	-	ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES	(Y2) MULT		CONSTRUCTION		D. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '		CONSTRUCTION	· · ·	PLETED
							с
		495121	B. WING				/17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02	
				37	710 LEE HIGHWAY		
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER		Α	RLINGTON, VA 22207		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`		PREFIX	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATORTORI	SC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		
F 000	INITIAL COMMENTS		FC	000			
1 000							
		dicare/Medicaid abbreviated					
	survey was conducted						
		laints were investigated					
		omplaint # VA00048863 was					
	unsubstantiated with	no deficient practice.					
	-	322 was unsubstantiated					
	with no deficient prac	•					
	VA00052756 was uns						
	substantiated with no	omplaint # VA00054111 was					
		1274 was substantiated with					
	deficient practices cite						
	VA00054352 was uns	•					
	deficient practice. Th	-					
		FR Part 482 Federal Long					
	Term Care requireme	nts.					
	The census in this 18	0 certified bed facility was					
		survey. The survey sample					
		ent Resident reviews and					
	five closed record rev	iews.					
F 580	Notify of Changes (In	jury/Decline/Room, etc.)	F 5	580			3/21/22
SS=D	CFR(s): 483.10(g)(14	.)(i)-(iv)(15)					
	§483.10(g)(14) Notific	ediately inform the resident;					
		ent's physician; and notify,					
		her authority, the resident					
	representative(s) whe	-					
		ving the resident which					
	results in injury and h	as the potential for requiring					
	physician intervention						
		ge in the resident's physical,					
	mental, or psychosoc	•					
		n, mental, or psychosocial reatening conditions or					
	clinical complications						
		,,					
LABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

**Electronically Signed** 

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.

03/08/2022

	-	ND HUMAN SERVICES MEDICAID SERVICES				FOI	ED: 03/28/202 RM APPROVE VO. 0938-039	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495121	B. WING			0	2/17/2022	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER		37	10 LEE HIGHWAY			
UNEIGNE				A	RLINGTON, VA 22207			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 580	Continued From page	e 1	Í -	580				
1 300				560				
	a need to discontinue	eatment significantly (that is,						
		erse consequences, or to						
	commence a new for	•						
	(D) A decision to tran	sfer or discharge the						
	resident from the faci	ility as specified in						
	§483.15(c)(1)(ii).							
		ification under paragraph (g)						
		, the facility must ensure that ion specified in §483.15(c)(2)						
	-	ided upon request to the						
	physician.							
		also promptly notify the						
	resident and the resid	dent representative, if any,						
	when there is-							
		n or roommate assignment						
	as specified in §483.							
		lent rights under Federal or ons as specified in paragraph						
	(e)(10) of this section							
		record and periodically						
		mailing and email) and						
	phone number of the	resident						
	representative(s).							
	§483.10(g)(15)							
		osite distinct part. A facility						
		istinct part (as defined in						
		e in its admission agreement						
		tion, including the various						
		se the composite distinct						
		fy the policies that apply to						
		en its different locations						
	under §483.15(c)(9).	Γ is not met as evidenced						
	by:							
	-	rview, staff interview, clinical			The statements made in the fo	llowing		
	-	document review, and in the			plan of correction are not an ad	-		
		t investigation, the facility			and do not constitute an agreer			

Facility ID: VA0064

If continuation sheet Page 2 of 68

		MEDICAID SERVICES				<u> </u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· · ·	E SURVEY PLETED
		495121	B. WING			C
	ROVIDER OR SUPPLIER	400121		STREET ADDRESS, CITY, STATE, ZIP CODE	02	/17/2022
	ROVIDER OR SOFFLIER			3710 LEE HIGHWAY		
HERRYD	OALE HEALTH AND REP	ABILITATION CENTER		ARLINGTON, VA 22207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 580	Continued From pag	e 2	F 58	0		
1 000	· · · · ·		F JO		norted	
		physician of a change in nine residents, Resident #1.		the alleged deficiencies nor the re conversations and other informati		
		unwitnessed fall on 01/07/22		in support of the alleged deficience		
		. The resident's physician		facility sets forth the following plan		
		party) were not notified until		correction to remain in compliance		
	two days later on 01			federal and state regulations. The		
				has taken or will take the actions	set forth	
	Findings include:			in the plan of correction. The follo		
				plan of correction constitutes the f	•	
		nitted to the facility on		allegation of compliance. All alleg	•	
		ost current readmission on		deficiencies cited have been or w		
		ent was discharged from the		corrected by the date or dates ind	icated.	
	facility on 01/14/22 a	ent #1 included, but were not				
	limited to: Atrial fibri			F580		
		y (Xalrelto 15 mg/milligrams		1. Resident #1 is no longer a re	sident in	
	daily), history of a sti			the center.		
		gia, dysphagia, constipation,		2. Falls from the last 30 days wi	ll be	
	dementia, anxiety ar			reviewed to ensure RP/MD was n		
	-			timely.		
	The most recent full	MDS (minimum data set)		3. The SDC will in-service the n	ursing	
		day/annual) assessment		staff on the center⊡s policy for no	tification	
		s MDS assessed the resident		of MD/NP for unusual incidents in	cluding	
		erm memory impairment and		the policy for falls.		
	· ·	a daily decision making skills.		4. DON/UM will review unusual		
		o assessed as requiring total ast one staff person for bed		including falls daily during clinical 5x weekly to ensure the RP/MD	meeting	
		ressing, toileting, and		notification was completed and no	tification	
		e for eating and hygiene.		documented in the medical record		
		ed that the resident did not		5. The results of the review will		
		corridor during the look back		discussed at the quarterly QAPI n	neeting.	
		0300. "Balance during		Once the QAPI committee determ	ines the	
	transitions and walki			problem no longer exists, the revi	ews will	
		did not occur" for the		be conducted on a random basis.		
		om seated to standing				
		ning around, and/or moving		The Administrator/Director of Nurs	-	
		This MDS assessed the		responsible for implementation of	the plan	
	(12/24/21), not major	ne fall since readmission		of correction.		

Facility ID: VA0064

If continuation sheet Page 3 of 68

	-	ID HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES	(X2) MU		E CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:	· /				LETED
			7	_			C
		495121	B. WING			02/	17/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
CHERRYE	ALE HEALTH AND REH	ABILITATION CENTER		3	3710 LEE HIGHWAY		
ONEIGHTE				4	ARLINGTON, VA 22207		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		COMPLETION DATE
					DEFICIENCY)		
F 580	Continued From page	e 3	F	580			
					Date of compliance: 03/21/2022		
		records were reviewed and					
	included the following	]:					
	A physician's progres	s note dated 01/07/22 at					
		I, "to be seenfor positive					
	COVIDgeneralized						
	impairment, advance	•					
		v nurse practitioner (NP)."					
	NP's note.	ation regarding a fall in the					
	A progress note dated	d 01/09/22 at 1:58 AM					
		t grimacing and moaning,					
	Tylenolgiven, well to						
	monitor for changes	."					
	A post fall assessmer	nt dated 01/09/22 and timed					
		l, "date and time of fall:					
		ate and time physician					
		0 AMdate and time RP					
	notified 01/09/22 1:15	•					
		requires assistance to ement/assessmentpatient					
	assisted back to bed.						
		PN (licensed practical					
		as no other information on					
	the post fall assessme	ent.					
	No documentation wa	as found in Resident #1's					
		ding a fall or any type of					
	injury sustained by Re	esident #1 until 01/09/22 at					
		mented, "Patient observed					
	, , ,	de her bed face down,					
		on right side of the head VS (vital signs)ROM					
		nin normal limit (sic)MD					
		RP notifiedsignature of					
	LPN#1.	U U					

Facility ID: VA0064

If continuation sheet Page 4 of 68

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	): 03/28/2022 MAPPROVED ). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495121	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRYI	DALE HEALTH AND REH	ABILITATION CENTER			3710 LEE HIGHWAY ARLINGTON, VA 22207		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	- 4	F	580			
	A progress note dated documented, "Patient beside her bed face d on right side of the her VSROM within norm notifiedsignature of A physician's progres 5:17 PM documented and right anterior fore hematomageneraliz (Resident #1's blood) respiration were dated progress note, and we date of 01/09/22 note advanced age, frailr precautionsforehear to hematoma TID (thr 650 mg for painsign A progress note dated documented, "Situatio ofA-Fibright hemig (RN)/Appearance (LP assessment done hea side of the head close supervisor aware, RC remain afebrileconti resident to call for hel positionsignature of No other documentati #1's clinical record res fall. According to the resident's clinical record fall with injury on 01/0	a 01/09/22 at 3:54 PM observed lying on the floor own, hematoma observed ad close to the forehead hal limit (sic)MD and RP LPN #1. s note dated 01/09/22 at , "S/P (status post) fall head ed weaknessVital Signs: oressure, pulse and d from 12/24/21 on this ere not current as of the ) cognitive impairment, nuscle weaknessfall d hematoma start apply ice ee times daily) Start Tylenol ed by NP." d 01/09/22 at 10:18 PM on: Post fall 3-11history paresis. Assessment N): Head to toe amatoma (sic) noted on right e to the forehead, NP and M within normal limit, nue to monitoreducate p, bed in the lowest LPN #1." on was located in Resident garding the details of this documentation in the ords the resident sustained a					

Facility ID: VA0064

If continuation sheet Page 5 of 68

TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       DATE         F 580       Continued From page 5 administrator, DON (director of nursing) and the corporate nurse were made aware of a complaint regarding Resident #1 and were asked for any       F 580       F		-	ID HUMAN SERVICES MEDICAID SERVICES			FC	TED: 03/28/2022 DRM APPROVED NO. 0938-0391
495121     B. WING     02/17/2022       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     3710 LEE HIGHWAY       CHERRYDALE HEALTH AND REHABILITATION CENTER     3710 LEE HIGHWAY     ARLINGTON, VA 22207       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     (X5) COMPLETIC DATE       F 580     Continued From page 5 administrator, DON (director of nursing) and the corporate nurse were made aware of a complaint regarding Resident #1 and were asked for any     F 580				· · ·			OMPLETED
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         CHERRYDALE HEALTH AND REHABILITATION CENTER       3710 LEE HIGHWAY         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         F 580       Continued From page 5 administrator, DON (director of nursing) and the corporate nurse were made aware of a complaint regarding Resident #1 and were asked for any       F 580			495121	B. WING		_	-
CHERRYDALE HEALTH AND REHABILITATION CENTER       ARLINGTON, VA 22207         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (X5) COMPLETIC DATE         F 580       Continued From page 5 administrator, DON (director of nursing) and the corporate nurse were made aware of a complaint regarding Resident #1 and were asked for any       F 580	NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STA		
(X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (x5) COMPLETIC DATE         F 580       Continued From page 5 administrator, DON (director of nursing) and the corporate nurse were made aware of a complaint regarding Resident #1 and were asked for any       F 580	CHERRY	DALE HEALTH AND REH	ABILITATION CENTER				
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETIC DATE         F 580       Continued From page 5 administrator, DON (director of nursing) and the corporate nurse were made aware of a complaint regarding Resident #1 and were asked for any       F 580       F 580       F 580       F 580       F 580       F 580		1					
administrator, DON (director of nursing) and the corporate nurse were made aware of a complaint regarding Resident #1 and were asked for any	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE	COMPLETION
information or investigation regarding a fall with injury for Resident #1 in January 2022. The administrator stated that the investigation was currently underway and that it would be completed on 02/16/22. The administrator stated they were made aware that Resident #1 had a fall on 01/09/22 by the Unit Manager (LPN #2) in a "morning meeting" on 01/10/22. The administrator stated that it wasn't until an investigator called and came to the facility on 02/08/22 that they were made aware of concerns regarding alleged significant injuries. The administrator stated that was when the investigation was initiated and that this information was what prompted the investigation. The administrator stated that was when the investigation was initiated and that this information was what prompted the investigation. The administrator stated that was when the for envestigation regarding Resident #1.         On 02/15/22 at approximately 2:30 PM, the hospital medical records obtained by the facility were presented for review. The corporate nurse stated that the facility had obtained hospital records for Resident #1 (discharged from the facility on 01/14/22 and thild to the hospital on 01/14/22 after being notified by the Investigator of concerns with injuries that were alleged to have occurred at the facility prior Resident #1's discharge.         The ED (emergency department) provider note dated 01/14/22 at 11:22 AM documented, "Sent to the ER, for evaluation of tehargy and mental status change since yesterdayPatient is on Xairetto It is reported that patient has been lethargic and sleeping all day since	F 580	administrator, DON (c corporate nurse were regarding Resident # information or investig injury for Resident #1 administrator stated t currently underway a completed on 02/16/2 they were made awar on 01/09/22 by the U "morning meeting" or administrator stated t investigator called an 02/08/22 that they we regarding alleged sig administrator stated t investigation was initi information was what The administrator stated t investigation was initi facility on 01/14/22 at appro- hospital medical reco were presented for re- stated that the facility records for Resident f facility on 01/14/22 at appro- hospital medical reco were presented for re- stated that the facility records for Resident f facility on 01/14/22 at appro- hospital medical reco were alleged to have occur Resident #1's dischar The ED (emergency of dated 01/14/22 at 11: to the ER for evaluati status change since y Xalrelto. It is reported	director of nursing) and the made aware of a complaint 1 and were asked for any gation regarding a fall with in January 2022. The hat the investigation was nd that it would be 22. The administrator stated re that Resident #1 had a fall nit Manager (LPN #2) in a 01/10/22. The hat it wasn't until an d came to the facility on ere made aware of concerns nificant injuries. The hat was when the ated and that this prompted the investigation. ted that there had not been in regarding Resident #1. eximately 2:30 PM, the rds obtained by the facility eview. The corporate nurse had obtained hospital #1 (discharged from the nd admitted to the hospital ing notified by the rns with injuries that were rred at the facility prior rge. department) provider note 22 AM documented, "Sent on of lethargy and mental vesterdayPatient is on d that patient has been	F 5	30		

Facility ID: VA0064

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI				LETED
						(	C
		495121	B. WING			02/	17/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER			3710 LEE HIGHWAY		
				-	ARLINGTON, VA 22207		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	Y	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
= = = = = =		_					
F 580	Continued From page		F	580			
		l status, lethargypatient					
		ing commands, lying on osedEcchymosis (bruises)					
		al left eyeA-fib at 100 bpm					
		rauma and CNS (central					
	· · · /	re or compromiseC1					
	anterior tubercle fract	ure, right and left posterior					
	-	th moderate distraction of					
		on-displaced fracture C3 left					
		ticular facet fracture of C2 vertebral foramen, right					
	impacted fracture of p						
		wing commandsopens					
		away noxious stimuli,					
		lligible soundsRight					
	-	tomaLeft peri-orbital					
		earm ecchymosisHIP,					
	LEG, FOOT: left with painrightdeformity						
		ecchymosis right knee,					
		right upper thighright hip					
	fracturetrauma cons	sultedhold XalreltoC1-C3					
	fractures right proxir	nal femur displaced					
	impacted fracture"						
	Thore were no other	assessments. information					
		l occurred, or specific details					
		ape, color of the hematoma,					
		ng sustained. There was no					
		ormation concerning the fall,					
		at the resident was currently					
		ong term anticoagulant					
	inerapy (Xairelto 15 n	ng daily since June 2020).					
	Resident #1's current	CCP (comprehensive care					
		e fall documented, "The					
		alls related to gait/balance					
		awarenessassist bars for					
	bed mobility, wheelch	air for locomotion, pommel					

If continuation sheet Page 7 of 68

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/28/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495121	B. WING		C 02/17/2022
NAME OF PI	ROVIDER OR SUPPLIER	l	ST	REET ADDRESS, CITY, STATE, ZIP CO	
CHERRYD	OALE HEALTH AND REH	ABILITATION CENTER		10 LEE HIGHWAY RLINGTON, VA 22207	
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONIE APPROPRIATEDATE
F 580	safety reminders and occursrounding and anticipate to meet the needsenvironment anticoagulant therapy (created on 05/12/20) orderedmeds as or such as unusual bruis stool, red or dark brov painswellingbleed nosereport symptor signs/symptoms of bl anticoagulation thera bilateral forearms, rig on 01/09/22)" On 02/16/22 at appro administrator and cor final investigation had 01/09/22 which docur (Name of patient)N observed lying on the floor face down. Patie explain due to demer Taken: Head to Toe a hematoma observed close to forehead, pt bed by two staffHer scalpalertoriented consciousness: (blar	oningcall light in sident to use it for deducate caregivers about what to do if a fall d close monitoring, and e resident's free of hazardsis on y related to Atrial Fibrillation 20)Lab work as deredMonitor for bleeding sing, bloody or black tarry wn urine, abdominal ding from eyes, gums, ms to MDObserve for any eeding related to pySKIN: bruises to ht head hematoma (revised eximately 9:00 AM, the porate nurse presented their review. d an incident report dated, mented, "UN-witnessed: ursing Description: e floor beside her bed on the ent Description: cannot ntiaImmediate Action assessment done, on right side of the head (patient) assisted back to matoma top of d to personLevel of nk)No witness found."	F 580		
	statement which docu	nvestigation was LPN #1's umented, "date of incident: On 01/07/22 I was the only			

