialysis Access Site; Lab Tests (attach copy if needed); Result/Date Received; Diet Order / Fluid Restrictions (include patient compliance and I&O [input and output] monitoring); Current Medications (attach copy if needed); Changes in medication regime since last dialysis treatment; Nurse Signature; and Date."						
	The eTAR [electroni	c treatment record] for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)	·	15	TREET ADDRESS, CITY, STATE, ZIP CODE 310 COLLINGWOOD ROAD LEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 698	fistula (R-[right] Upper shift." Further review blanks on the 7:00 a. 12/12/2021, 12/27/20 The eTAR [electronic Resident # 45 dated in part, "Check AV [at [right] Upper Arm) thr Further review of the the 7:00 a.m. to 3:00 On 01/20/2022 at appinterview was conductive was conductive was conductive was conductive was conductive to the purpose communication book communicate between center." RN #1 was a for completing Section "Hemodialysis Communicated, "The nurse will when asked why it will be section 1 of the "Henform", RN # 1 stated would know the conductive wing Resident # communication forms RN # 1 was asked if RN # 1 stated, "No, as the filled in." After review December 2021 and listed above, RN # 1 state it's not done."	December 2021 Check AV [arterial/venous] Ar Arm) thrill/bruit every day of the eTAR revealed m. to 3:00 p.m. shift on 121 and on 12/30/2021. Treatment record] for January 2022 documented Arterial/venous] fistula (R- ill/bruit every day shift." eTAR revealed blanks on p.m. shift on 01/07/2022. Droximately 10:24 a.m., an arted with RN [registered ger. When asked to of a resident's dialysis RN # 1 stated, "Use to an us [facility] and the dialysis asked who was responsible an 1 of the facility's munication Form." RN # 1 no is working at the time." as important to complete modialysis Communication , "So the dialysis center ition of the resident." After	F	598			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '			(X3) DATE SURVEY COMPLETED		
	495011	B. WING _			01/20/2022		
	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP (1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	•			
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFII TAG	X (EACH CORRECTIVE ACTURE CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
interview was conductable asked to describe the dialysis communicate. "Use to communicate when asked who was Section 1 of the facil Communication Fornurse who is working why it was important." "Hemodialysis Communicated, "So there is a when they go to dial Resident # 45's herr forms for the dates I asked if the forms w stated, "No, they're is asked if the forms w stated, "No, th	ceted with LPN # 3. When e purpose of a resident's ion book, LPN # 3 stated, e with the dialysis center." as responsible for completing lity's "Hemodialysis m" LPN # 3 stated, "The g at the time." When asked to complete Section 1 of the munication Form" LPN # 3 a baseline of the resident ysis." After reviewing nodialysis communication isted above, LPN # 3 was ere complete. LPN # 3 not completed." Approximately 4:06 p.m., ASM member] # 1, administrator, clinical services, ASM # 3, consultant, were made aware is. On was provided prior to exit. Id-stage kidney failure. It is your blood when your er do their job. Hemodialysis dialysis) does some of the job they stop working well. This ained from the website: gov/ency/patientinstructions/0 chronic kidney disease. This	F	698				
	CORRECTION ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF SUPPLIER) Continued From page interview was conducted asked to describe the dialysis communicated. "Use to communicate When asked who was Section 1 of the facil Communication Forn nurse who is working why it was important "Hemodialysis Communication Forn stated, "So there is a when they go to dial Resident # 45's herr forms for the dates I asked if the forms w stated, "No, they're in a sked if the forms w stated, "No, they're in Con 01/20/2022 at approximate [administrative staff] ASM # 2, director of Quality Assurance Co of the above findings. No further information References: [1] Dialysis treats en removes waste from kidneys can no long (and other types of confidence) of the kidneys when information was obtain the stage of its when your kidneys body's needs. This	A95011 ROVIDER OR SUPPLIER CA SKILLED NURSING AND REHAB (ALEXANDRIA) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 48 interview was conducted with LPN # 3. When asked to describe the purpose of a resident's dialysis communication book, LPN # 3 stated, "Use to communicate with the dialysis center." When asked who was responsible for completing Section 1 of the facility's "Hemodialysis Communication Form" LPN # 3 stated, "The nurse who is working at the time." When asked why it was important to complete Section 1 of the "Hemodialysis Communication Form" LPN # 3 stated, "So there is a baseline of the resident when they go to dialysis." After reviewing Resident # 45's hemodialysis communication forms for the dates listed