Facility ID: VA0064

If continuation sheet Page 8 of 68

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		495121	B. WING				_ 17/2022
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRYD	OALE HEALTH AND REH	ABILITATION CENTER			3710 LEE HIGHWAY ARLINGTON, VA 22207		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	nurse for 7-3 shift on (Name of LPN #2/Uni room (number) with u doing patient care (in run to him due to the getting into the room (Name of Resident #1 manager in the room was suppose (sic) to documentationIn re- reported about (Reside patient headsigned There was no statement the Unit Manager. On 02/16/22 at 10:25 was interviewed via p that she was notified of 01/09/22; she was un- it was later in the day female nurse called h mother had a fall and The daughter stated th how it happened and happened on the 5th The daughter stated to been notified of her m 01/09/22. On 02/16/22 at 1:35 F physician was interviet that he did not see Re- physician stated that completed an assessi that he was notified, to stated, "I get so many	that day, when my manager t Manager) called me in rgencyI was in middle of another room) but I have to urgency from himupon (number) I saw resident I) lying on the floor with my told me she fellmanager do the necessary port out going nurse lent #1) huge swelling on on 02/11/22 by LPN #1." ent from LPN #2 who was AM, Resident #1's daughter hone. The daughter stated of the fall on Sunday sure of the time, but stated . The daughter stated that a er and told her that her had a bump on her head. hat she asked the nurse the nurse told her that it floor and she didn't know. hat was the first she had nother having a fall was on PM, Resident #1's attending ewed. The physician stated out was unsure of when, and r calls." The physician sure of the details and did	F	580			

Facility ID: VA0064

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495121	B. WING _				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				37	710 LEE HIGHWAY		
CHERRYL	OALE HEALTH AND REH	ABILITATION CENTER		Α	RLINGTON, VA 22207		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	9	F 5	580			
	On 02/16/22 at 1:55 F regarding Resident # aware of the investiga LPN #1 that Resident 01/07/22. The NP stat the fall on the 9th and Resident #1 she had fully assessed. The N should have been ser evaluation, as the res injury and was on Xal of the fall. The NP stat the placement (of the would go away, and b didn't show any distre have sent her out." T not sure why staff did resident's fall on the o 01/07/22). On 02/16/22 at 2:20 F via phone. LPN #1 st (01/07/22); I was the around at that time ar positive and was sent (5th floor). I was in the manager was calling get into the room, pat down, he (LPN #2) as patient back to bed." not in the room when not know what happe LPN #2 didn't say what but it did happen on the documented). LPN # was on the 3rd floor, f moved to the 5th floor	PM, the NP was interviewed I's fall. The NP was made ation and the statement by #1's fall occurred on ated that she was notified of I that when she saw a hematoma and she was NP was asked if Resident #1 nt out at that time for an ident had sustained a head relto 15 mg daily at the time ated, "In most cases yes, hematoma), I figured it based on my assessment ess, but probably should the NP stated that she was not notify her of the lay it occurred (on PM, LPN #1 was interviewed tated, "It happened on Friday only nurse on the floor and nd Resident #1 tested to the COVID positive floor e middle of care and my me with urgency to come. I ient is lying on the floor face sked me to help get the LPN #1 stated that he was it happened and that he did ned. LPN #1 stated that at happened to Resident #1					

Facility ID: VA0064

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 03/28/2022 FORM APPROVED MB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				3) DATE SURVEY COMPLETED
		495121	B. WING				C 02/17/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
CHERRYD	OALE HEALTH AND REH	ABILITATION CENTER		3710 LEE HIGHWAY ARLINGTON, VA 22207			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	#1 stated that he pass oncoming nurse that report it to the physic #2 was the one who f supposed to do all the #1 stated that the onl the patient, LPN #1 a Resident #1 was put "I just noticed swelling stated that he didn't r time. LPN #1 stated, that was on Friday." off on Saturday and p Sunday. When he ca there was no docume he called LPN #2 and document the fall and LPN #1 stated that LF wasn't in the facility th LPN #1 then stated th the fall on 01/09/22, b LPN #1 stated that he informed her of the fa asked if Resident #1 stated that he did not notify the physician, a manager) must not ha A policy titled, "Docur documented, "unit r ensuring that notificat physician's and respon changehave proper is responsible for noti and/or RP whenever	fore he left for the day. LPN sed it on in report to the the resident fell, but did not ian. LPN #1 stated that LPN found Resident #1 and was at and the paperwork. LPN y people in the room were nd LPN #2, and that back in bed. LPN #1 stated, g on the face." LPN #1 notice any bruising at that "I did not witness the fall LPN #1 stated that he was bicked up another shift on me in on Sunday he noticed entation regarding the fall, so d asked why he didn't d report for Resident #1. PN #2 told him that since he hat LPN #1 needed to do it. hat is when he documented but it happened on 01/07/22. e texted the NP and all on 01/09/22. LPN #1 was was assessed. LPN #1 assess Resident #1 or and that LPN #2 (the unit ave either. mentation and Notification" manager is responsible for tions by the charge nurses to onsible parties regarding a dy occurredCharge Nurse ifying the physician (MD) there is a will occur when there is a: conditionchange	F	580			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495121	B. WING				C / <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				;	3710 LEE HIGHWAY		
CHERRYI	DALE HEALTH AND REH	ABILITATION CENTER			ARLINGTON, VA 22207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	ordernotification of the aboveconsidered there is a notification information in the shift Unit Manager is ultim that notification of the has been documented. A policy titled, "Falls I documented, "Imme not move or reposition nurse has completed assessmentNotify party" On 02/16/22 at 2:35 F and corporate nurse has completed assessmentNotify party" On 02/16/22 at 2:35 F and corporate nurse has completed above information. T aware that according interviews with staff th actually occurred on 0 facility staff were made concerns regarding h the lack of immediate physician/NP and the with a head injury. Thaware that Resident for 01/07/22 and was after, and the resident was fracture, fractures to the and a hematoma to the eyes and knees. The on vacation when the made aware after (on work). The administrem made aware that the the the the the the the the the th	the MD/RP is not limited to a a sampleWhenever of the MD/RPinclude this it reportdocumentThe ately responsible to ensure MD/RP has occurred and d accurately" Management Program" ediate responsibilities:do in patient until a licensed a physical and mental ohysician, responsible PM, the administrator, DON, were made aware of the he facility staff were made to their investigation and nat were present, the fall had D1/07/22 not 01/09/22. The le aware of the serious arm for Resident #1 due to notification to the . RP, of an unwitnessed fall he facility staff were made #1 sustained a fall with injury not assessed until two days t was not sent out for /22 at 11:14 AM, at which found to have a right femur the neck (C1 through C3) he head, with bruising to the e DON stated that she was fall occurred and she was 10/17/22 upon return to ator stated that she was	F	580			

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		495121	B. WING			17/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		-
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER		3710 LEE HIGHWAY ARLINGTON, VA 22207		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 580 F 607 SS=D	process, unfortunately performance improve stated, "No one can te (sic)we base on our review." No further information exit conference on 02 Develop/Implement A CFR(s): 483.12(b)(1)- §483.12(b) The faciliti implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re §483.12(b)(2) Establis to investigate any suc §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on staff intervi facility document revic complaint investigatio implement abuse poli injury of unknown orig in the survey sample, had an unwitnessed f which not reported un was not started until 0 completed until during	d, "I see missteps in our y there is room for ment." The corporate nurse ell we saw this in this patient own findings and our own was presented prior to the //17/22. buse/Neglect Policies -(3) y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures th allegations, and t training as required at t is not met as evidenced iew, clinical record review, ew, and in the course of a in, the facility staff failed cies and procedures for an gin for one of nine residents Resident #1. Resident #1 all with injury on 01/07/22 til 01/09/22; an investigation 02/08/22 and was not	F 54	<ul> <li>F607</li> <li>Resident #1 is no longer a resider the center.</li> <li>A review of unusual incidents including falls will be reviewed from the last 30 days to ensure a thorough investigation was completed and outsid agencies were notified if a Facility Reported Incident is required.</li> <li>Facility staff will be educated by th SDC/Designee on the center □s policy</li> </ul>	de le	3/21/22
	Findings include:			abuse and neglect. Nursing		

Event ID: XKJC11

Facility ID: VA0064

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 03/28/2022 M APPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		495121	B. WING				C / <b>17/2022</b>
NAME OF PF	ROVIDER OR SUPPLIER		•	SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER			710 LEE HIGHWAY RLINGTON, VA 22207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI2 TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	06/29/18, with the model 12/24/21. The resider facility on 01/14/22 are Diagnoses for Resider limited to: Atrial fibrill anticoagulant therapy daily), history of a struch hemiparesis/hemipleg dementia, anxiety and The most recent full M was an admission (5 dated 01/10/22. This with long and short teres evere impairment in Resident #1 was also assistance from at lear mobility, transfers, druextensive assistance This MDS documente ambulate in room or operiod. In Section G transitions and walkin assessed as "activity following: moving from position, walking, turr on and off the toilet. The resident #1's clinical included the following: 01/09/22 at 3:33 PM, the floor beside her b observed on right side the following to the section of the section of the section of the following the floor beside her b observed on right side the following to the section of the floor beside her b observed on right side the following to the section of the floor beside her b observed on right side the following to the section of the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on right side the floor beside her b observed on the floor beside her b observed on right side the floor beside her b observed on the floor beside her b observed on the floor beside her b observed on the floor besi	hitted to the facility on ost current readmission on on twas discharged from the hd did not return. ent #1 included, but were not lation with long term (Xalrelto 15 mg/milligrams oke with right sided gia, dysphagia, constipation, d depression. MDS (minimum data set) day/annual) assessment MDS assessed the resident erm memory impairment and daily decision making skills. assessed as requiring total ast one staff person for bed essing, toileting, and for eating and hygiene. ed that the resident did not corridor during the look back 0300. "Balance during ng" Resident #1 was did not occur" for the n seated to standing ning around, and/or moving This MDS assessed the e fall since readmission in injury. records were reviewed and	F	607	Leadership/Administrator will be educ by the Regional Director of Clinical Services/designee on the process for conducting a thorough investigation for unwitnessed falls with injuries/injuries unknown origin. 4. DON/UM will review unusual inci- including falls daily during clinical mee 5x weekly to ensure a thorough investigation was completed for unwitnessed injuries/injuries of unkno- origin. 5. The results of the review will be discussed at the quarterly QAPI meet Once the QAPI committee determines problem no longer exists, the reviews be conducted on a random basis. The Administrator/Director of Nursing responsible for implementation of the of correction. Date of compliance: 03/21/2022	or of dents eting wn ing. s the will are	

If continuation sheet Page 14 of 68

	-	ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 03/28/2022 ORM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495121	B. WING				C 02/17/2022
	ROVIDER OR SUPPLIER	ABILITATION CENTER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 710 LEE HIGHWAY IRLINGTON, VA 22207	I	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 607	RP notifiedsignatur nurse) #1. A post fall assessmer 2:46 PM documented 01/09/22 1:00 AMd. notified: 01/09/22 1:15 assistchair bound, n transferpain manag assisted back to bed. assisted2signed L other information on t A progress note dated documented, "Patient beside her bed face of on right side of the her VSROM within norr notifiedsignature of A progress note dated documented, "Situation ofA-Fibright hemi (RN)/Appearance (LF assessment done her side of the head close supervisor aware, RC remain afebrilecont resident to call for her positionsignature of A physician's progress 5:17 PM documented and right anterior fore hematomageneraliz (Resident #1's blood	c)MD (medical doctor) and e of LPN (licensed practical nt dated 01/09/22 and timed l, "date and time of fall: ate and time physician 00 AMdate and time RP 5 AMtwo person requires assistance to rement/assessmentpatient staff members LPN #1." There was no the post fall assessment. d 01/09/22 at 3:54 PM t observed lying on the floor down, hematoma observed ead close to the forehead nal limit (sic)MD and RP LPN #1. d 01/09/22 at 10:18 PM on: Post fall 3-11history paresis. Assessment PN): Head to toe amatoma (sic) noted on right e to the forehead, NP and DM within normal limit, inue to monitoreducate lp, bed in the lowest f LPN #1." as note dated 01/09/22 at l, "S/P (status post) fall ehead zed weaknessVital Signs:	F	607			

Facility ID: VA0064

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/28/2022 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	PLE CONSTRUCTION		(X3) DATE COMP	
		495121	B. WING				- 17/2022
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CI	ITY, STATE, ZIP CODE	1	
CHERRY	OALE HEALTH AND REH	ABILITATION CENTER		3710 LEE HIGHWAY ARLINGTON, VA 2	22207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD I FERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	date of 01/09/22 note advanced age, fraili precautionsforehea to hematoma TID (thr 650 mg for painsign On 02/15/22 at appro administrator, DON (d corporate nurse were regarding Resident #1 information or investig injury for Resident #1 administrator stated t currently underway al completed on 02/16/2 they were made awar on 01/09/22 by the Ut "morning meeting" or administrator stated t investigator called an 02/08/22 that they we regarding alleged sign administrator stated t investigation was initi information was what The administrator sta any other investigation On 02/16/22 at appro administrator and cor final investigation had 01/09/22 which docur (Name of patient)Ni observed lying on the floor face downPatie	ere not current as of the e) cognitive impairment, muscle weaknessfall d hematoma start apply ice ree times daily) Start Tylenol hed by NP." eximately 10:00 AM, the director of nursing) and the e made aware of a complaint 1 and were asked for any gation regarding a fall with in January 2022. The hat the investigation was nd that it would be 22. The administrator stated re that Resident #1 had a fall nit Manager (LPN #2) in a 01/10/22. The hat it wasn't until an d came to the facility on ere made aware of concerns nificant injuries. The hat was when the lated and that this prompted the investigation. ted that there had not been on regarding Resident #1. eximately 9:00 AM, the porate nurse presented their review. d an incident report dated, mented, "UN-witnessed:	F 6	07			

Facility ID: VA0064

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/28/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495121	B. WING		C 02/17/2022
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CC	DDE
CHERRYD	DALE HEALTH AND REH	ABILITATION CENTER		8710 LEE HIGHWAY ARLINGTON, VA 22207	
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETIONHE APPROPRIATEDATE
F 607	close to forehead, pt bed by two staffHer scalpalertoriented consciousness: (blar Also included in the in statement which docu 7-3 (shift) 01/07/22 nurse for 7-3 shift on (Name of LPN #2/Un room (number) with u doing patient care (in run to him due to the getting into the room (Name of Resident # manager in the room was suppose (sic) to documentationIn re reported about (Resident patient headsigned There was no statem the Unit Manager. On 02/16/22 at 2:20 F via phone. LPN #1 s Friday (01/07/22); I w floor and around at th tested positive and w positive floor (5th floo care and my manage urgency to come. I ge lying on the floor face me to help get the pa stated that he was no happened and that he	assessment done, on right side of the head (patient) assisted back to matoma top of d to personLevel of nk)No witness found." nvestigation was LPN #1's umented, "date of incident: On 01/07/22 I was the only that day, when my manager it Manager) called me in argencyI was in middle of another room) but I have to urgency from himupon (number) I saw resident 1) lying on the floor with my told me she fellmanager do the necessary sport out going nurse dent #1) huge swelling on on 02/11/22 by LPN #1." ent from LPN #2 who was PM, LPN #1 was interviewed tated, "It (fall) happened on vas the only nurse on the nat time and Resident #1 as sent to the COVID or). I was in the middle of er was calling me with et into the room, patient is e down, he (LPN #2) asked tient back to bed." LPN #1 ot in the room when it	F 607		

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	-	ND HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/28/202 A APPROVE ). 0938-039
TATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		SURVEY LETED
		495121	B. WING				C 02/17/2022	
	ROVIDER OR SUPPLIER	ABILITATION CENTER	- 1	371	EET ADDRESS, CITY, STATE, ZIP CO <b>) LEE HIGHWAY</b>	DE		
	1			AR	LINGTON, VA 22207			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE		(X5) COMPLETIOI DATE
F 607	on the 7th (not the 9t stated that Resident is tested positive and w was in the afternoon, shift and he wasn't th left for the day. LPN on in report to the on resident fell, but did r LPN #1 stated that LI found Resident #1 ar that and the paperwor only people in the roo and LPN #2, and that in bed. LPN #1 state the face." LPN #1 state the documented the face." LPN he documented the face happened on 01/07/2 texted the NP and inf 01/09/22. LPN #1 wa assessed. LPN #1 state immediately (no later	esident #1 but it did happen h as documented). LPN #1 #1 was on the 3rd floor, as moved to the 5th floor, it and that he worked the 7-3 ere much longer before he #1 stated that he passed it coming nurse that the not report it to the physician. PN #2 was the one who do was supposed to do all wk. LPN #1 stated that the ow were the patient, LPN #1 t Resident #1 was put back d, "I just noticed swelling on ated that he didn't notice any LPN #1 stated, "I did not vas on Friday." LPN #1 f on Saturday and picked up day. When he came in on here was no documentation he called LPN #2 and asked ent the fall and report for I stated that LPN #1 #1 then stated that is when all on 01/09/22, but it 22. LPN #1 stated that he formed her of the fall on as asked if Resident #1 was tated that he did not assess the physician, and that LPN ) must not have either.	F	607				

Facility ID: VA0064

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	S FOR MEDICARE &					O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	E SURVEY
			A. BUILDING	3		
		495121	B. WING			С
		495121	D. WING			2/17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER		3710 LEE HIGHWAY		
	1			ARLINGTON, VA 22207		
(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)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 607	Continued From page	<u>-</u> 18	F 60	7		
		ncident does not involve	1 00	· /		
	abuse or bodily injury					
		eir absence, the director of				
	nursingupon notific					
	violationsincluding					
	-	rator will immediately report				
	to the State Agency	no later than 24 hours if the				
	eventsdo not involv	e abuse or do not result in				
		injuries of unknown origin.				
		d or patient can't state what				
		handled the same as an				
	•	ment, neglect or abuse and				
	must be reported to t					
		ainingprotecting patients ect and their responsibility to				
	-	ny cases of suspected or				
	witnessed"					
	On 02/16/22 at 2:35 l	PM, the administrator, DON,				
		were made aware of the				
	above information. T	he facility staff were made				
		ent #1's fall with injury had				
		2 not 01/09/22, and it was not				
		equired in the facility's policy				
	-	e facility staff were made				
	and notification of an	s with the delay of reporting				
		Ill with injury for Resident #1.				
		she was on vacation when				
		she was made aware after				
	(on 01/17/22 upon re					
		hat she was made aware				
		a fall on 01/09/22 in a				
		01/10/22. The corporate				
		given you everything on this				
		d medical records and there				
		additional injury and we sent				
		ed incident). I see missteps				

Facility ID: VA0064

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/28/2022 M APPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495121	B. WING				C / <b>17/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER			/10 LEE HIGHWAY RLINGTON, VA 22207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 607 F 609 SS=D	stated, "No one can tr (sic)we base on our review." No further information exit conference on 02 Reporting of Alleged CFR(s): 483.12(c)(1) §483.12(c) In response neglect, exploitation, must: §483.12(c)(1) Ensure involving abuse, negle mistreatment, includin source and misappro are reported immedia hours after the allegat serious bodily injury, the events that cause abuse and do not ress the administrator of th officials (including to adult protective service for jurisdiction in long	ment." The corporate nurse ell we saw this in this patient r own findings and our own n was presented prior to the 2/27/22. Violations (4) se to allegations of abuse, or mistreatment, the facility that all alleged violations		607	DEFICIENCY)		3/21/22
	s483.12(c)(4) Report investigations to the a designated represent accordance with State Survey Agency, within incident, and if the all	-					

Facility ID: VA0064

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		ND HUMAN SERVICES			FORM	): 03/28/202 /I APPROVE ). 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495121	B. WING			C 17/2022
NAME OF P	ROVIDER OR SUPPLIER	•	-	STREET ADDRESS, CITY, STATE, ZIP CODE	• •	-
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER		3710 LEE HIGHWAY ARLINGTON, VA 22207		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 609	by: Based on staff interv facility document revi complaint investigation report an injury of uni- fall to the State Agen the survey sample, R was found in her room 01/07/22. There were facility documentation incident was docume 01/09/22, two days a incident was not repo- until 02/10/22 (over a Findings include: Resident #1 was adm 06/29/18, with the mo- 12/24/21. The resider facility on 01/14/22 at	F is not met as evidenced riew, clinical record review, ew and in the course of a on, the facility staff failed to known origin/unwitnessed cy for one of 9 residents in resident #1. Resident #1 m, face down on the floor on e no witnesses according to n and interviews. The nted as occurring on fter the actual event. The orted to the State Agency month later).	F 609		s made I injuries, he of a 5 day ts n origin days to was s were cident if d by the policy on e educated cal ing ills with	
	anticoagulant therapy daily), history of a str hemiparesis/hemiple dementia, anxiety an	/ (Xalrelto 15 mg/milligrams oke with right sided gia, dysphagia, constipation, d depression.		4. DON/UM will review unusua daily during clinical meeting 5x v ensure incidents for unwitnessed injuries/injuries of unknown origi reported to the outside agencies	al incidents weekly to d falls with in are	
	was an admission (5 dated 01/10/22. This with long and short te severe impairment in Resident #1 was also	MDS (minimum data set) day/annual) assessment MDS assessed the resident erm memory impairment and daily decision making skills. assessed as requiring total ast one staff person for bed		required. 5. The results of the review wi discussed at the quarterly QAPI Once the QAPI committee deter problem no longer exists, the re- be conducted on a random basis The Administrator/Director of Nu	meeting. mines the views will s.	
		for eating and hygiene. This		responsible for implementation of		

Facility ID: VA0064

		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 03/28/2022 RM APPROVED IO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED
		495121	B. WING			0	C 2/17/2022
NAME OF PI	ROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER			3710 LEE HIGHWAY ARLINGTON, VA 22207		
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 609	Continued From page	<b>&gt;</b> 21	Í F	609			
	MDS assessed the re	esident as having one fall 2/24/21), not major in injury.		000	of correction. Date of compliance: 03/21/2022	2	
	Resident #1's clinical included the following	records were reviewed and g:					
	the floor beside her b observed on right sid forehead VS (vital sig within normal limit (si	"Patient observed lying on ed face down, hematoma e of the head close to the gns)ROM (range of motion) c)MD (medical doctor) and e of LPN (licensed practical					
	2:46 PM documented 01/09/22 1:00 AMd notified: 01/09/22 1:0 notified 01/09/22 1:15 assistchair bound, n transferpain manag assisted back to bed. assisted2signed I	requires assistance to ement/assessmentpatient					
	documented, "Patien beside her bed face o on right side of the he	d 01/09/22 at 3:54 PM t observed lying on the floor down, hematoma observed ead close to the forehead nal limit (sic)MD and RP LPN #1.					
	administrator, DON ( corporate nurse were regarding Resident # information or investi injury for Resident #1	eximately 10:00 AM, the director of nursing) and the e made aware of a complaint 1 and were asked for any gation regarding a fall with in January 2022. The hat the investigation was					

Facility ID: VA0064

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 03/28/2022 ORM APPROVE NO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY
		495121	B. WING				C 02/17/2022
	ROVIDER OR SUPPLIER	ABILITATION CENTER		3710	EET ADDRESS, CITY, STATE, ZIP COE D LEE HIGHWAY LINGTON, VA 22207	DE	
(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 CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 609	they were made awar on 01/09/22 by the U "morning meeting" or administrator stated to investigator called an 02/08/22 that they we regarding alleged sig administrator stated to investigation was initi information was what The administrator stated to investigation was what The administrator stated to investigation was what The administrator stated to information was what The administrator and cor- final investigation for The investigation for The investigation had 01/09/22 which docur (Name of patient)N observed lying on the floor face downPatie explain due to demer Taken: Head to Toe a hematoma observed close to forehead, pt bed by two staffHer scalpalertoriented consciousness: (blar Also included in the in statement which docu 7-3 (shift) 01/07/22 nurse for 7-3 shift on (Name of LPN #2/Un room (number) with u	nd that it would be 22. The administrator stated re that Resident #1 had a fall nit Manager (LPN #2) in a 0 01/10/22. The hat it wasn't until an d came to the facility on ere made aware of concerns nificant injuries. The hat was when the fated and that this prompted the investigation. ted that there had not been on regarding Resident #1. eximately 9:00 AM, the porate nurse presented their review. an incident report dated, mented, "UN-witnessed: ursing Description: a floor beside her bed on the ent Description: cannot ntiaImmediate Action assessment done, on right side of the head (patient) assisted back to matoma top of	F	509			

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/28/20 FORM APPROVE OMB NO. 0938-039		
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495121	B. WING		C 02/17/2022		
NAME OF P	ROVIDER OR SUPPLIER	l	STF	REET ADDRESS, CITY, STATE, ZIP CO	•		
CHERRY	OALE HEALTH AND REH	ABILITATION CENTER	3710 LEE HIGHWAY ARLINGTON, VA 22207				
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPLETION E APPROPRIATE DATE		
F 609	getting into the room (Name of Resident # manager in the room was suppose (sic) to documentationIn re- reported about (Resid- patient headsigned On 02/16/22 at 1:55 F regarding Resident # aware of the investiga LPN #1 that Resident 01/07/22. The NP sta- the fall on the 9th and Resident #1 she had fully assessed. The F should have been se- evaluation, as the res- injury and was on Xa of the fall. The NP sta the placement (of the would go away, and F didn't show any distre- have sent her out." T not sure why staff did resident's fall on the of 01/07/22). On 02/16/22 at 2:20 F via phone. LPN #1 s Friday (01/07/22); I w floor and around at the tested positive and w positive floor (5th floo- care and my manage urgency to come. I ge lying on the floor face	urgency from himupon (number) I saw resident 1) lying on the floor with my told me she fellmanager do the necessary port out going nurse dent #1) huge swelling on on 02/11/22 by LPN #1." PM, the NP was interviewed 1's fall. The NP was made ation and the statement by t #1's fall occurred on ated that she was notified of d that when she saw a hematoma and she was NP was asked if Resident #1 nt out at that time for an sident had sustained a head Irelto 15 mg daily at the time ated, "In most cases yes, thematoma), I figured it based on my assessment ess, but probably should The NP stated that she was I not notify her of the day it occurred (on PM, LPN #1 was interviewed tated, "It (fall) happened on vas the only nurse on the nat time and Resident #1 as sent to the COVID or). I was in the middle of	F 609				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/28/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495121	B. WING		C 02/17/2022
NAME OF F	ROVIDER OR SUPPLIER	•	· ·	STREET ADDRESS, CITY, STATE, ZIP C	
				3710 LEE HIGHWAY	
CHERRY	DALE HEALTH AND REH	ABILITATION CENTER		ARLINGTON, VA 22207	
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETION HE APPROPRIATE DATE
F 609	stated that he was not happened and that he happened. LPN #1 s what happened to Re on the 7th (not the 9th stated that Resident # tested positive and w was in the afternoon, shift and he wasn't th left for the day. LPN on in report to the one resident fell, but did m LPN #1 stated that LF found Resident #1 and that and the paperwo only people in the roc and LPN #2, and that in bed. LPN #1 state the face." LPN #1 state the face." LPN #1 state the face." LPN #1 state the face." LPN #1 state the face that he was off another shift on Sund Sunday he noticed th regarding the fall, so why he didn't docume Resident #1. LPN #1 that since he wasn't in needed to do it. LPN he documented the fa happened on 01/07/2 texted the NP and inf 01/09/22. LPN #1 wa assessed. LPN #1 state the face #1 or notify #2 (the unit manager)	the in the room when it e did not know what tated that LPN #2 didn't say esident #1 but it did happen h as documented). LPN #1 #1 was on the 3rd floor, as moved to the 5th floor, it and that he worked the 7-3 ere much longer before he #1 stated that he passed it coming nurse that the not report it to the physician. PN #2 was the one who ad was supposed to do all rk. LPN #1 stated that the powere the patient, LPN #1 t Resident #1 was put back d, "I just noticed swelling on ated that he didn't notice any LPN #1 stated, "I did not vas on Friday." LPN #1 f on Saturday and picked up lay. When he came in on ere was no documentation he called LPN #2 and asked ent the fall and report for stated that LPN #1 #1 then stated that is when	F 60	99	

Facility ID: VA0064

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	S FOR MEDICARE &					O. 0938-03
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY
			A. BUILDING	3		С
		495121	B. WING			2/17/2022
AME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		2/1//2022
				3710 LEE HIGHWAY		
HERRYD	DALE HEALTH AND REH	ABILITATION CENTER		ARLINGTON, VA 22207		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETIO
F 609	Continued From page	a 25	F 60	00		
1 003			FOU	19		
	to be at risk for fallsfall is defined as unintentional change in position coming to rest on					
	-					
		ower surfaceNotify the				
	physician, responsibl	· ·				
		services), as well as the ative personnelevaluate,				
		nt patient responseinclude				
	neurological assessn	• •				
		he patient hit his/her head"				
	A policy titled,					
	"Abuse/Neglect/Misa	ppropriation/Crime"				
		mployees are responsible for				
		than two hours afterif the				
		se or bodily injuryno later				
		ncident does not involve				
	abuse or bodily injury	,				
		eir absence, the director of				
	nursingupon notific					
	violationsincluding	-				
		rator will immediately report				
		no later than 24 hours if the				
		e abuse or do not result in				
		injuries of unknown origin d or patient can't state what				
		handled the same as an				
		ment, neglect or abuse and				
	must be reported to t	-				
		ainingprotecting patients				
		ect and their responsibility to				
	•	ny cases of suspected or				
		f unknown origin (injuries not				
	-	can't state what happened)				
		e same as an allegation of				
		t or abuse and must be				
		Survey AgencyCenters are				
	to reportany unusu					

Event ID: XKJC11

Facility ID: VA0064

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	S FOR MEDICARE &				OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
495121		B. WING		C 02/17/2022	
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CO	DDE
HERRYD	ALE HEALTH AND REH	ABILITATION CENTER		LEE HIGHWAY LINGTON, VA 22207	
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE
F 609 F 610 SS=D	and corporate nurse of concerns regarding the reported to the State of time frame. The facilit that the Resident #1's on 01/07/22 not 01/05 by staff as required in procedures. The DON vacation when the fall made aware after (on work). The administre made aware that the 01/09/22 in a morning corporate nurse state everything on this pat medical records and the additional injury [othe and we sent an FRI [If see missteps in our p is room for performant corporate nurse state this in this patient (sid findings and our own No further information presented prior to the 02/17/22. Investigate/Prevent/O CFR(s): 483.12(c)(2)- §483.12(c) In response neglect, exploitation, must:	PM, the administrator, DON , were made aware of the his incident not being Agency within the required ity staff were made aware a fall with injury had occurred 0/22, and it was not reported the facility's policy and N stated that she was on I occurred and she was 0 01/17/22 upon return to ator stated that she was resident had a fall on g meeting on 01/10/22. The d, "We've given you tient, we [facility] requested there was no indication of r than hematoma/bruising] facility reported incident], I rocess, unfortunately there use improvement." The d, "No one can tell we saw c)we base on our own review." an and/or documentation was a exit conference on Correct Alleged Violation -(4) se to allegations of abuse, or mistreatment, the facility vidence that all alleged	F 609		3/21/22