above, LPN # 3 was asked if the forms were complete. LPN # 3 stated, "No, they're not completed." On 01/20/2022 at approximately 4:06 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of clinical services, ASM # 3, Quality Assurance Consultant, were made aware of the above findings. No further information was provided prior to exit. References: [1] Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00707.htm. [2] The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained	A BUILDI A BOVIDER OR SUPPLIER CA SKILLED NURSING AND REHAB (ALEXANDRIA) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 48 interview was conducted with LPN # 3. When asked to describe the purpose of a resident's dialysis communication book, LPN # 3 stated, "Use to communicate with the dialysis center." When asked who was responsible for completing Section 1 of the facility's "Hemodialysis Communication Form" LPN # 3 stated, "The nurse who is working at the time." When asked why it was important to complete Section 1 of the "Hemodialysis Communication Form" LPN # 3 stated, "So there is a baseline of the resident when they go to dialysis." After reviewing Resident #45's hemodialysis communication forms for the dates listed above, LPN # 3 was asked if the forms were complete. LPN # 3 stated, "No, they're not completed." 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This information was obtained	A BUILDING 495011 ROVIDER OR SUPPLIER CA SKILLED NURSING AND REHAB (ALEXANDRIA) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 48 Interview was conducted with LPN # 3. When asked to describe the purpose of a resident's dialysis communication book, LPN # 3 stated, "Use to communication book, LPN # 3 stated, "Use to communication book, LPN # 3 stated, why it was important to complete Section 1 of the "Hemodialysis Communication Form" LPN # 3 stated, "The nurse who is working at the time." When asked why it was important to complete Section 1 of the "Hemodialysis Communication Form" LPN # 3 stated, "So there is a baseline of the resident when they go to dialysis." After reviewing Resident # 45's hemodialysis communication forms for the dates listed above, LPN # 3 stated, "No, they're not completed." 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This information was obtained	A BUILDING BUPPLIER A95011 ROWDER OR SUPPLIER CA SKILLED NURSING AND REHAB (ALEXANDRIA) SUMMARY STATEMENT OF DEFICIENCES (EACH DEFOCEMENT OF THE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 48 Continued From page 48 Continued From page 47 Continued From page 48 F 698 F 698		

l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495011	B. WING		01/20/2022	
	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 698 F 700 SS=D	Bedrails CFR(s): 483.25(n)(1) §483.25(n) Bed Rails The facility must atter alternatives prior to ir a bed or side rail is used or side rail succorrect installation, userails, including but not elements. §483.25(n)(1) Assess entrapment from bed §483.25(n)(2) Review bed rails with the resire representative and of to installation. §483.25(n)(3) Ensure are appropriate for the second mendations an and maintaining bed This REQUIREMENT by: Based on observation	cov/ency/article/000500.htm. -(4) mpt to use appropriate astalling a side or bed rail. If sed, the facility must ensure se, and maintenance of bed at limited to the following the resident for risk of rails prior to installation. The risks and benefits of dent or resident obtain informed consent prior that the bed's dimensions e resident's size and weight. The manufacturers' dispecifications for installing rails. The is not met as evidenced The resident interview, staff	F 69	The statements made on this plan of		
	document review it w facility staff failed to a for the use of bed rail the survey sample, R The facility staff failed	ord review and facility as determined that the assess and obtain consent as for one of 34 residents in esident #65. It to evidence an assessment e of a bed rail for Resident		correction are not an admission to an not constitute an agreement with the alleged deficiencies herein. To remail compliance with all Federal and State regulations, the center has taken or vertake the actions set forth in the follow plan of correction. The following POC constitutes the center's allegation of compliance such that all alleged	n in e vill ing	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		E SURVEY PLETED
		495011	B. WING _			01.	/20/2022
	ROVIDER OR SUPPLIER CA SKILLED NURSING A	AND REHAB (ALEXANDRIA)		15	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 700	diagnoses that includ atrial fibrillation (1) ar Resident #65's most set), a quarterly asse (assessment reference coded Resident #65 assessment for ment of 0 - 15, 15- being codaily decisions. Sect as requiring extensive member for bed mob personal hygiene. On 1/19/2022 at approbservation was mad room. Resident #65 with one quarter bed upper right side of the interview was conducted Resident #65 stated to grab onto for position Resident #65 stated to they had signed a conthey used it. Additional observation 1/19/2022 at 2:45 p.n. 1/20/2022 at 9:15 a.n. bed with the quarter to side of the bed. The physician orders evidence an order for	mitted to the facility with ed but were not limited to ad muscular dystrophy (2). The recent MDS (minimum data assment with an ARD assment with an ARD as scoring a 15 on the staff all status (BIMS) of a score agnitively intact for making in G coded Resident #65 assistance from one staff allity, eating, toilet use and an extended with Resident #65. The the up position on the extended the bed. At that time an attended with Resident #65, that they used the bed rail to ing and during care. The they were not sure if the sent for the bed rail but the sof Resident #65 on the and 4:15 p.m. and the revealed Resident #65 in the revealed Resident #65 failed to	F	700	deficiencies cited have been or will be corrected by the date indicated. Corrective Action: Upon notification, resident #65 was assessed for bed rail and consent obtained. Identification: 100 percent audit completed of residents with bed rails. System Change: Staff will be re-educa on bed rail guidelines. Monitoring: Administrator and/or design will monitor 5 residents with bed rails of x5, weekly x4 and monthly x2 to ensur compliance. Date of Compliance: 2/24/2022	ted nee aily	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495011	B. WING _			01/	/20/2022		
	ROVIDER OR SUPPLIER	AND REHAB (ALEXANDRIA)		1510	ET ADDRESS, CITY, STATE, ZIP CODE COLLINGWOOD ROAD (ANDRIA, VA 22308	,			
(X4) ID PREFIX TAG			ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHO		3E	(X5) COMPLETION DATE		
F 700	dated 10/01/2018 doc complications due to r/t (related to) muscul unavoidable. Date In on: 10/01/2018." The documentation of the On 1/19/2022 at apprequest was made to member) #1, the admitted rail assessment abed rails for Resident On 1/20/2022 at 3:00 conducted with RN (right manager. RN #1 star required bed rails we ensure they were appropriate they were for Resident #65 become that they were for Resident #65 become resident who have ago. RN #1 stated that they were appropriate for Resident Work and may have ago. RN #1 stated they were appropriate for Resident who have ago. RN #1 stated they were still to determine they were ago. RN #1 stated they were still looking for the consent for Resident. A quality assurance conwere still looking for the consent for Resident.	cumented in part, "At risk for musculoskeletal problems lar dystrophy, loss may be ditiated: 10/01/2018, Revision e care plan failed to evidence use of bed rails. coximately 4:30 p.m., a ASM (administrative staff ninistrator for evidence of a land consent for the use of a land consent for the use of a land to a la	F	700					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495011	B. WING			01/	20/2022	
	ROVIDER OR SUPPLIER	G AND REHAB (ALEXANDRIA)	-	15	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD LEXANDRIA, VA 22308		-	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 700	bed rail, the interdiversity evaluation of the phospital discharge other historical document and family about the patient's identification of premedical evaluation symptom necessity resident assessment appropriateness of Whenever bed rail available intervent explains to the patternessentative how treat the patient's representative how treat the patient in attain practicable level of well-being. In add consequences of being used; circum applied" On 01/20/2022 at administrator, ASM and ASM #3, the owner made aware. No further informatical references:	t, "Prior to the utilization of a sciplinary team completes an atient including review of records, transfer sheets or cuments; an interview of the or resident representative history and risk factors; evious interventions utilized; of the presenting medical ating the use of the bed rail; ent for risk of entrapment and if bed dimensions for patient. Use is determined as the only ions, the interdisciplinary team itent, family and resident in the use of the bed rail would medical symptom and assists hing or maintaining the highest if physical or psychological ition, the potential negative oved rail use are explained and is obtained. A physician's order des the number of bed rails; the for which the bed rail(s) is instances in which the bed rail is 4:00 p.m., ASM #1, the M # 2, the director of nursing uality assurance consultant of the findings. The Aproblem with the speed or the teat. This information was	F	700				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495011	B. WING			01/	/20/2022