Facility ID: VA0064

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/28/20/ FORM APPROVE OMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495121	B. WING		C 02/17/2022	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRYD	DALE HEALTH AND REH	ABILITATION CENTER		710 LEE HIGHWAY RLINGTON, VA 22207		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTIO	
F 610			F 610			
		nt further potential abuse, or mistreatment while the gress.				
	designated represent accordance with Stat Survey Agency, withi incident, and if the al appropriate corrective	the results of all administrator or his or her tative and to other officials in e law, including to the State n 5 working days of the leged violation is verified e action must be taken. Γ is not met as evidenced				
	facility document revi complaint investigation thoroughly investigate origin/unwitnessed factor the survey sample, R was found in her root 01/07/22. There were facility documentation incident was docume 01/09/22, two days a incident was not investigation	view, clinical record review, iew and in the course of a on, the facility staff failed to e an injury of unknown all for one of 9 residents in tesident #1. Resident #1 m, face down on the floor on e no witnesses according to n and interviews. The ented as occurring on fter the actual event. The stigated until 02/08/22 and tate Agency until 02/10/22		<ol> <li>F610</li> <li>Resident #1 is no longer a rest the center.</li> <li>A review of unusual incidents including falls will be reviewed from last 30 days to ensure a thorough investigation was completed and cagencies were notified if a Facility Reported Incident is required.</li> <li>Facility staff will be educated SDC/Designee on the center □s per abuse and neglect. Nursing Leadership/Administrator will be e by the Regional Director of Clinical</li> </ol>	m the outside by the olicy on ducated	
	06/29/18, with the mo 12/24/21. The reside facility on 01/14/22 a Diagnoses for Reside limited to: Atrial fibril	ent #1 included, but were not lation with long term		<ul> <li>Services/designee on the process conducting a thorough investigation unwitnessed falls with injuries/i</li></ul>	on for ries of incidents meeting	
	daily), history of a str	y (Xalrelto 15 mg/milligrams oke with right sided gia, dysphagia, constipation,		origin. 5. The results of the review will l discussed at the quarterly QAPI m		

Facility ID: VA0064

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/28/2022 MAPPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495121	B. WING				C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER			710 LEE HIGHWAY IRLINGTON, VA 22207		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	Continued From page	e 28	F	610			
	dementia, anxiety and			010	Once the QAPI committee determines	s the	
	The meet recent full N	(IDC (minimum data aat)			problem no longer exists, the reviews	will	
		MDS (minimum data set) day/annual) assessment			be conducted on a random basis.		
		MDS assessed the resident			The Administrator/Director of Nursing		
	•	erm memory impairment and daily decision making skills.			responsible for implementation of the of correction.	pian	
		assessed as requiring total			Date of compliance: 03/21/2022		
	mobility, transfers, dr	ast one staff person for bed essing, toileting, and					
	extensive assistance	for eating and hygiene.					
		ed that the resident did not corridor during the look back					
	period. In Section G	0300. "Balance during					
	transitions and walkir assessed as "activity	-					
	following: moving from						
		ning around, and/or moving This MDS assessed the					
		he fall since readmission					
	(12/24/21), not major	in injury.					
	Resident #1's clinical included the following	records were reviewed and J:					
	the floor beside her b observed on right side	"Patient observed lying on ed face down, hematoma e of the head close to the					
	within normal limit (si	ns)ROM (range of motion) c)MD (medical doctor) and e of LPN (licensed practical					
	2:46 PM documented 01/09/22 1:00 AMd notified: 01/09/22 1:0 notified 01/09/22 1:15	nt dated 01/09/22 and timed I, "date and time of fall: ate and time physician 00 AMdate and time RP 5 AMtwo person requires assistance to					

Facility ID: VA0064

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 03/28/2022 DRM APPROVED NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495121	B. WING				02/17/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	I	
	ALE HEALTH AND REH			3	710 LEE HIGHWAY		
CHERRID	ALE REALTH AND REH	ABILITATION CENTER		Α	RLINGTON, VA 22207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 610	Continued From page	o 20		240			
FOID			F	610			
	transferpain manag assisted back to bed.	gement/assessmentpatient					
		staff members LPN #1." There was no					
		the post fall assessment.					
		d 01/09/22 at 3:54 PM					
		t observed lying on the floor down, hematoma observed					
		ead close to the forehead					
	0	mal limit (sic)MD and RP					
	notifiedsignature of						
		oximately 10:00 AM, the					
		director of nursing] and the					
	corporate nurse were						
		on and were asked for any vestigation regarding injuries					
		t #1 in January 2022.					
		oximately 10:00 AM, the					
		director of nursing) and the					
	•	e made aware of a complaint					
		1 and were asked for any gation regarding a fall with					
		in January 2022. The					
		hat the investigation was					
	currently underway a						
		22. The administrator stated					
	they were made awa	re that Resident #1 had a fall					
	•	nit Manager (LPN #2) in a					
	"morning meeting" or						
	administrator stated t						
	0	id came to the facility on					
	regarding alleged sig	ere made aware of concerns					
	administrator stated t	-					
	investigation was initi						
	-	t prompted the investigation.					
		ited that there had not been					

Facility ID: VA0064

If continuation sheet Page 30 of 68

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE			
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILD	ING _					
		495121	B. WING				C 17/2022		
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER	3710 LEE HIGHWAY						
				<b>A</b>	ARLINGTON, VA 22207				
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE		
F 610	Continued From page any other investigatio	e 30 n regarding Resident #1.	F	610					
	On 02/16/22 at appro administrator and cor final investigation for The investigation had 01/09/22 which docur (Name of patient)No observed lying on the floor face down. Patie explain due to demen Taken: Head to Toe a hematoma observed close to forehead, pt bed by two staffHer scalpalertoriented consciousness: (blar Also included in the ir statement which docu 7-3 (shift) 01/07/22( nurse for 7-3 shift on (Name of LPN #2/Uni room (number) with u doing patient care (in run to him due to the getting into the room (Name of Resident #7	eximately 9:00 AM, the porate nurse presented their review. I an incident report dated, mented, "UN-witnessed: ursing Description: a floor beside her bed on the ent Description: cannot atiaImmediate Action assessment done, on right side of the head (patient) assisted back to matoma top of to personLevel of ak)No witness found." hvestigation was LPN #1's umented, "date of incident: On 01/07/22 I was the only that day, when my manager it Manager) called me in irgencyI was in middle of another room) but I have to urgency from himupon (number) I saw resident 1) lying on the floor with my told me she fellmanager							
	documentationIn re reported about (Resic patient headsigned There was no statement the Unit Manager.								

If continuation sheet Page 31 of 68

		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495121	B. WING				C 17/2022		
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE					
CHERRYDALE HEALTH AND REHABILITATION CENTER					3710 LEE HIGHWAY ARLINGTON, VA 22207				
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 610	documented, "I was accident happened, I patient room to chang and black eye on pati patient daughter camp patient in a bad condi happened to patient a know what happened not aroundsigned of statement by CNA #6 when the CNA "return "bump and black eye" RN #5's statement do work on Monday (01/ had a fall over the we 02/11/22." CNA #8's statement of on 3-11 shift patient we and seen she had bru was notifiedsigned of CNA #8 did not provid CNA saw the bruising The remainder of the documented that were duty, or not assigned provide any information On 02/16/22 at 1:35 F physician was intervise that he did not see Re physician stated that completed an assessi that he was notified, b stated, "I get so many	a not around when the came back to work I went to ge patient and I saw bump ent forehead (sic) and e in the room and said tion and she asked me what and I told her that I don't to patient because I was in 02/10/22 by CNA #6." The did not provide a date as to ned to work" or observed the ' on Resident #1. cumented, "Return to 10/22). I was told resident ekendsigned RN #5 locumented, "I came to work vas in bed I change her (sic) tises on both knees nurse CNA #8." The statement by de a date as to when the on Resident #1. statements from staff e on off, on vacation, off to Resident #1, and did not on to the investigation. PM, Resident #1's attending ewed. The physician stated esident #1 after the fall. The NP saw Resident #1 and ment. The physician stated out was unsure of when, and r calls." The physician sure of the details and did	F	610					

Facility ID: VA0064

If continuation sheet Page 32 of 68

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED C         495121       B. WING       02/17/202	FORM APF OMB NO. 093			ND HUMAN SERVICES		
495121 B. WING 02/17/202	NSTRUCTION (X3) DATE SURV COMPLETED			(X1) PROVIDER/SUPPLIER/CLIA	OF DEFICIENCIES	STATEMENT C
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIP CODE			B. WING	495121		
	ET ADDRESS, CITY, STATE, ZIP CODE	STREET ADDR			ROVIDER OR SUPPLIER	NAME OF PF
CHERRYDALE HEALTH AND REHABILITATION CENTER 3710 LEE HIGHWAY	LEE HIGHWAY	3710 LEE HIG		ABILITATION CENTER	ALE HEALTH AND REH	CHERRYD
ARLINGTON, VA 22207	NGTON, VA 22207	ARLINGTON				UNEIGHT
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION     (x       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE     COMPI       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE     DA	(EACH CORRECTIVE ACTION SHOULD BE COM CROSS-REFERENCED TO THE APPROPRIATE		PREFI	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC)	PREFIX
F 610       Continued From page 32       F 610         about this incident after the fact than when it actually happened.       F 610         On 02/16/22 at 1:55 PM, the NP was interviewed regarding Resident #1's fall. The NP was made aware of the investigation and the statement by LPN #1 that Resident #1's fall occurred on 01/07/22. The NP stated that she was notified of the fall on the 9th and that when she saw         Resident #1's hall. The NP was interviewed regarding Resident #1 should have been sent out at that time for an evaluation, as the resident #1 sustained a head injury and was on Xaireto 15 mg daily at the time of the fall. The NP stated that sustained a head injury and was on Xaireto 15 mg daily at the time of the fall. The NP stated that sustained a head injury siteres, but probably should have sent her out." The NP stated that the was not it would go away, and based on my assessment dint's show any distress, but probably should have sent her out." The NP stated that the was not in the resident #1 tested positive and was sent to the COVID positive fall on the day it occurred (on 01/107/22). I was the only nurse on the floor and around at that time and Resident #1 tested positive and was sent to the COVID positive floor (Sh floor). I was in the middle of care and my manager was calling me with urgency to come. I get into the room, patient is lying on the floor face down, he (LPN #2) asked me to help get the patient back to bed." LPN #1 stated that LPN #2 didn't say what happened at that dive and know that happened at the to did happened in the room whan it happened to Resident #1 tested bat the did popened is low what happened to Resident #1 bit did happened		610	F	he has found out more ter the fact than when it PM, the NP was interviewed 1's fall. The NP was made ation and the statement by t #1's fall occurred on ated that she was notified of d that when she saw a hematoma and she was NP was asked if Resident #1 nt out at that time for an sident had sustained a head Irelto 15 mg daily at the time tated, "In most cases yes, hematoma), I figured it based on my assessment ess, but probably should The NP stated that she was I not notify her of the day it occurred (on PM, LPN #1 was interviewed tated, "It (fall) happened on vas the only nurse on the hat time and Resident #1 tas sent to the COVID br). I was in the middle of er was calling me with et into the room, patient is e down, he (LPN #2) asked titent back to bed." LPN #1 ot in the room when it e did not know what tated that LPN #2 didn't say	physician stated that i about this incident aft actually happened. On 02/16/22 at 1:55 F regarding Resident # aware of the investiga LPN #1 that Resident 01/07/22. The NP stat the fall on the 9th and Resident #1 she had fully assessed. The N should have been ser evaluation, as the res- injury and was on Xal of the fall. The NP stat the placement (of the would go away, and b didn't show any distre have sent her out." T not sure why staff did resident's fall on the o 01/07/22). On 02/16/22 at 2:20 F via phone. LPN #1 st Friday (01/07/22); I w floor and around at th tested positive and wa positive floor (5th floo care and my manager urgency to come. I ge lying on the floor face me to help get the par stated that he was no happened and that he happened. LPN #1 st	F 610

Facility ID: VA0064

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/28/2022 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		495121	B. WING				C / <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP CODE	•	
				3710	) LEE HIGHWAY		
CHERRYL	DALE HEALTH AND REH	ABILITATION CENTER		ARI	INGTON, VA 22207		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 610	stated that Resident # tested positive and w was in the afternoon, shift and he wasn't th left for the day. LPN on in report to the one resident fell, but did m LPN #1 stated that LF found Resident #1 and that and the paperwo only people in the roc and LPN #2, and that in bed. LPN #1 state the face." LPN #1 state the documented the regarding the fall, so why he didn't docume Resident #1. LPN #1 that since he wasn't in needed to do it. LPN he documented the fa happened on 01/07/2 texted the NP and info 01/09/22. LPN #1 wa assessed. LPN #1 state Resident #1 or notify #2 (the unit manager) A policy titled, "Falls I documented, "the c to be at risk for falls unintentional change the ground ornext for physician, responsible	#1 was on the 3rd floor, as moved to the 5th floor, it and that he worked the 7-3 ere much longer before he #1 stated that he passed it coming nurse that the not report it to the physician. PN #2 was the one who d was supposed to do all rk. LPN #1 stated that the ow were the patient, LPN #1 : Resident #1 was put back d, "I just noticed swelling on ated that he didn't notice any LPN #1 stated, "I did not vas on Friday." LPN #1 f on Saturday and picked up lay. When he came in on ere was no documentation he called LPN #2 and asked ent the fall and report for stated that LPN #2 told him in the facility that LPN #1 #1 then stated that is when all on 01/09/22, but it 2. LPN #1 stated that he ormed her of the fall on as asked if Resident #1 was stated that he did not assess the physician, and that LPN ) must not have either.	F	610			

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	S FOR MEDICARE &					O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	E SURVEY PLETED
			A. BUILDING			
		495121	B. WING			С
		495121				2/17/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER		3710 LEE HIGHWAY		
				ARLINGTON, VA 22207		1
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 610	Continued From page	e 34	F 61	n		
1 010			FOI	0		
	Supervisor/Administrative personnelevaluate, monitor and document patient responseinclude					
	neurological assessn					
		he patient hit his/her head"				
	A policy titled,					
	"Abuse/Neglect/Misa	ppropriation/Crime"				
		mployees are responsible for				
		than two hours afterif the				
		se or bodily injuryno later				
		ncident does not involve				
	abuse or bodily injury					
	nursingupon notific	eir absence, the director of				
	violationsincluding					
	-	rator will immediately report				
		.no later than 24 hours if the				
		e abuse or do not result in				
	serious bodily injury	injuries of unknown origin.				
	(injuries not witnesse	d or patient can't state what				
	happened) should be	handled the same as an				
		ment, neglect or abuse and				
		he state agencyThe				
		director of nursing will				
	immediately initiate a	-				
	investigationwill inc	nterviewingvictimsand				
	-	priate individuals, agents, or				
	authorities to assist in					
		oroughly investigate and file				
		port of the investigation of				
		the state agency within 5				
		igative reporting document				
	submitted must conta					
		orough investigation was				
		nclude, but not limited to:				
		cename of patient, staff, or location and description of				

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STATE NEW OF DEFICIENCIES AND PLAN OF CORRECTION         (20) INTERSIDENT IDENTIFICATION NUMBER         (20) INTERSIDENT BUILTING         (20) INTE		-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/28/203 FORM APPROVE OMB NO. 0938-039
Mail: OP PROVIDER OR SUPPLIER         Distribution         Op/17/2022           CHERRYDALE HEALTH AND REHABILITATION CENTER         STREET ADDRESS. CITY, STATE, 2P CODE         37/0 LEE HIGHWAY           Arg. In         SUMAWAY STATUBIENT OF DEPICIENCIES         Breen A COMPARES ALLY AND REHABILITATION CENTER         Distribution         Distribution <td< td=""><td>STATEMENT (</td><td>OF DEFICIENCIES</td><td>(X1) PROVIDER/SUPPLIER/CLIA</td><td>. ,</td><td></td><td>COMPLETED</td></td<>	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		COMPLETED
NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE           CHERKYDALE HEALTH AND REHABILITATION CENTER         STREET ADDRESS, CITY, STATE, ZIP CODE           (PA)ID         SUMMARY STATEMENT OF DEFICIENCIES         IPPOVIDER PLAN OF CORRECTION         200, IPPOVIDER PLAN OF CORRECTION           PRETIX         IEACH DEFICIENCIES         IPPOVIDER PLAN OF CORRECTION         000, IPPOVIDER PLAN OF CORRECTION           TAG         ISOUMARY STATEMENT OF DEFICIENCIES         IPPOVIDER PLAN OF CORRECTION         000, IPPOVIDER PLAN OF CORRECTION           PRETIX         IEACH DEFICIENCIES         IPPOVIDER PLAN OF CORRECTION         IPPOVIDER PLAN OF CORRECTION         000, IPPOVIDER PLAN OF CORRECTION           TAG         IPPOVIDER PLAN OF CORRECTION         IPPOVIDER PLAN OF CORRECTION         IPPOVIDER PLAN OF CORRECTION           PRETIX         IEACH DEFICIENCIES         IPPOVIDER PLAN OF CORRECTION         IPPOVIDER PLAN OF CORRECTION           TAG         Continued From page 35         IPPOVIDER PLAN OF CORRECTION         IPPOVIDER PLAN OF CORRECTION           The facility staff were made aware of the         Construction         IPPOVIDER PLAN OF CORRECTION         IPPOVIDER PLAN OF CORRECTION           The facility staff were made aware of the their         Thre resultation or Resident #11         IPPOVIDER PLAN OF CORRECTION         IPPOVIDER PLAN OF CORRECTION           The facility staff were made sore tachend f			495121	B. WING		_
CHERRYDALE HEALTH AND REHABILITATION CENTER         ARLINGTON, VA 22207           (M)(1) TWO         SUMMARY STATEMENT OF DEFICIENCES (PAC) EPECIAL RESULATORY OR LS: DEMTEYING INFORMATION)         ID ID PREFIX RESULATORY OR LS: DEMTEYING INFORMATION)         ID ID PREFIX RESULATORY OR LS: DEMTEYING INFORMATION)         ID ID ID ID ID RESULATORY OR LS: DEMTEYING INFORMATION)         ID ID ID ID ID ID ID ID ID ID ID ID ID I	NAME OF P	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZI	
PREFIX TAG         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR US.DEMITPING INFORMATION)         PREFIX TAG         CEACH CORREPT & ACTION 3HOULD BE CROSS.REFERENCED TO THAT APPROPRIATE         COMMETTION BATE           F 610         Continued From page 35 protectfrom further injury"         F 610         F 610           On 02/16/22 at 2.35 PM, the administrator, DON, and corporate nurse were made aware of the concerns that the investigation for Resident #1 was not a complete and thorough investigation. The facility staff were made aware of the concerns that the investigation of Resident #1 westigation revealed discrepancies with dates or lack thereof, and that one employee statement revealed the injury to Resident #1 occurred on 01/07/22, not on 01/09/22, and was not followed up on by the facility staff were made aware that some of the statements did not have dates to indicate when observations actually occurred. The state filter were also informed that a statement or interview was not indication of additional injury and we sent an RRI (facility reported incident). Ise emissteps in our process, unfortunately there is room for performance improvement. <sup>*</sup> The corporate nurse stated, "No one can tell we saw this in this patient (were), we base on our own findings and our own review. <sup>*</sup> F 684         3/21/22           F 644         Quality of Care SCFR(s): 483.25         F 684         3/21/22	CHERRYE	ALE HEALTH AND REH	ABILITATION CENTER			
protectfrom further injury "       On 02/16/22 at 2:35 PM, the administrator, DON, and corporate nurse were made aware of the concerns that the investigation for Resident #1 was not a complete and thorough investigation. The facility staff were made aware that their investigation revealed discrepancies with dates or lack thereof, and that one employee statement revealed the injury to Resident #1 occurred on 01/07/22 not on 10/09/22. The facility staff were made aware that the injury on by the facility. It was also documented multiple times and locations that the injury occurred on 01/09/22. The facility staff were made aware that a some of the statements did not have dates to indicate when observations actually occurred on 01/09/22. The facility staff were made aware that some of the statements did not have dates to indicate when observations actually occurred on 01/09/22. The facility staff were made aware that some of the statements did not have dates to indicate when observations actually occurred on 01/09/22. The facility staff were made aware that some of the statements did not have dates to indicate when observations actually occurred on 01/09/22. The facility staff were made aware that a statement or interview was not obtained for LPN #2 (unit manager) who was documented as the first person to find Resident #1 according to LPN #2 (unit manager) who was not indication of additional injury and we sent an FRI (facility reported incident). I see missteps in our process, unfortunately there is room for performance improvement." The corporate nurse stated, "No one can tell we saw this in this patient (sic)we base on our own findings and our own review."       F 684       3/21/22         F F 684       S/21/22       § 483.25       § 483.25       \$/21/22	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED T	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
and corporate nurse were made aware of the concerns that the investigation Resident #1         was not a complete and thorough investigation.         The facility staff were made aware that their investigation revealed discrepancies with dates or lack thereof, and that one employee statement revealed the injury to Resident #1 occurred on 01/07/22 not on 01/09/22. The facility staff were made aware that some of the statemented multiple times and locations that the injury occurred on 10/19/22. The facility staff were made aware that some of the statements did not have dates to indicate when observations actually occurred. The staff were also informed that a statement or interview was not obtained for LPN #2 (unit manager) who was documented a the first person to find Resident #1 according to LPN #1. The corporate nurse stated, "We've given you everything on this patient, we requested medical records and there was no indication of additional injury and we sent an FRI (facility reported incident). I see missteps in our process, unfortunately there is room for performance improvement." The corporate nurse stated, "No one can tell we saw this in this patient (sc)we base on our own findings and our own review."         No further information and/or documentation was presented prior to the exit conference on 02/17/22.       F 684       Cuality of Care       F 684       3/21/22         § 483.25 Quality of care       § 483.25 Quality of care       F 684       S/21/22       S/21/22	F 610	10		F 61	o	
§ 483.25 Quality of care		and corporate nurse of concerns that the inve- was not a complete a The facility staff were investigation revealed lack thereof, and that revealed the injury to 01/07/22 not on 01/09 up on by the facility. multiple times and loo occurred on 01/9/22. aware that some of th dates to indicate whe occurred. The staff we statement or interview #2 (unit manager) wh first person to find Ree #1. The corporate nu you everything on this medical records and additional injury and we reported incident). I suffortunately there is improvement." The consecution one can tell we saw to base on our own find No further information presented prior to the 02/17/22. Quality of Care	were made aware of the estigation for Resident #1 ind thorough investigation. made aware that their d discrepancies with dates or one employee statement Resident #1 occurred on 0/22, and was not followed It was also documented cations that the injury The facility staff were made the statements did not have n observations actually were also informed that a v was not obtained for LPN o was documented as the esident #1 according to LPN urse stated, "We've given s patient, we requested there was no indication of we sent an FRI (facility ee missteps in our process, room for performance corporate nurse stated, "No his in this patient (sic)we ings and our own review."	F 68	4	3/21/22
	55=G	§ 483.25 Quality of ca				
		Quality of care is a fu	ndamental principle that			

Facility ID: VA0064

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-	TH AND HUMAN SERVICES			PRINTED: 03/28/20 FORM APPROVE OMB NO. 0938-03
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
	495121	B. WING		02/17/2022
NAME OF PROVIDER OR SUPPL	IER		STREET ADDRESS, CITY, STATE, ZIP CO	DDE
CHERRYDALE HEALTH AN	D REHABILITATION CENTER		3710 LEE HIGHWAY ARLINGTON, VA 22207	
PREFIX (EACH DE	MARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL DRY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIO IE APPROPRIATE DATE
facility residem assessment of that residents a accordance wi practice, the oc care plan, and This REQUIRE by: Based on fam record review, course of a col staff failed ens provided in a ti residents, Res Resident #1 ha and was not as 01/09/22. Resi days after the was sent to the to have a hem bruising, along (C1-C3) and a Findings incluo Resident #1 w 06/29/18, with 12/24/21. The facility on 01/1 for Resident # Atrial fibrillation therapy (Xalrel of a stroke with hemiparesis/he dementia, anxi	eatment and care provided to s. Based on the comprehensive a resident, the facility must ensure eceive treatment and care in th professional standards of omprehensive person-centered the residents' choices. EMENT is not met as evidenced ily interview, staff interview, clinical facility document review, and in the nplaint investigation, the facility ure care and treatment were mely manner for one of nine dent #1, resulting in harm. ad an unwitnessed fall on 01/07/22, sessed until two days later on dent #1's condition declined in the unwitnessed fall and the resident a hospital on 01/14/22, and found atoma to the head with facial with fractures to the cervical neck right hip. le: as admitted to the facility on the most current readmission on resident was discharged from the 4/22 and did not return. Diagnoses I included, but were not limited to: n with long term anticoagulant to 15 mg/milligrams daily), history		<ul> <li>F684</li> <li>Resident is no longer a center.</li> <li>A review of falls for the will be conducted to ensure notification was completed. the review will include check there is a thorough assessmaresident documented in the records at the time of the fal appropriate interventions plates. Licensed nurses will be the SDC/designee on timely the RP/MD when falls with in falls management program, head to toe assessments, do in the medical record and pot transfer determination.</li> <li>DON/ADON/UM will re incidents daily during clinica weekly to ensure a thorough was completed for unwitness injuries/injuries of unknown of documented head to toe assessments in the results of the review discussed at the quarterly Q</li> </ul>	last 30 days timely RP//MD In addition, king whether hent of the medical I and aced. educated by notification of hjuries occur, conducting ocumentation bost fall ER view unusual I meeting 5x h investigation sed falls with origin, seessment was etermination rring resident w will be

Facility ID: VA0064

If continuation sheet Page 37 of 68

		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 03/28/2022 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		495121	B. WING				C / <b>17/2022</b>
NAME OF PF	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CHEDDAD				37	710 LEE HIGHWAY		
CHERRID	ALE NEALIN AND REN	ABILITATION CENTER		A	RLINGTON, VA 22207		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	684	problem no longer exists, the reviews be conducted on a random basis. The Administrator/Director of Nursing responsible for implementation of the of correction. Date of compliance: 03/21/2022	are	
		d 01/09/22 at 1:58 AM t grimacing and moaning,					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 03/28/2022 MAPPROVED D. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495121	B. WING			17/2022	
NAME OF PI	ROVIDER OR SUPPLIER	1	s	TREET ADDRESS, CITY, STATE, ZIP CC	•		
CHERRYD	OALE HEALTH AND REH	ABILITATION CENTER		710 LEE HIGHWAY RLINGTON, VA 22207			
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	2:46 PM documented 01/09/22 1:00 AMd notified: 01/09/22 1:0 (responsible party) nd AMtwo person assi assistance to transfer management/assess to bedstaff member (licensed practical nu other information on the A progress note date which documented, " floor beside her bed for observed on right sid forehead VS (vital sig within normal limit (si RP notifiedsignatur A progress note date documented, "Patien beside her bed face of on right side of the her VSROM within norr notifiedsignature of A physician's progress 5:17 PM documented and right anterior fore	oleratedcontinue to ." Int dated 01/09/22 and timed I, "date and time of fall: ate and time physician 00 AMdate and time RP otified 01/09/22 1:15 stchair bound, requires rpain mentpatient assisted back rs assisted2signed LPN rse) #1." There was no the post fall assessment. d 01/09/22 at 3:33 PM, Patient observed lying on the face down, hematoma e of the head close to the gns)ROM (range of motion) c)MD (medical doctor) and e of LPN#1." d 01/09/22 at 3:54 PM t observed lying on the floor down, hematoma observed ead close to the forehead mal limit (sic)MD and RP LPN #1."	F 684				
	(Resident #1's blood respiration were date progress note, and w date of 01/09/22 note						

Facility ID: VA0064

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-					FOR	M APPROVED D. 0938-0391
F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE COMF	E SURVEY PLETED
	495121	B. WING				C / <b>17/2022</b>
OVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
ALE HEALTH AND REH	ABILITATION CENTER					
(EACH DEFICIENC)			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
precautionsforehead to hematoma TID (thr 650 mg for painsign There was no mention an long term anticoag mg daily since June 2 A progress note dated documented, "Situatio ofA-Fibright hemip (RN)/Appearance (LP assessment done head side of the head close supervisor aware, RC remain afebrileconti resident to call for hel positionsignature of No other documentati #1's clinical record reg fall. According to the resident's clinical record fall with injury on 01/0 A progress note dated documented, "Situatio Background:hemi-r HTN, Dysphagia. Ass (LPN): Pt. is alert and given as ordered, tole mental statusBruise knees and hematoma normal limitNo distro shiftsignature of RN A progress note dated documented, "Alert	d hematoma start apply ice ree times daily) Start Tylenol hed by NP." In of Resident #1 being on gulant therapy (Xalrelto 15 2020). d 01/09/22 at 10:18 PM on: Post fall 3-11history paresis. Assessment PN): Head to toe amatoma (sic) noted on right to the forehead, NP and DM within normal limit, inue to monitoreducate p, bed in the lowest FLPN #1." ion was located in Resident garding the details of this documentation in the ords the resident sustained a 09/22. d 01/10/22 at 10:48 AM on: S/P fall 7-3 shift neglect of right sideAFIB, ressment (RN)/Appearance I verbally responsive. Meds erated well. No changes in a remain on pt. (patient) both a foreheadROM with in ess noted during I #3."	F	684			
	S FOR MEDICARE &     F DEFICIENCIES CORRECTION  OVIDER OR SUPPLIER  ALE HEALTH AND REHA  SUMMARY ST, (EACH DEFICIENC) REGULATORY OR I  Continued From page precautionsforehea to hematoma TID (thr 650 mg for painsign There was no mention an long term anticoag mg daily since June 2  A progress note dated documented, "Situatio ofA-Fibright hemip (RN)/Appearance (LF assessment done hea side of the head close supervisor aware, RC remain afebrileconti resident to call for hel positionsignature of No other documentati #1's clinical record ref fall. According to the resident's clinical record fall with injury on 01/C A progress note dated documented, "Situatio fall According to the resident's clinical record fall with injury on 01/C A progress note dated documented, "Situatio Background:hemi-r HTN, Dysphagia. Ass (LPN): Pt. is alert and given as ordered, tole mental statusBruise knees and hematoma normal limitNo distr A progress note dated documented, "Alert	CORRECTION IDENTIFICATION NUMBER:	S FOR MEDICARE & MEDICAID SERVICES         PEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL A BUILD         OVIDER OR SUPPLIER       495121       B. WING,         OVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIT TAG         Continued From page 39 precautionsforehead hematoma start apply ice to hematoma TID (three times daily) Start Tylenol 650 mg for painsigned by NP."       F         There was no mention of Resident #1 being on an long term anticoagulant therapy (Xalrelto 15 mg daily since June 2020).       F         A progress note dated 01/09/22 at 10:18 PM documented, "Situation: Post fall 3-11history ofA-Fibright hemiparesis. Assessment (RN)/Appearance (LPN): Head to toe assessment done heamatoma (sic) noted on right side of the head close to the forehead, NP and supervisor aware, ROM within normal limit, remain afebrilecontinue to monitoreducate resident to call for help, bed in the lowest positionsignature of LPN #1."         No other documentation was located in Resident #1's clinical record regarding the details of this fall. According to the documentation in the resident's clinical records the resident sustained a fall with injury on 01/09/22.         A progress note dated 01/10/22 at 10:48 AM documented, "Situation: S/P fall 7-3 shift Backgroundhemi-neglect of right sideAFIB, HTN, Dysphagia. Assessment (RN)/Appearance (LPN): Pt. is alert and verbally responsive. Meds given as ordered, tolerated well. No changes in mental statusBruise remain on pt. (patient) both knees and hematoma foreheadROM with in norma	S FOR MEDICARE & MEDICAID SERVICES         FOEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLER/CL/A IDENTIFICATION NUMBER:       (X2) MULTIPL A BUILDING.         495121       B. WING         OVIDER OR SUPPLIER       495121         OUDER OR SUPPLIER       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 39       F 684         precautionsforehead hematoma start apply ice to hematoma TID (three times daily) Start Tylenol 650 mg for painsigned by NP."       F 684         There was no mention of Resident #1 being on an long term anticoagulant therapy (Xalrelto 15 mg daily since June 2020).       F 684         A progress note dated 01/09/22 at 10:18 PM documented, "Situation: Post fall 3-11history ofA-Fibright hemiparesis. Assessment (RN)/Appearance (LPN): Head to tce assessment done heamatoma (sic) noted on right side of the head close to the forehead, NP and supervisor aware, ROM within normal limit, remain afebrilecontinue to monitoreducate resident to call for help, bed in the lowest positionsignature of LPN #1."       No other documentation was located in Resident #1's clinical record regarding the details of this fall. According to the documentation in the resident's clinical records the resident sustained a fall with injury on 01/09/22.       A progress note dated 01/10/22 at 10:48 AM documented, "Situation: S/P fall 7-3 shift Background:hemi-neglect of right sideAFIB, HTN, Dysphagi, Assessment (RN)/Appearance (LPN): Pt. is alert and verbally responsive. Meds given as ordered, tolerated well. No changes i	EPR MEDICARE & MEDICAID SERVICES         DEFICIENCIES       (x) PROVIDERSUPPLIERCULA UBENTIFICATION MUMBER:       (x2) MULTIFIE CONSTRUCTION A BUILDING         495121       (x) PROVIDERSUPPLIERCULA UBENTIFICATION MUMBER:       (x2) MULTIFIE CONSTRUCTION A BUILDING         OVIDER OR SUPPLIER       3710 LEE HIGHWAY ARLINGTON, VA 22207         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEIDED BY FULL RECOLLATORY OR LSC DENTIFINANTION)       PROVIDERS FLAN OF CORRECTIVE PRECINCE TO THE APPROVE (EACH DEFICIENCY MUST BE PRECEIDED BY FULL RECOLLATORY OR LSC DENTIFINANTION)         Continued From page 39 precalitionsforehead hematoma start apply ice to hematoma TID (hree times daily) Start Tylenol 650 mg for painsigned by NP.*       F 684         There was no mention of Resident #1 being on an long term anticoagulant therapy (Xalreito 15 mg daily since June 2020).       F 684         A progress note dated 01/09/22 at 10:18 PM documented, "Situation: Post fall 3-11history ofA-Fibright hemiparesis. Assessment (RN)/Appearance (LPN): Head to to assessment done heamatoma (sic) noted on right assessment done heamatoma (sic) noted on right assessment for help, bed in the lowest positionsignature of LPN #1.*         No other documentation was located in Resident #1's clinical records the resident sustained a fall with injury on 01/09/22.         A progress note dated 01/10/22 at 10:48 AM documented, "Situation: S/P fall 7-3 shift Background"hemin-regise CH. No changes in mental statusBruise remain on pt. (patient) both knees and hematoma foreheadROM with in normal limit No distress noted during shiftsignature of RH 3.**	HENT OF HEALTH AND HUMAN SERVICES       FOR         STOR MEDICARE & MEDICALD SERVICES       ONB NO         CORRECTION       (x1) PROVDERSUPPLERCIA. IDENTIFICATION NUMBER.       (x2) MLTTPLE CONSTRUCTION       (x2) OLT         ABULDING       1       9 WINO       100       02         OWDER OR SUPPLER       3116EET ADDRESS. CITY. STATE, 2IP CODE       3710 LEE HIGHWAY       02         ALE HEALTH AND REHABILITATION CENTER       STREET ADDRESS. CITY. STATE, 2IP CODE       02         WINAMERY STATEMENT OF DEPICIENCIES       ID       PROVIDERS PLAN OF CORRECTION       02         (#CAH DEFICIENCY MUST BE PRECEDED BY FILL       PREFIX       REGULATORY OR LOCATE AND REMARKANDON       DEFICIENCY         Continued From page 39       IF 684       PREFIX       PROVIDERS PLAN OF CORRECTION       ID         (CAH DEFICIENCY MUST BE PRECEDED BY FILL       FE 684       PREFIX       REGULATORY OR LOCATE AND REMARKANDON       DEFICIENCY         Continued From page 39       IF 684       ID       PREFIX       REGULATORY OR LOCATE AND REMARKANDON       DEFICIENCY         Continued From page 39       IF 684       ID       ID