	ROVIDER OR SUPPLIER	AND REHAB (ALEXANDRIA)		1	TREET ADDRESS, CITY, STATE, ZIP CODE 510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757 SS=D	ion.html>. 2. Muscular dystroph is a group of more that They all cause muscl loss. Some forms of I childhood. Others made or later. The diffethey affect, which must the symptoms are. At as the person's musc with MD eventually low there is no cure for more than the prevent complications speech therapy, orthomodications. Some prevent complications are speech therapy, orthomodications. Some prevent complications speech therapy, orthomodications. Some prevent complications are speech therapy, orthomodications. Some prevent complications and severe obtained from the well-shall speech therapy (1) speech the severe obtained from the well-shall speech therapy (2) speech the severe obtained from the well-shall speech therapy (3) speech therapy (3) speech therapy (3) speech the severe obtained from the well-shall speech the severe obtained from the well-shall speech therapy (3) speech therapy	ny: Muscular dystrophy (MD) an 30 inherited diseases. e weakness and muscle MD appear in infancy or ay not appear until middle erent types can vary in whom scles they affect, and what I forms of MD grow worse eles get weaker. Most people ese the ability to walk. In the symptoms and so the symptoms and so the symptoms and expedic devices, surgery, and eople with MD have mild expedic devices, surgery, and expedic devices, surgery, and expedic devices, surgery an		700			2/3/22
	3403.43(a)(3) WILNOU	ii auequate monitoring, or					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495011	B. WING _			01/20/2022	
	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP COD 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 757	Continued From pag	e 54	F 7	757			
	§483.45(d)(4) Withoutuse; or	ut adequate indications for its					
	§483.45(d)(5) In the consequences which reduced or discontinu	indicate the dose should be					
	§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:						
	Based on staff intervand clinical record refacility staff failed to one of 34 residents in			The statements made on this correction are not an admission not constitute an agreement valleged deficiencies herein. To compliance with all Federal aregulations, the center has tall	on to and do with the o remain in nd State		
	Resident #69's physician ordered pain medication as needed every twelve hours for mild pain. On 1/17/22 the facility staff administered the as needed pain medication to Resident #69's when the residents documented pain level rating was zero indicating no pain.			take the actions set forth in the plan of correction. The following constitutes the center's allegated compliance such that all allegated deficiencies cited have been corrected by the date indicated	ne following ing POC ation of led or will be		
	The findings include:			Corrective Action: Upon notification resident #69 was assessed for			
	Resident #69 was admitted to the facility on 5/17/2018 with diagnoses that included but were not limited to: stroke (abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak,			reported a 0 pain score at the to one in-service conducted wemployee regarding not admit PRN pain medication when rescore is 0.	e time. One vith nistering esident pain		
	diabetes, and high bl	or if severe, death) (1), ood pressure. S (minimum data set)		residents with PRN pain medi unnecessary medications-rec pain medication when pain let indicating no pain	eiving PRN		
	THE HOST TECENT MD	ر (۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱۱		mulcaling no pain			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495011	B. WING _			01:	/20/2022
	ROVIDER OR SUPPLIER CA SKILLED NURSING A	AND REHAB (ALEXANDRIA)		15	REET ADDRESS, CITY, STATE, ZIP CODE 10 COLLINGWOOD ROAD LEXANDRIA, VA 22308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 757	assessment reference the resident as scorin interview for mental stresident was capable decisions. In Section coded as receiving so resident was coded at the time of the assess. The physician order of documented, Ibuprofe 400 mg (milligrams); hours as needed for resident was received administration record physician order. On documented pain level was received to documented pain level with a pain level wi	erly assessment with an e date of 12/28/2021, coded g a "15" on the BIMS (brief tatus) score, indicating the of making daily cognitive J0100, the resident was cheduled pain regimen. The s stating she had no pain at sment. dated, 10/19/2021, en (used to treat pain) (2) Give 1 tablet orally every 12 mild pain. AR (medication of documented the above 1/17/2022 at 5:27 p.m., the el for Resident #69 was documented the staff nurse profen 400 mg to Resident of zero. 69's nurse's notes and MAR tent the location of Resident evel or if interventions were care plan dated, 5/17/2018, 2021, documented in part, alized." The "Interventions" Administer pain medication	F	757	System Change: Staff will be re-education following pain management progratinclude not administering PRN pain medication when resident pain score is Monitoring: DON and/or designee will monitor 5 residents with PRN pain medications for unnecessary medications-receiving PRN pain medications when pain level zero indicating no pain daily x5, weekly x4, monthly x2 to ensure compliance. Date of Compliance: 2/24/2022	m to	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495011	B. WING			01/20/2022	