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		495121	B. WING				C / <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	L	<b>I</b>	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY	DALE HEALTH AND REH	ABILITATION CENTER		3710 LEE HIGHWAY ARLINGTON, VA 22207			
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 684	<ul> <li>A progress note dated documented, "A-Fik and verbally responsi in mental statusbrui and on hematoma he assistmonitor freque Progress note dated documented, "hema headhealing in proglimitcontinue with pl</li> <li>A progress noted dated documented, "hema headhealing in proglimitcontinue with pl</li> <li>A progress noted dated documented, "alert. on both knees and he foreheadobserved assistNP notified"</li> <li>A progress noted dated documented, "Pt. receprovided by staff with ordered, pt. observed her eye (sic) intermitt sleepNP notifiedF condition"</li> <li>A progress note dated documented, "VS o timedaughter came (sic) with non emerge aware (name of trans was sent out to the he 01/14/22, at 11:14 AM Resident #1's current plan) at the time of th</li> </ul>	d 01/10/22 at 6:48 PM expressive aphasiaalert vemeds givenno change ise remain on both knees r forehead (sic)ate with ently" 01/11/22 at 8:00 PM atoma to the right side of the gress, ROM within normal an of care" ed 01/12/22 a 8:23 PM responsivebruise remain ematoma on her .weakmealsstaff ed 01/13/22 at 1:46 PM eived in bed this amcare total assist. Meds given as very weak on shift, open ently and fall back to RP updated about pt d 01/13/22 at 9:59 PM btained at this in to visit. Pt. to be send ency for further eval NP port) called." Resident #1 ospital the following day	F	684			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 03/28/2022 RM APPROVED IO. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED C		
		495121	B. WING		0	2/17/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
	ALE HEALTH AND REH			3710 LEE HIGHWAY			
CHERRIL	ALE NEALTH AND REN	ADILITATION CENTER		ARLINGTON, VA 22207			
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	bed mobility, wheelch cushion for w/c positive reachencourage reasons assistance as needed safety reminders and occursrounding and anticipate to meet the needsenvironment anticoagulant therapy (created on 05/12/202 orderedmeds as or such as unusual bruis stool, red or dark brow painswellingbleect nosereport symptor signs/symptoms of bl anticoagulation therap bilateral forearms, rig on 01/09/22)" On 02/15/22 at appro administrator, DON (corporate nurse were regarding Resident # information or investig injury for Resident #1 administrator stated t currently underway an completed on 02/16/2 they were made awan on 01/09/22 by the Un "morning meeting" or administrator stated t investigator called an	awarenessassist bars for hair for locomotion, pommel oningcall light in sident to use it for deducate caregivers about what to do if a fall a close monitoring, and e resident's free of hazardsis on related to Atrial Fibrillation 20)Lab work as deredMonitor for bleeding sing, bloody or black tarry wn urine, abdominal ling from eyes, gums, ns to MDObserve for any eeding related to pySKIN: bruises to ht head hematoma (revised ximately 10:00 AM, the director of nursing) and the made aware of a complaint 1 and were asked for any gation regarding a fall with in January 2022. The hat the investigation was nd that it would be 22. The administrator stated re that Resident #1 had a fall nit Manager (LPN #2) in a 01/10/22. The hat it wasn't until an d came to the facility on ere made aware of concerns nificant injuries. The hat was when the	F 68	4			

Facility ID: VA0064

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		O. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED
			/		С	
		495121	B. WING		02	2/17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	•	-
			:	3710 LEE HIGHWAY		
CHERRIL	JALE NEALIN AND REP	ABILITATION CENTER		ARLINGTON, VA 22207		
(X4) ID	-	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIO DATE
	Continued From pag	je 42	F 684			
	information was what	t prompted the investigation.				
		ated that there had not been				
	any other investigati	on regarding Resident #1.				
	0. 00/45/00 at any					
		oximately 2:30 PM, the ords obtained by the facility				
		eview. The ED (emergency				
		r note dated 01/14/22 at				
	, , , , , , , , , , , , , , , , , , , ,	ed, "Sent to the ER for				
	evaluation of letharg	y and mental status change				
		tient is on Xalrelto. It is				
		has been lethargic and				
		e yesterdayreport of a fall eekAltered mental status,				
		n verbal, not following				
	commands, lying on	-				
		(bruises) to forehead and				
	-	at 100 bpm (beats per				
		d CNS (central nervous				
	, ,	mpromiseC1 anterior				
		ht and left posterior arch				
		noderate distraction of				
		non-displaced fracture C3 left rticular facet fracture of C2				
		) vertebral foramen, right				
		proximal femur1:20				
		wing commandsopens				
		s away noxious stimuli,				
		elligible soundsRight				
		atomaLeft peri-orbital				
	LEG, FOOT: left wit	rearm ecchymosisHIP, bdrawals to				
	painrightdeformit					
		ecchymosis right knee,				
	healing abrasions to	right upper thighright hip				
		sultedhold XalreltoC1-C3				
	fracturesright prox	imal femur displaced				
	impacted fracture"	-				

Facility ID: VA0064

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495121	B. WING				C / <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	•	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				3	3710 LEE HIGHWAY		
CHERRIL	OALE HEALTH AND REH	ABILITATION CENTER			ARLINGTON, VA 22207		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 684	administrator and cor final investigation for The investigation for The investigation had 01/09/22 which docur (Name of patient)Nr observed lying on the floor face down. Patie explain due to demen Taken: Head to Toe a hematoma observed close to forehead, pt bed by two staffHer scalpalertoriented consciousness: (blar Also included in the ir statement which docu 7-3 (shift) 01/07/22( nurse for 7-3 shift on (Name of LPN #2/Uni room (number) with u doing patient care (in run to him due to the getting into the room (Name of Resident #7 manager in the room was suppose (sic) to documentationIn re reported about (Resid patient headsigned CNA (certified nursing documented, "I was accident happened, I patient room to chang and black eye on pati	ximately 9:00 AM, the porate nurse presented their review. an incident report dated, mented, "UN-witnessed: ursing Description: floor beside her bed on the ent Description: cannot tiaImmediate Action assessment done, on right side of the head (patient) assisted back to matoma top of to personLevel of hk)No witness found." hvestigation was LPN #1's umented, "date of incident: On 01/07/22 I was the only that day, when my manager it Manager) called me in irgencyI was in middle of another room) but I have to urgency from himupon (number) I saw resident 1) lying on the floor with my told me she fellmanager do the necessary	F	684			

Facility ID: VA0064

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	-	D HUMAN SERVICES MEDICAID SERVICES		FORM	APPROVED 0. 0938-0391		
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495121	B. WING				C 17/2022
NAME OF PRO	OVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				3	3710 LEE HIGHWAY		
CHERRIDA	LE HEALTH AND REH	ABILITATION CENTER		A	ARLINGTON, VA 22207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
 	happened to patient a know what happened not aroundsigned on statement by CNA #6 when the CNA "return 'bump and black eye" RN #5's statement do work on Monday (01/- had a fall over the we 02/11/22." CNA #8's statement do on 3-11 shift patient w and seen she had bru was notifiedsigned 0 CNA #8 did not provid CNA #8 did not provid CNA #8 did not provid CNA #8 did not provid CNA saw the bruising On 02/16/22 at 10:25 was inferviewed. The was informed of the fa Resident #1 on Mond that LPN #2 told her n care of Resident #1. 1 asked what happened what happened to her stated that bump on h big, I knew it was a he asked the facility staff stated they acted as t The daughter stated t Thursday (01/13/22) a she wasn't responding unconscious." The da and wanted Resident that staff told her, "ma	tion and she asked me what and I told her that I don't to patient because I was in 02/10/22 by CNA #6." The did not provide a date as to used to work" or observed the ' on Resident #1. cumented, "Return to 10/22). I was told resident ekendsigned RN #5 locumented, "I came to work vas in bed I change her (sic) tises on both knees nurse CNA #8." The statement by le a date as to when the on Resident #1. AM, Resident #1's daughter e daughter stated that she all on 01/09/22 and she saw ay 01/10/22. She stated not to worry they were taking The daughter stated that she d and no one could tell her mother. The daughter ter mother's head was "So ead injury." The daughter to send Resident #1out and hough they didn't want to. hat she went back on and her mother was "gone",	F	684			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495121	B. WING				C 1 <b>7/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				3	3710 LEE HIGHWAY		
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER			ARLINGTON, VA 22207		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684	out, but not 911, beca The daughter stated to on 01/13/22 and the f 3:00 AM and told her her mother up betweed daughter stated that F hospital and was adm and broken hip. On 02/16/22 at 1:35 F physician was intervied that he did not see Re physician stated that completed an assess that he was notified, to stated, "I get so many stated that he was un not see Resident #1 of On 02/16/22 at 1:55 F regarding Resident # aware of the investiga LPN #1 that Resident 01/07/22. The NP stat the fall on the 9th and Resident #1 she had fully assessed. The N what happened. The fell out of the wheelch where that information resident's clinical reco information in the not assessment. The NP resident's head and th discomfort and stated bruising on both knee	d to have Resident #1 sent huse it wasn't an emergency. hat she left at around 10 PM acility staff called her around that transport would pick en 7 and 8 AM. The Resident #1 went to the hitted with a broken neck PM, Resident #1's attending ewed. The physician stated esident #1 after the fall. The NP saw Resident #1 and ment. The physician stated but was unsure of when, and calls." The physician sure of the details and did during this time. PM, the NP was interviewed 1's fall. The NP was made ation and the statement by #1's fall occurred on ated that she was notified of I that when she saw a hematoma and she was NP was asked if she knew NP stated, "she literally hair" The NP was asked in came from as the ords did not document that es or the post fall ' stated it was documented stated that she palpated the	F	684			

Facility ID: VA0064

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 03/28/2022 DRM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED
		495121	B. WING				C 02/17/2022
NAME OF PROVIDER OR S	JPPLIER	·		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
				371	0 LEE HIGHWAY		
CHERRYDALE HEALTI	1 AND REH	ABILITATION CENTER		AR	LINGTON, VA 22207		
PREFIX (EAC			ID PREFI TAG	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
sustained a mg daily at "In most ca hematoma based on r distress, b The NP wa anytime af had not, ar long with a 01/13/22 at about send because si why the re being sent sent out not the patient On 02/16/2 via phone. (01/07/22) around at t positive an (5th floor). manager w get into the down, he ( patient bac not in the r not know v LPN #2 did but it did h documente was on the moved to t	evaluatior a head inju the time of ases yes, ti ), I figured ny assessi- ut probably as asked if ter 01/09/2 nd that stad ny change round 9 or ling Reside the was "sle sident was non-emerge is sleepy a 22 at 2:20 I LPN #1 s I was the hat time aid d was sen I was the hat time aid d floor, he 5th floo	e 46 h, as the resident had iny and was on Xalrelto 15 of the fall. The NP stated, he placement (of the it would go away, and ment didn't show any y should have sent her out." she saw the resident 2. The NP stated that she f did not call her all week is. The NP stated that on 10 PM, she was notified ent #1 out for an evaluation eepy." The NP was asked not sent via 911, instead of gentl. The NP stated, "Yes, ntthe way it was described, and vital signs were stable." PM, LPN #1 was interviewed tated, "It happened on Friday only nurse on the floor and nd Resident #1 tested t to the COVID positive floor e middle of care and my me with urgency to come. I tient is lying on the floor face sked me to help get the LPN #1 stated that he was it happened and that he did ened. LPN #1 stated that at happened to Resident #1 he 7th (not the 9th as f1 stated that Resident #1 tested positive and was r, it was in the afternoon, he 7-3 shift and he wasn't	F	584			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495121	B. WING				_ 17/2022
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRY	OALE HEALTH AND REH	ABILITATION CENTER			3710 LEE HIGHWAY ARLINGTON, VA 22207		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR I	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 684	oncoming nurse that is report it to the physici #2 was the one who f supposed to do all that #1 stated that the only the patient, LPN #1 a Resident #1 was put "I just noticed swelling stated that he didn't n time. LPN #1 stated, that was on Friday." off on Saturday and p Sunday. When he can there was no docume he called LPN #2 and document the fall and LPN #1 stated that LF wasn't in the facility th LPN #1 stated that LF wasn't in the facility th the fall on 01/09/22, b LPN #1 stated that he informed her of the fa asked if Resident #11 stated that he did not notify the physician, a manager) must not hat A policy titled, "Falls N documented, "the c to be at risk for falls unintentional change the ground ornext lo physician, responsible (emergency medical s Supervisor/Administra monitor and documer neurological assessm	the resident fell, but did not an. LPN #1 stated that LPN ound Resident #1 and was at and the paperwork. LPN y people in the room were nd LPN #2, and that back in bed. LPN #1 stated, g on the face." LPN #1 otice any bruising at that "I did not witness the fall LPN #1 stated that he was ticked up another shift on me in on Sunday he noticed entation regarding the fall, so asked why he didn't report for Resident #1. PN #2 told him that since he hat LPN #1 needed to do it. hat is when he documented but it happened on 01/07/22. te texted the NP and II on 01/09/22. LPN #1 was was assessed. LPN #1 assess Resident #1 or and that LPN #2 (the unit ave either. Management Program" enter considers all patients fall is defined as in position coming to rest on ower surfaceNotify the e party, and/or EMS services), as well as the ative personnelevaluate, at patient responseinclude	F	684			

Facility ID: VA0064

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/28/20 FORM APPROVI OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495121	B. WING		02/17/2022
NAME OF PF	ROVIDER OR SUPPLIER	1	S	TREET ADDRESS, CITY, STATE, ZIP CO	•
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER		710 LEE HIGHWAY RLINGTON, VA 22207	
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COMPLETIO HE APPROPRIATE DATE
F 684	and corporate nurse of concerns regarding the and assessment for F that occurred on 01/0 as 01/09/22. Resider seen by the NP until it staff were also made began to have a decid documented by nursi notification of the NP #1 was not assessed at that time for evaluar made aware of concerner contacted the NP on the NP agreed to sen evaluation non-emerge facility on 01/14/22 at hospital, and found we lethargy, a right femu neck (C1 through C3 with bruising to the ey knees. The DON stat when the fall occurred after (on 01/17/22 up administrator stated to that the resident had morning meeting on 0 nurse stated, "I see no unfortunately there is improvement." The of one can tell we saw to base on our own find	PM, the administrator, DON , were made aware of the ne lack of immediate care Resident #1 related to the fall 17/22, but was documented int #1 was not assessed or two days later. The facility aware that the resident ine with noticeable changes ing staff leading up to the on 01/13/22 and Resident by the NP or MD or sent out ation. The staff were also erns that when nursing 01/13/22 at 9:59 PM, that id the resident out for gently. Resident #1 left the tith altered mental status and r fracture, fractures to the ), hematoma to the head yes, and bruising to the ted that she was on vacation d and she was made aware on return to work). The hat she was made aware a fall on 01/09/22 in a 01/10/22. The corporate nissteps in our process, room for performance corporate nurse stated, "No his in this patient (sic)we ings and our own review."	F 684		
F 758	02/17/22. Free from Unnec Psy		F 758		3/21/22

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Event ID: XKJC11

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE		
		495121	B. WING			C 02/17/20		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-		
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER		3710 LEE HIGHWAY				
					ARLINGTON, VA 22207			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 758	CFR(s): 483.45(c)(3)( §483.45(c)(3) A psychatron §483.45(c)(3) A psychatron §483.45(c)(3) A psychatron §483.45(c)(3) A psychatron (i) Anti-psychotic; (ii) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe resident, the facility m §483.45(e)(1) Reside psychotropic drugs ar unless the medication specific condition as of in the clinical record; §483.45(e)(2) Reside drugs receive gradua behavioral interventio contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs pu unless that medicatio diagnosed specific co in the clinical record; §483.45(e)(4) PRN of	re)(1)-(5) appic Drugs. notropic drug is any drug that associated with mental ior. These drugs include, drugs in the following ensive assessment of a nust ensure that nts who have not used re not given these drugs a is necessary to treat a diagnosed and documented nts who use psychotropic I dose reductions, and ns, unless clinically effort to discontinue these Its do not receive ursuant to a PRN order n is necessary to treat a undition that is documented and rders for psychotropic drugs . Except as provided in ttending physician or	F	758	8			

Facility ID: VA0064

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 03/28/202 MAPPROVE 0. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495121	B. WING		02	C 2/17/2022	
NAME OF P	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE		-	
CHERRYI	OALE HEALTH AND REH	ABILITATION CENTER		710 LEE HIGHWAY ARLINGTON, VA 22207			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 758	beyond 14 days, he of rationale in the reside indicate the duration §483.45(e)(5) PRN of drugs are limited to 1 renewed unless the a prescribing practition the appropriateness of This REQUIREMENT by: Based on family inte record review, facility course of a complain staff failed to ensure #1, was free from an medication, resulting originally ordered Xat tablet every 24 hours medication was chan Xanax 0.25 mg TID ( clinical rationale or ju #1 was administered course of several day was sent to the hospi Findings include: Resident #1 was adm 06/29/18, with the mo 12/24/21. The reside facility on 01/14/22 at Diagnoses for Reside limited to: Atrial fibrill anticoagulant therapy daily), history of a stru-	RN order to be extended or she should document their ent's medical record and for the PRN order. rders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. is not met as evidenced rview, staff interview, clinical document review, and in the t investigation, the facility one of 9 residents, Resident unnecessary anti-anxiety in harm. Resident #1 was nax 0.25 mg (milligrams) one PRN (as needed). The ged to a scheduled dose of three times daily) without a stification of need. Resident the medication over the vs, became lethargic and tal for evaluation.	F 758	<ul> <li>F758</li> <li>1. Resident #1 is no longer a the center.</li> <li>2. A review will be conducted residents on psychotropic medi ensure appropriateness of the rediagnosis for usage of the med</li> <li>3. Licensed nurses will be ed the SDC/designee on appropriating diagnosis for the usage of psyce medications. In addition, educe include documentation in the mister records for resident s behaviou</li> <li>4. Nursing Leadership/design review in clinical meeting 5x we new orders for psychotropic medications to ensure appropriations to ensure appropriations for the change.</li> <li>5. The results of the review we discussed at the quarterly QAP Once the QAPI committee deterproblem no longer exists, the results of the results of the review we change the conducted on a random bas The Administrator/Director of Niresponsible for implementation</li> </ul>	for cations to need and ications. ucated by ate hotropic ration will redical rs. nee will redical rs. nee will redications cate the ill be I meeting. rmines the eviews will is. ursing are		

Facility ID: VA0064

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/28/2022 M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495121	B. WING			C 02/17/2022		
	ROVIDER OR SUPPLIER	ABILITATION CENTER	•	37	TREET ADDRESS, CITY, STATE, ZIP CODE 710 LEE HIGHWAY RLINGTON, VA 22207	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 758	The most recent full N was an admission (5 dated 01/10/22. This with long and short te severe impairment in Resident #1 was also assistance from at lea mobility, transfers, dr extensive assistance Section E 0200. Beha coded as not having a screaming or disrupti day look back period. Resident #1 did not re medications in the pro- period. Resident's #1's currer set) for January 2022 following: "Alprazo Give one tablet by mo needed for Anxiety fo 01/04/22start date: "Alprazolam (Xanax tablet by mouth three 01/10/22start date: Resident #1's current plan) for January 202 "behavioral sympto and anxiety: MONITe (crying, screaming ar assistance)screams when out of bedadr ordered, monitor /doo effectivenessanticip	MDS (minimum data set) day/annual) assessment MDS assessed the resident arm memory impairment and daily decision making skills. assessed as requiring total ast one staff person for bed essing, toileting, and for eating and hygiene. In avior, Resident #1 was any behaviors to include ve sounds during the seven . This MDS assessed that eccive any anti-anxiety evious seven day look back ant POS (physician's order included orders for the lam (Xanax) tablet 0.25 mg outh every 24 hours as r 14 days (order date: 01/04/22)" a) tablet 0.25. mg Give 1 times(order date: 01/11/22)" a) CCP (comprehensive care 22 documented, ms related to depression OR FOR THE FOLLOWING: nd getting out of bed without is while in and also screams minister medications as cument side effects and	F	758	of correction. Date of compliance: 03/21/2022			

Facility ID: VA0064

If continuation sheet Page 52 of 68

	-	ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 03/28/2022 ORM APPROVED NO. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495121	B. WING				02/17/2022	
NAME OF P	ROVIDER OR SUPPLIER	1		STF	REET ADDRESS, CITY, STATE, ZIP COE			
CHERRYI	DALE HEALTH AND REH	ABILITATION CENTER			0 LEE HIGHWAY LINGTON, VA 22207			
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 758	and anxietymonitor consult as needed, p. gradual dose reduction medicationThe resi to gait/balance probled awarenesswheelch cushion for w/c (wheel in reachencourage caregivers about safe if a fall occursround monitoringanticipate needsenvironment anticoagulant therapy (created on 05/12/20) orderedmeds as or such as unusual bruis stoolpainswelling nosereport symptor signs/symptoms of bl anticoagulation thera bilateral forearms, rig on 01/09/22)" A "Geriatric Psychiatr documented, "hosp failed GDR (gradual of antidepressantalert language problems PRNDepression-sta med changesdeme donerecommend tr aboveprovided staf follow the recomment abovesignature of r The resident's MARs records) were review According to Resider	for side effects, psych sychiatrist to review for onuse alternatives to PRN dent is at risk for falls related ems/poor safety air for locomotion, pommel elchair) positioningcall light resident to useeducate ety reminders and what to do ling and close emeet the resident's free of hazardson y related to Atrial Fibrillation 20)Lab work as deredMonitor for bleeding sing, bloody or black tarry gbleeding from eyes, gums, ms to MDObserve for any eeding related to pySKIN: bruises to the head hematoma (revised ry" note dated 12/31/21 bitalized and returnedin part dose reduction) of dysfluentexpressive Xanax 0.25 (mg) able, failed part GDR no ntia follow up eatment as clearly described f educationthe facility will dations outlined mental health MD."	F	758				

Facility ID: VA0064

If continuation sheet Page 53 of 68

	-	ID HUMAN SERVICES MEDICAID SERVICES					NTED: 03/28/2022 FORM APPROVED B NO. 0938-0391	
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495121	B. WING			C 02/17/2022		
	ROVIDER OR SUPPLIER	ABILITATION CENTER		37	REET ADDRESS, CITY, STATE, ZIP CODE 10 LEE HIGHWAY RLINGTON, VA 22207			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	why the resident rece anti-anxiety medication The MAR also had a symptoms, "ANTIAN," MONITOR FOR DRC SPEECH, DIZZINES: AGGRESSIVE/IMPU Document if any of the shift" This section of mark and initials for C Resident #1 did not re- of PRN Xanax until the daily) dose was started The resident's Janua Resident #1 received times daily (schedule Resident #1 received three more doses on dose on 01/13/22. The 9:00 PM doses docum (hold/see progress not the MAR monitoring "ANTIANXIETY MED DROWSINESS, SLU DIZZINESS, NAUSE, AGGRESSIVE/IMPU Document if any of the shift" This section of mark and initials from (2:00 PM)." A progress note dated documented, "Pt. (particular)	a no documentation as to sived this dose of the on. section for monitoring XIETY MEDICATION DWSINESS, SLURRED S, NAUSEA, LSIVE BEHAVIOR. the above observed every was marked with a check D1/06/22." ecceived any additional doses the scheduled (three times ed on 01/11/22. ry 2022 MAR documented the Xanax 0.25 mg three d dose) starting on 01/11/22. three doses on 01/11/22, 01/12/22, and the 9:00 AM the 01/13/22 2:00 PM and mented the number 5 otes). section for symptoms, ICATION MONITOR FOR RRED SPEECH, A,	F	758				

Facility ID: VA0064

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	E CONSTRUCTION	(X3) DATE SURVEY					
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			PLETED
		495121	B. WING		C 02/17/2022		
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CHERRYD	OALE HEALTH AND REH	ABILITATION CENTER			3710 LEE HIGHWAY ARLINGTON, VA 22207		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	given as ordered, pt. o open her eye (sic) inte sleepNP notifiedF condition" A progress note dated documented, "Orders Alprazolam 0.25 mg O times a dayPt. is ve A progress note dated documented,"patier eyes intermittently. ca total assist" A progress note dated documented, "Orde Alprazolam 0.25 mg O times a daymedicat A progress note dated documented, "Orde Alprazolam 0.25 mg O times a daymedicat A progress note dated documented, "VS o timedaughter came (sic) with non emerge (evaluation) NP award called." A progress noted dated documented, "held On 02/16/22 at 1:55 F and asked why Resid medication Alprazolar been changed from o needed to one tablet The NP was made aw progress notes Resid and sustained a head	observed very weak on shift, ermittently and fall back to RP updated about pt d 01/13/22 at 4:57 PM Administration Note: Give 1 tablet by mouth three ry sleepy." d 01/13/22 at 7:36 PM at remain sleepy open her are provided by staff with d 01/13/22 at 8:23 PM rs Administration Note: Give 1 tablet by mouth three ion held, pt is sleepy." d 01/13/22 at 9:59 PM btained at this in to visit. Pt. to be send et (Name of transport) ed 01/14/22 at 9:51 AM for pt. been sleepy." PM, the NP was interviewed ent #1's anti-anxiety m (Xanax) 0.25 mg had ne tablet every 24 hours as three times daily scheduled.	F	758			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 03/28/2022 DRM APPROVED NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		ONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495121	B. WING				02/17/2022	
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP COD			
CHERRYI	DALE HEALTH AND REH	ABILITATION CENTER			0 LEE HIGHWAY LINGTON, VA 22207			
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 758	#1 having any behavi aggression. The NP and stated that she d agreed stating, "That regards to a medicati made aware that acc Resident #1 started to medication was held resident was "sleepy. was made aware that was held or that the r decline and/or chang sleepiness/weakness progress notes. The see Resident #1 at an further stated that did notification of any cor Resident #1 until arou and was told the resid stated that she had n week for any concerr 10 PM. The NP state staff Resident #1's vir resident wasn't in resident wasn't in resident do on evaluation. The would not go ahead a 911 given that the resi with a head injury and exhibiting weakness a again stated that staff Resident #1 was "jus On 02/16/22 at appro- corporate nurse was physician notification and change of condit	iors, anxiety, agitation or stated that she didn't know idn't change the order and doesn't make sense" in on increase. The NP was ording to progress notes o exhibit a decline and the per staff documenting the " The NP was asked if she t Resident #1's medication resident was showing a e in condition with a sa documented in the NP stated that she did not ny time after 01/09/22. She I not get any calls or neerns from staff regarding und 9 or 10 PM on 01/13/22 dent was sleepy. The NP ot been contacted by staff all ns until 01/13/22 around 9 or ed that according to nursing tal signs were stable and the piratory distress so she resident out non-emergently ne NP was asked why she and send the resident out via sident had a fall days prior d now the resident was and sleepiness. The NP of reported to her that t sleepy."	F	758				

Facility ID: VA0064

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 03/28/2022 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE COMP	SURVEY PLETED
		495121				C 02/17/2022		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, Z	IP CODE		
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER			ARLINGTON, VA 22207			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULD B		(X5) COMPLETION DATE
F 758	document the reason attending physician a medicationssuspect policy titled, "Docume documented, "nurse the physicianwhene related to the care of condition, change in t (sic)" The NP was interview 2:28 PM regarding Re change. The NP aga notified of any change 01/13/22 at around 9 asked if she changed Xanax order. The NP it." The NP stated tha and see who entered the ordering provider. with the NP present. by RN (registered nur PM under the physici provider), not the NP. "prescriber written." T meant and where it w that you have to have this type of medicatio pharmacy. The NP was a photocopy of the ac The NP was made aw documented and refe progress note dated 0 was on scheduled Xa	hs immediately after roughout shiftwhen eded" (PRN) medications, for givingNotify the nd/or prescriber ofHeld ted drug reactions" A entation and Notification" e is responsible for notifying ever there is a change a patientchange in he medication regiment ved again on 02/16/22 at esident #1's medication in stated that she was not es with Resident #1 until or 10 PM. The NP was or ordered the scheduled P stated, "No, I didn't change at you can look in the system the order and the name of The order was reviewed The order had been entered rse) #3 on 01/10/22 at 9:27 an's name (as the ordering It was documented, the NP was asked what that ras written. The NP stated e an actual prescription for n and it's faxed to the vas asked if the facility keeps ctual written prescription.	F	758				

Facility ID: VA0064

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	S FOR MEDICARE &					OMB NO. 0938-03 (X3) DATE SURVEY		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · · ·	E SURVEY IPLETED		
			A. BUILDING			С		
		495121	B. WING					
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		2/17/2022		
	NONDER OR OUT LIER			3710 LEE HIGHWAY	· <b>L</b>			
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER	ARLINGTON, VA 22207					
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CC	PRECTION	(YE)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE		
F 758	Continued From page	e 57	F 758	3				
		e NP stated that the notes						
		nformation was probably in						
		s time. The NP was asked						
		the irrelevant information						
	and keep Resident #	1's current medications and						
		NP stated that she didn't						
	•	remove the information. The						
		that she had dated and						
		rogress note as being						
		The NP again stated that it entation and should have						
		he note. The NP stated that						
		ed the resident on 01/09/22						
		I of the fall with injury on						
	01/09/22. The NP st	ated that she did not see						
		me after 01/09/22 and did						
		otifications of any concerns						
		Resident #1 until around 9 or						
		vas told the resident was						
		asked if the resident was						
		nowing any signs and for the Xanax to be						
	symptoms of a need	uled around the clock. The						
		sident #1) did not have						
		r anxiety at the time of this						
	-	is calm and shouldn't have						
		nax) three times daily." The						
		had spoken with Resident						
		ing the resident's condition.						
		he had not. The NP was						
		was exhibiting pain. The NP #1 did not appear to be in						
	pain, except when sh							
		atoma). The NP was asked						
	how Resident #1 cou							
		three times a day if the						
	resident didn't need i	t. The NP stated, "I don't						