	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP COI 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 757	When asked if pain repain should administ is documented at zershould not be given in the should not be given in the should be given for a zero, RN #1 stated, regiven. An interview was considered, RN #1 stated, regiven. An interview was considered, and interview was consider	n 1/20/2022 at 10:35 a.m. medication ordered for mild ered if the pain scale rating ro, LPN #3 stated, no, it if the resident has no pain. Inducted with RN (registered lo22 at 10:45 a.m. When cation ordered for mild pain a documented pain level of no, it should not have been in the should not have been at 11:00 a.m. When asked medication ordered by the in should be administered for zero, ASM #2 stated, no, if pain, then you don't give the resident aware of the should be aware of the resident aware of the should be aware of the resident aware for the should be aware for the state of the should be aware of the resident aware for the should be aware of the resident aware for the should be aware for the state of the should be aware for the sho	F 75			2/3/22	
SS=D		,					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP COL 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308)E		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 758	affects brain activities processes and behave but are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compreh resident, the facility in \$483.45(e)(1) Reside psychotropic drugs a unless the medication specific condition as in the clinical record; \$483.45(e)(2) Reside drugs receive gradual behavioral interventic contraindicated, in an drugs; \$483.45(e)(3) Reside psychotropic drugs punless that medication diagnosed specific coin the clinical record; \$483.45(e)(4) PRN of are limited to 14 days	ppic Drugs. hotropic drug is any drug that is associated with mental vior. These drugs include, drugs in the following ensive assessment of a must ensure that ents who have not used re not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic all dose reductions, and ons, unless clinically in effort to discontinue these ents do not receive ursuant to a PRN order on is necessary to treat a condition that is documented and erders for psychotropic drugs is. Except as provided in attending physician or	F 7	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495011	B. WING			01/20/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	'	0.1120.12011	
				1510 COLLINGWOOD ROAD			
PROMEDI	CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		ALEXANDRIA, VA 22308			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	Continued From page	e 58	F 7	58			
	appropriate for the Pl	RN order to be extended or she should document their ent's medical record and					
	drugs are limited to 1 renewed unless the a prescribing practition the appropriateness. This REQUIREMENT by:	「 is not met as evidenced			who of		
	Based on staff interview, facility document review and clinical record review it was determined that the facility staff failed to ensure one of 34 residents in the survey sample was free from unnecessary psychotropic medications, Resident #16. The facility staff failed to ensure specified targeted behaviors for qualitative quantitative monitoring for the administration and use of the antipsychotic medication Seroquel for Resident #16.			The statements made on this correction are not an admission not constitute an agreement walleged deficiencies herein. To compliance with all Federal aregulations, the center has taltake the actions set forth in the plan of correction. The following constitutes the center's allegated compliance such that all allegate deficiencies cited have been described by the data indicate and corrected by the da	on to and do with the to remain in and State ken or will the following ang POC tition of thed or will be		
	diagnoses that include Alzheimer's disease depressive disorder (Resident #16's most set), an annual asses (assessment reference Resident #16 as scor assessment for ment of 0 - 15, 7- being set daily decisions. Sect #16 displaying wands	recent MDS (minimum data ssment with an ARD ce date) of 11/2/2021, coded ring a 7 (seven) on the staff al status (BIMS) of a score verely impaired for making ion E documented Resident		Corrected by the date indicate Corrective Action: Upon notificare plan reviewed and devel comprehensive care plan regimentary monitoring resident specific/ the behavior for the administration anti-psychotic medication Seruldentification: 100 percent autresidents with psychotropic machines Seroquel for unnecessary medications-specified targete for qualitative and quantitative for the administration of Serogeneric Serogener	cation, #16 oped a arding argeted n and use of roquel. dit of nedications- d behaviors e monitoring		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495011	B. WING _			01/:	20/2022
	ROVIDER OR SUPPLIER CA SKILLED NURSING	AND REHAB (ALEXANDRIA)		STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308			