Facility ID: VA0064

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	MENT OF HEALTH AN	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/28/2022 A APPROVED ). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION		(X3) DATE COMP	LETED
		495121	B. WING			_		_ 17/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER			710 LEE HIGHWAY RLINGTON, VA 22207			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	asked for assistance i the prescription for Re Xanax 0.25 mg three On 02/16/22 at 4:28 F was interviewed. The NP had spoken with h phone regarding Resi agitation and anxiety. stated neither the NP had not spoken to her changes or increased On 02/16/22 at 4:50 F interviewed regarding Resident #1 receiving three times daily with asked if he had writter for Resident #1. The have to have an actual medication and stated anything about it, and calls. The physician s would have faxed a so the last time I faxed a On 02/16/22 at 5:10 F called. The pharmacy and asked to find the tech #4 stated that the dispensed was on Jar mg TID and 90 (pills). stated that (Name of I and a valid prescriptio 01/10/22. The pharm	PM, the corporate nurse was n locating a photocopy of esident #1 regarding the times daily. PM, Resident #1's daughter daughter was asked if the er either in person or via dent #1 having increased Resident #1's daughter nor nursing staff person regarding any medication anxiety or agitation. PM, the physician was the concerns related to an anti-anxiety medication no clinical rationale and was n a prescription for Xanax physician stated that you al "script" to change that I that he did not know he never received any stated, "No, I didn't order. I cript and I can't remember script for this facility." PM, the pharmacy was v tech #4 was interviewed prescription. The pharmacy e medication was last nuary 10th for Xanax 0.25 The pharmacy tech #4 NP) is who wrote the order in was faxed on 6:26 PM on acy tech #4 stated that osis listed for what the	F	758				

If continuation sheet Page 59 of 68

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	: 03/28/2022 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION		(X3) DATE S COMPL	SURVEY ETED
		495121	B. WING			C 02/17/2022		
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODI	E		-
CHERRY	ALE HEALTH AND REH	ABILITATION CENTER		371	0 LEE HIGHWAY			
ONEIGHT				AR	LINGTON, VA 22207			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 758	corporate nurse prese prescription. The pre- name of Resident #1 (01/10/22) for Alprazo TID dispense 90. The and was signed by th On 02/16/22 at 5:45 F RN #3 stated, "It was order." RN #3 was m was entered into the the physician's name RN #3 stated, "I may physician) instead of asked if she knew wh #3 stated, "I may physician) instead of asked if she knew wh #3 stated, "I may physician) instead of had been crying" F Resident #1 was cryin Resident #1 was cryin Resident #1 may hav fall with injury days phy say if she was in pain The ED (emergency of dated 01/14/22 at 11: to the ER for evaluati status change since y Xalrelto. It is reported lethargic and sleeping yesterdayreport of a weekAltered menta non verbal, not follow stretcher with eyes cl to forehead and orbita (beats per minute)T nervous system) failu anterior tubercle fract arch fracture of C1 w	eximately 5:30 PM, the ented a photocopy of the escription documented the and the date written olam 0.25 mg by mouth 1 tab e prescription had one refill e NP. PM, RN#3 was interviewed. (Name of NP) that gave the hade aware that the order system by her and that it had as the ordering provider. have hit (Name of (Name of NP)." RN#3 was by the order was written. RN Resident #1) cries a lot and RN #3 was asked why ng and if she thought te been in pain related to the rior. RN #3 stated, "I can't h, but she was crying a lot." department) provider note 22 AM documented, "Sent on of lethargy and mental yesterdayPatient is on d that patient has been	F	758				

Facility ID: VA0064

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		ND HUMAN SERVICES MEDICAID SERVICES				ļ	NTED: 03/28/202 FORM APPROVE B NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	495121		B. WING			C 02/17/2022		
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	•=••=•==	
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER		37	10 LEE HIGHWAY			
GHERRE				A	RLINGTON, VA 22207			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	Continued From page	e 60	F	758				
	facetleft superior a	rticular facet fracture of C2						
	• • •	vertebral foramen, right						
		proximal femur1:20						
	PMawake, not follo eyes on own, pushes							
	moans, makes uninte							
	forehead/scalp hema							
		rearm ecchymosisHIP,						
	LEG, FOOT: left with painrightdeformit							
		ecchymosis right knee,						
		right upper thighright hip						
		sultedhold XalreltoC1-C3						
	fracturesright proxi	mal femur displaced						
	impacted fracture							
	A progress note date	d 01/14/22 and timed 12:19						
	PM documented, "							
	0	conditionfood and/or fluid						
		unable to eat/drink adequate nad the following medication						
		week: NONEResident is						
		ESObserved been sleepy						
		appetite send to ER for						
	further evalsend re	sident to hospital"						
	On 02/16/22 at appro	oximately 6:30 PM, the						
	administrator, DON (	director of nursing), and						
	corporate nurse were							
		Resident #1 receiving an						
		ety medication after a fall with thout clinical rationale or						
		edication. Resident #1 had						
	a decline over the co	urse of several days after						
	-	prescribed and administered						
		NP she was not made						
	staff and on 01/14/22	s documented by nursing ? the resident was						
		the hospital for evaluation						

Facility ID: VA0064

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	-	D HUMAN SERVICES				FORM	M APPROVED
STATEMENT C	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDII	NG _		COMPLETED	
		495121	B. WING				C 17/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER			710 LEE HIGHWAY RLINGTON, VA 22207		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 758 F 842 SS=D	and corporate nurse withe concerns regarding corporate nurse states this case, a lesson to the information receive no indication that the the bump or hematom something different." No further information exit conference on 02 Resident Records - Io CFR(s): 483.20(f)(5), §483.20(f)(5) Residen (i) A facility may not re- resident-identifiable to accordance with a cor- agrees not to use or co- except to the extent the to do so. §483.70(i) Medical refe §483.70(i)(1) In accor- professional standard must maintain medicat that are- (i) Complete; (ii) Readily accessible (iv) Systematically or g	AM, the administrator, DON, were again made aware of ng Resident #1. The d, "Last points, looking at be learned, but based on red, no documentation and patient has injury beyond ha and transferred for h was presented prior to the /17/22. lentifiable Information 483.70(i)(1)-(5) ht-identifiable information. lease information that is o the public. lease information that is o an agent only in ntract under which the agent disclose the information he facility itself is permitted cords. cdance with accepted is and practices, the facility al records on each resident		342	DEFICIENCY)		3/21/22
	9483.70(I)(2) The faci	lity must keep confidential					

Facility ID: VA0064

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/28/20 FORM APPROV OMB NO. 0938-03		
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED			
	495121		B. WING		C 02/17/2022		
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CC	DDE		
CHERRY	OALE HEALTH AND REH	ABILITATION CENTER		) LEE HIGHWAY LINGTON, VA 22207			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIC TE APPROPRIATE DATE		
F 842	all information contail regardless of the form records, except where (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pa operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purp purposes, research p medical examiners, fr a serious threat to he by and in compliance §483.70(i)(3) The fact record information ag unauthorized use. §483.70(i)(4) Medica for- (i) The period of time (ii) Five years from the there is no requirement (iii) For a minor, 3 year legal age under State §483.70(i)(5) The met (i) Sufficient informatii (ii) A record of the rest (iii) The comprehension provided;	ned in the resident's records, in or storage method of the in release is- por their resident is permitted by applicable law; yment, or health care ted by and in compliance cativities, reporting of abuse, violence, health oversight l administrative proceedings, poses, organ donation purposes, or to coroners, uneral directors, and to avert ealth or safety as permitted is with 45 CFR 164.512. Fility must safeguard medical gainst loss, destruction, or I records must be retained required by State law; or use date of discharge when ent in State law; or ars after a resident reaches is law. edical record must contain- tion to identify the resident; sident's assessments; ive plan of care and services y preadmission screening evaluations and	F 842				

If continuation sheet Page 63 of 68

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
	495121		B. WING			С	
	ROVIDER OR SUPPLIER	435121			TREET ADDRESS, CITY, STATE, ZIP CODE	0	2/17/2022
	NO NDER OR OUT LIER				710 LEE HIGHWAY		
CHERRYD	OALE HEALTH AND REH	ABILITATION CENTER			ARLINGTON, VA 22207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIOI DATE
F 842	Continued From page	- 63	Í -	842			
1 042			F	84Z			
		's, and other licensed					
	professional's progre	-					
		logy and other diagnostic					
		equired under §483.50.					
		is not met as evidenced					
	by: Based on family inte	rview, staff interview, clinical			F842		
	-	the course of a complaint			1. Resident #1 is no longer a resider	nt in	
		lity staff failed ensure a			the center.		
		te clinical record for one of 9			2. A review of NP progress notes for	the	
	residents, Resident #				last 30 days will be reviewed to ensure		
					information documented is current and		
	Findings include:				accurate.		
					3. Medical Director/designee will		
	Resident #1 was adm	nitted to the facility on			educate the Nurse Practitioner(s) on		
	06/29/18, with the mo	ost current readmission on			writing and updating an electronic med	lical	
	12/24/21. The reside	ent was discharged from the			progress note and how to avoid		
	facility on 01/14/22 a	nd did not return.			automated noncurrent information in a	n	
		ent #1 included, but were not			electronic medical progress note.		
	limited to: Atrial fibril				4. The Medical Director/ designee w		
		/ (Xalrelto 15 mg/milligrams			review 5 progress notes written by the		
	daily), history of a str				weekly to ensure the documentation is	up	
		gia, dysphagia, constipation,			to date and accurate.		
	dementia, anxiety an	u uepression			5. The results of the review will be	na	
	The most recent full	MDS (minimum data set)			discussed at the quarterly QAPI meetin Once the QAPI committee determines	-	
		day/annual) assessment			problem no longer exists, the reviews		
		MDS assessed the resident			be conducted on a random basis.	vv III	
		erm memory impairment and					
		daily decision making skills.			The Administrator/Director of Nursing a	are	
		assessed as requiring total			responsible for implementation of the		
		ast one staff person for bed			of correction.		
	mobility, transfers, dr	-					
		for eating and hygiene. In			Date of compliance: 03/21/2022		
		avior, Resident #1 was					
		any behaviors to include					
		ve sounds during the seven					
		This MDS assessed that					
	Resident #1 did not r	eceive any anti-anxiety					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					NTED: 03/28/2022 FORM APPROVED B NO. 0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED C		
		495121	B. WING			02/17/2022			
NAME OF PI	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE				
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER			3710 LEE HIGHWAY				
ONEIGHT					ARLINGTON, VA 22207				
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
F 842	Continued From page	64		0.47					
1 042		evious seven day look back		842	2				
	set) for January 2022 following: "Alprazo Give one tablet by mo needed for Anxiety fo 01/04/22start date: "Alprazolam (Xanax	x) tablet 0.25. mg Give 1							
		01/11/22)" CCP (comprehensive care							
	and anxiety: MONIT (crying, screaming ar	2 documented, ms related to depression OR FOR THE FOLLOWING: nd getting out of bed without s while in and also screams							
	ordered, monitor /doo effectivenessanticip	ninister medications as cument side effects and pate needsuses ions related to depression							
	consult as needed, pagradual dose reduction	for side effects, psych sychiatrist to review for onuse alternatives to PRN							
	to gait/balance proble awarenesswheelch	dent is at risk for falls related ems/poor safety air for locomotion, pommel elchair) positioningcall light							
	in reachencourage	resident to useeducate ty reminders and what to do							
	monitoringanticipate needsenvironment anticoagulant therapy	emeet the resident's free of hazardson / related to Atrial Fibrillation							
	(created on 05/12/20) orderedmeds as or	20)Lab work as deredMonitor for bleeding							

Facility ID: VA0064

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 03/28/2022 RM APPROVED O. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED		
		495121	B. WING		02	C 2/17/2022		
NAME OF P	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP COD				
CHERRYI	DALE HEALTH AND REH	ABILITATION CENTER		3710 LEE HIGHWAY ARLINGTON, VA 22207				
(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 842	such as unusual bruis stoolpainswelling nosereport symptor signs/symptoms of bl anticoagulation thera bilateral forearms, rig on 01/09/22)" A "Geriatric Psychiatr documented, "hosp failed GDR (gradual of antidepressantalert language problems PRNDepression-sta med changesdeme donerecommend tra aboveprovided staf follow the recommend abovesignature of r On 02/16/22 at 1:55 F and asked why Resid medication Alprazolar been changed from o needed to one tablet The NP was made aw progress notes Resid and sustained a head there was no docume #1 having any behavi aggression. The NP and stated that she d agreed stating, "That regards to a medicati	sing, bloody or black tarry gbleeding from eyes, gums, ms to MDObserve for any eeding related to pySKIN: bruises to ht head hematoma (revised y" note dated 12/31/21 italized and returnedin part dose reduction) of dysfluentexpressive Xanax 0.25 (mg) able, failed part GDR no ntia follow up eatment as clearly described f educationthe facility will dations outlined mental health MD." PM, the NP was interviewed lent #1's anti-anxiety m (Xanax) 0.25 mg had one tablet every 24 hours as three times daily scheduled. ware that according to lednt #1 recently had a fall d injury with bruising, and entation regarding Resident iors, anxiety, agitation or stated that she didn't know idn't change the order and doesn't make sense" in on increase. PM, the NP was interviewed esident's medication a made aware that she had	F 842					

Facility ID: VA0064

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	3	CO	
						С
		495121	B. WING		0	2/17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
			3710 LEE HIGHWAY			
CHERRYL	OALE HEALTH AND REH	ABILITATION CENTER		ARLINGTON, VA 22207		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIC		COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY		DATE
					/	
F 040		22				
F 842			F 84	.2		
		01/09/22 that Resident #1				
		nax three times a day and				
		1, increased agitation/anxiety				
		e NP stated that the notes				
		nformation was probably in				
		time. The NP was asked				
	•	the irrelevant information				
		1's current medications and				
		IP stated that she didn't				
	know why she didn't i	remove the information. The				
		that she had dated and				
		rogress note as being				
		The NP again stated that it				
		entation and should have				
		he note. The NP stated that				
		ed the resident on 01/09/22				
		l of the fall with injury on				
		ated that she did not see				
		me after 01/09/22 and did				
		otifications of any concerns				
		Resident #1 until around 9 or				
		vas told the resident was				
		asked if the resident was				
	crying or in pain or sh					
	symptoms of a need					
		uled around the clock. The				
		sident #1) did not have				
		r anxiety at the time of this				
		s calm and shouldn't have				
		nax) three times daily." The				
		had spoken with Resident				
		ing the resident's condition.				
		ne had not. The NP was				
		was exhibiting pain. The NP				
		#1 did not appear to be in				
	pain, except when sh					
		atoma). The NP was asked				
	how Resident #1 cou	ld be prescribed and				
		hree times a day if the				

Facility ID: VA0064

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/28/2022 MAPPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES (X1) F		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED			
		495121	B. WING		_		C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
CHERRYD	ALE HEALTH AND REH	ABILITATION CENTER		3710 LEE HIGHWAY ARLINGTON, VA 22207			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	know, I'm very confus that the documentatio 01/09/22 was inaccur regarding Resident #* On 02/16/22 at 4:28 F was interviewed. The NP had spoken with P phone regarding Resi agitation and anxiety. stated neither the NP had not spoken to her changes or increased On 02/16/22 at appro- administrator, DON (or corporate nurse were concerns regarding th Resident #1 on 01/09 information she docur on 01/09/22, was inac Resident #1. The adm corporate nurse were the resident's status in assessed the resident then stated the inform incorrect? The admin On 02/17/22 at 9:00 A and corporate nurse were the concerns regarding inaccurate information	<ul> <li>The NP stated, "I don't ed." The NP again stated in that she signed on ate documentation I.</li> <li>PM, Resident #1's daughter e daughter was asked if the per either in person or via dent #1 having increased Resident #1's daughter nor nursing staff person is regarding any medication anxiety or agitation.</li> <li>ximately 6:30 PM, the lirector of nursing), and made aware of the e NP's documentation for /22. The NP stated the mented, dated and signed courate information for ninistrator, DON, and asked how you would know if the NP stated that she t and documented, but then the tot of stated, "You don't."</li> <li>MM, the administrator, DON, were again made aware of g the NP documenting in for Resident #1. No d/or documentation was</li> </ul>	F 842				

Facility ID: VA0064

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