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F 758	On 1/19/2022 at approbservation was made room. Resident #16 side of the bed eating. Additional observation 1/19/2022 at approximal 1/20/2022 at approximal 1/20/2021 documented on. The comprehensive of dated 9/8/2021 documented to: use use of antidepressant history of dementia. Revision on: 12/22/20/20 documented "Show immood/behavior. Date Revision on 11/23/20/20 documented in part, side effects of medical decrease/elimination Initiated: 09/08/2021. evidence resident sproymptoms for the use medication Seroquel. The physician order's documented in part the "Monitor for side effects of signs and every shift for Monito psychotropic medication 10/11/2021."	idepressant medications. coximately 12:30 p.m., an e of Resident #16 in their was observed sitting on the plunch. Ins of Resident #16 on mately 3:15 p.m. and mately 10:45 a.m. revealed in the hallways of the unit the plunch. Care plan for Resident #16 mented, "At risk for adverse to of antianxiety medication, that plunch in the hallways of the unit the little of the plunch in the little of the plunch in the little of the plunch in the little of plunch	F 7	System Change: Staff behavior practice guide documentation for unn medications-specified for qualitative and qual for the administration of Monitoring: DON and/or monitor 5 residents with medications of Seroquent medications-specified for qualitative and qual for the Administration of weekly x4 and monthly compliance. Date of Compliance: 2	e to include necessary targeted behavio ntitative monitorin of Seroquel or designee will th psychotropic nel for unnecessa targeted behavio ntitative monitorin of Seroquel daily y x2 to ensure	ors ng ry ors ng	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		495011	B. WING		01	/20/2022	
PROMEDICA SKILLED NURSING AND REHAB (ALEXANDRIA) 1510 COLLINGWOOD ALEXANDRIA, VA 2			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308	TY, STATE, ZIP CODE D ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 758	with BPSD (behaviorsymptoms). Order - "Trazodone HCL stablet orally at bedt 07/29/2021." The "Psychotropic 7/29/2021 for Resident receiving a antidepressant and medications. It dooresponse to medications are identify/document to symptoms for the unchanged" The identify/document to symptoms for the undication Seroque The "Social Service Resident #16 dated documentation of a The eMARs (electropy for Resident 10/1/2021-10/31/20 documented side epsychotropic medication be psychotropic medication of 1/20/2022 at apprequest was made	mouth at bedtime for dementia pral and psychological Date: 12/18/2021." 50 mg tablet Give 1 (one) ime for Insomnia. Order Date: Medication Use" dated dent #16 documented the antipsychotic, antianxiety, sedative/hypnotic sumented in part, "Patient ation: Behavioral symptoms form failed to the identified target behavioral se of the antipsychotic el. Se Assessment and History" for a 11/2/2021 failed to evidence my behaviors. Donic medication administration and #16 dated 121, 11/1/2021-11/30/2021, 121 and 1/1/2022-1/31/2022 ffect monitoring for the use of ations. The eMARs failed to g of behaviors.	F 75	58			
	of behavior monitor	ing for Resident #16. proximately 3:00 p.m., ASM					

		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BU		PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		495011	B. WING	·····		1/20/2022	
NAME OF PROVIDER OR SUPPLIER PROMEDICA SKILLED NURSING AND REHAB (ALEXANDRIA)			STREET ADDRESS, CITY, STATE, ZIP COD 1510 COLLINGWOOD ROAD ALEXANDRIA, VA 22308				
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F 758	Continued From page 61 #1 provided eMARs for Resident #16 dated 10/1/2021-10/31/2021, 11/1/2021-11/30/2021, 12/1/2021-12/31/2021 and 1/1/2022-1/31/2022 which documented side effect monitoring for the use of psychotropic medications every shift. The eMARs failed to evidence monitoring of behaviors. ASM #1 also provided "Geriatric Psychiatry Progress Notes" for Resident #16 dated 4/13/2021, 4/29/2021, 9/14/2021 and 12/18/2021 along with monthly pharmacy reviews with recommendations related to gradual dose reduction. The "Geriatric Psychiatry Progress Notes" for Resident #16 documented in part the following: - "4/13/2021agitated at night. nights are bad. restless, poor sleepBehaviors persist. leave or lower dose" - "4/29/2021Met with staff to discuss: Strategies to manage agitation & delusion" - "9/14/2021poor sleep. Pt (patient) has sleep		F 75	58			
	pace at times. Revii - "12/18/2021Pt fa restless, pacer, slee staff" The medication regindated 8/26/2021 for part, "still (with) be On 1/20/2022 at 1:2 conducted with LPN LPN #2 stated that r medications were m shift. LPN #2 stated documented on the	n. Noted to get restless & ewed sleep hygiene." ir, she has been very pyup entire night per men review progress note Resident #16 documented in haviors" D p.m., an interview was (licensed practical nurse) #2. esidents taking psychotropic onitored for behaviors every that behavior monitoring was eMAR in the computer.					

	IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
	495011	B. WING _			01/	20/2022	
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EFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	×	· ·		(X5) COMPLETION DATE	
at 3:35 h ASM he dire ehavio sident cing baen asken provide they have an of belong it. A or asse emorn was at eview iidents e morn was at eview iidents e morn was at eview iidents e morn was at eview iidents e so Resi iatrist steep of stated	cted with RN (registered ated that residents taking tions were monitored for and they were documented computer. RN #1 stated that red the hallways and did not in the morning meetings. The psychiatrist relied on the haviors to them, the nurse to manager for updates on the ed if wandering, pacing back eping were indications for Seroquel, ASM #2 stated, I that Seroquel was	F	758				
	many states of the unit of the unit of states of the unit of the u	IDENTIFICATION NUMBER: 495011 LIER	A BUILDI 495011 B. WING WARRY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL FORY OR LSC IDENTIFYING INFORMATION) TAG TO page 62 Conducted with RN (registered of the computer. RN #1 stated that wandered the hallways and did not of the computer. RN #1 stated that wandered the hallways and did not of the computer	A BUILDING 495011 B WING MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION) TAG TORY OR LSC IDENTIFYING INFORMATION) F758 F758	LIER ### A BUILDING ### A BU	LILER RSING AND REHAB (ALEXANDRIA) MARY STATEMENT OF DEFICIENCIES EFFICIENCY MUST BE PRECEIDED BY FULL ORY OR L.S. IDENTIFYING INFORMATION) DIP page 62 conducted with RN (registered 4 #1 stated that wandered the hallways and did not in the computer. RN #1 stated that wandered the hallways and did not in the computer. RN #1 stated that wandered the hallways and did not enasked about the eMAR n provided for Resident #16, ASM #2 stated that Resident #16, ASM they had a monitoring system in lift to watch for side effects of the ASM #2 stated that staff were lor assessment for any new lawries are provided for review and was at their baseline and had not eview in the morning meetings. It has their baseline and had not eview in the morning meetings. It has the psychiatris relied on the analyse had possible to them, the nurse the unit manager for updates on the an asked fly and pelaviors to them when they as Resident #16, ASM #2 stated itarits typoke to them, the nurse the unit manager for updates on the an asked if wandering, pacing back not sleeping were indications for tition of Seroquel, ASM #2 stated, 2 stated that Seroquel was psychiatric stenders and the psychiatric stenders and the unit manager for updates on the an asked if wandering, pacing back not sleeping were indications for tition of Seroquel, ASM #2 stated, 2 stated that Seroquel was psychiatric shearons and	

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F 758	asked how new staff #16's specific behavi they would receive the report each day. Whathe need for the anti-documentation of bel Resident #16 was at not documentation of were not displaying at the morning meeting. On 1/20/2022 at approperation of the facility policy of unnecessary psychial. On 1/20/2022 at 6:54 email, "Behavioral Sydemonstrates a new documents observed POC (plan of care) on note- Nursing and, or evaluation of behavior (progress note) & 24 behavioral symptom Review care plan or (non-pharmacological implement- Monitor for behavior" The facil Tag 758" documented Drugs. Based on a confidence of a resident, the facilResidents who use gradual dose reduction interventions, unless an effort to discontinuation of the symptom of th	would know what Resident ors were, ASM #2 stated that at information in their shift en asked what evidenced psychotic medication without haviors, ASM #2 stated that their baseline so there was behaviors because they any that triggered a review in secondary of the following that triggered a review in secondary without the following that triggered a review in secondary without the following that triggered a review in secondary without the following that triggered a review in secondary without the following that triggered a review in secondary without the following that triggered a review in secondary without the following that triggered a review in secondary without the following that triggered a review in secondary without the following that triggered a review in secondary without the following that the following the following that the following that the following that the following that the fo	F	758				

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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 758	appropriate, potential effects/consequence non-pharmacological high risk medications and opiods" On 1/20/2022 at app #1, the administrator nursing and ASM #3 consultant were notifurther information with the respective of the properties of the	a laboratory results when all adverse es, effectiveness of I interventions particularly for s, such as warfarin, insulin eroximately 4:00 p.m., ASM et, ASM #2, the director of et, the quality assurance fied of the findings. No eas provided prior to exit. The essive brain disorder that the essive brain disorder that the essive brain disorder that energy and thinking skills and, et to carry out the simplest ecommon cause of demential information is taken from the essive brain function that occurs es. It affects memory, thinking, and behavior. This estined from the website: gov/ency/article/000739.htm. I disorder: Major depression to occurs when feelings of et, or frustration get in the waying period of time. It also ody works. This information	F 754	В			