STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness Survey was conducted 3/15/22 through 3/17/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/15/22 through 3/17/22. One complaint (VA00053940-substantiated) was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 132 certified bed facility was 106 at the time of the survey. The survey sample consisted of 42 current resident reviews and 5 closed record reviews.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		4/20/22

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

Electronically Signed | 04/05/2022

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F 609	Continued From page 1 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to report injuries of unknown origin to the state agency for one of 47 residents in the survey sample, Resident #107. On 3/9/22, the facility staff observed injuries of unknown origin (bruises) on Resident #107's face and left hand. The facility staff failed to report the injuries of unknown origin to the state agency. The findings include: Resident #107 was admitted to the facility on 4/27/21. Resident #107's diagnoses included but were not limited to dementia and paralysis. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/22/22, the resident scored 1 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely cognitively impaired for making daily decisions.	F 609	1. Resident #107 injuries of unknown origin was investigated and reported to the state agency on 03/18/2022. The facility□s Prohibition of Abuse policy was updated on 03/18/2022 to include information regarding injuries of unknown origin. 2. All residents in the facility have the potential to be affected by this deficient practice. The facility completed a skin audit for all residents in the facility on 03/22/2022 to identify if any resident had any injuries of unknown origin requiring investigation and reporting to the state agency. 3. The Regional Director of operations on 03/30/22 educated the Administrative Staff Member (ASM) #1 & #2 on the importance of investigating and reporting injuries of unknown origin to the state agency within the required timeframe. The ASM #1 would thereafter, educate all Department Heads and Unit Managers who are responsible for	

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F 609	Continued From page 2 Review of Resident #107's clinical record revealed a nurse's note dated 3/9/22 that documented, "At exactly 0630 (6:30 a.m.), CNA (certified nursing assistant) informed this writer that she has observed some bruises to the left side of resident's face and left hand. This writer quickly went over to resident's room for further assessment. Head to toe assessment was done, findings from this writer's skin assessment confirmed the CNA's earlier report. When asked what happened, resident kept saying 'I am fine, leave me alone.' Alert and oriented, tolerated all scheduled medications and treatments well. Remains in stable condition, range of motion in all lower extremities. Vital signs obtained as follows- BP (blood pressure)-129/73/ Pulse-75, Temp (temperature)-97.4, Resp (respirations)-18, 02sat (oxygen level)-98% at Room Air. MD (medical doctor) notified, no new order given. Lung sound clear to auscultation bilaterally, no wheezing or rhonchi observed. Respiration even and unlabored. Abdomen soft, non tender, and non-distended. Bowel sounds present at all four quadrants. Head of bed elevated, call light bell and frequently used items placed within reach. In no acute distress, nursing staff will continue to monitor." Further review of Resident #107's clinical record failed to reveal documentation of the cause of the bruises and failed to reveal documentation that these injuries of unknown origin were reported to the state agency. On 3/16/22 at 2:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4 (the nurse who documented the above note). LPN #4 stated he was about to leave when Resident #107's bruises were observed. LPN #4 stated he believed the previous shift could have seen Resident #107's bruises and could have	F 609	reporting/investigating cases of potential abuse on the importance of investigating/reporting any form of abuse in a timely manner. 4. The facility□s Administrator/Designee will include investigating/reporting abuse to the morning meeting sheet and follow up daily with the team to ensure all incidents of injuries of unknown origin/abuse are investigated and reported. The Administrator will also update the weekend Manager on Duty (MOD) form to ensure all incidents of abuse/injuries of unknown origins are investigated/reported to the state agency in a timely manner on the weekends. Findings of the daily morning meeting sheets and weekend MOD forms will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance. 5. April 20, 2022	

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F 609	Continued From page 3	F 609		

done something about them. LPN #4 stated he reported the bruises to the oncoming nurse and the unit manager. LPN #4 stated he also asked the night shift staff and oncoming staff about the bruises and other staff stated they did not know about them.

On 3/16/22 at 3:25 p.m., ASM (administrative staff member) #1 (the administrator) stated she did not have an investigation regarding Resident #107's bruises but the unit manager said he was working on one. ASM #1 stated the injuries of unknown origin were not reported to the state agency.

On 3/16/22 at 2:55 p.m., ASM #2 (the director of nursing) presented a typed document that documented, "[Resident #107] - STAFF STATEMENT ON 3/9/22 BY THE CHARGE NURSE- "This writer quickly went over to resident's room for further assessment. Head to toe assessment was done, findings from this writer's skin assessment confirmed the CNA's earlier report. When asked what happened, resident kept saying 'I am fine, leave me alone.' Alert and oriented, tolerated all scheduled medications and treatments well. Remains in stable condition. Vital signs obtained as follows- BP (blood pressure)-129/73/ Pulse-75, Temp (temperature)-97.4, Resp (respirations)-18, 02sat (oxygen level)-98% at Room Air. MD (medical doctor) notified, no new order given. Lung sound clear to auscultation bilaterally, no wheezing or rhonchi observed. Respiration even and unlabored. Abdomen soft, non tender, and non-distended. Bowel sounds present at all four quadrants. Head of bed elevated, call light bell and frequently used items placed within reach." The documented was signed by RN (registered

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F 609	Continued From page 4	F 609		

nurse) #1 (unit manager).

On 3/16/22 at 3:37 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated he was made aware of Resident #107's bruises during the early morning on 3/9/22. RN #1 stated he reported the bruises to the administrator and the director of nursing that same morning during the morning meeting.

On 3/16/22 at 4:39 p.m., an interview was conducted with ASM #1 and ASM #2. ASM #1 stated an injury of unknown origin is an injury that staff cannot identify the root cause of and includes bruises. ASM #1 stated staff is supposed to immediately report injuries of unknown origin to the department head who is supposed to immediately report to her. ASM #1 stated she is supposed to report injuries of unknown origin to the state agency within two hours then complete an investigation. ASM #1 stated she was not aware of Resident #107's injuries of unknown origin that were identified on 3/9/22.

On 3/16/22 at approximately 5:50 p.m., ASM #1and ASM #2 were made aware of the above concern.

The facility policy titled, "Prohibition of Abuse" failed to document information regarding injuries of unknown origin. The facility grievance policy documented, "6. The following grievances are reported to Department of Health (DOH): Abuse and neglect, Misappropriation of items, Injury of Unknown Origin."

No further information was presented prior to exit.

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F 610	Continued From page 5	F 610		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to investigate injuries of unknown origin for one of 47 residents in the survey sample, Resident #107. On 3/9/22, the facility staff observed injuries of unknown origin (bruises) on Resident #107's face and left hand. The facility staff failed to investigate these injuries of unknown origin. The findings include: Resident #107 was admitted to the facility on 4/27/21. Resident #107's diagnoses included but	F 610	1. Resident #107 injuries of unknown origin was investigated and reported to the state agency on 03/18/2022. The facility□s Prohibition of Abuse policy was updated on 03/18/2022 to include information regarding injuries of unknown origin. 2. All residents in the facility have the potential to be affected by this deficient practice. The facility completed a skin audit for all residents in the facility on 03/22/2022 to identify if any resident had any injuries of unknown origin requiring investigation and reporting to the state agency. 3. The Regional Director of operations	4/20/22

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F 610	Continued From page 6 were not limited to dementia and paralysis. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/22/22, the resident scored 1 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely cognitively impaired for making daily decisions. Review of Resident #107's clinical record revealed a nurse's note dated 3/9/22 that documented, "At exactly 0630 (6:30 a.m.), CNA (certified nursing assistant) informed this writer that she has observed some bruises to the left side of resident's face and left hand. This writer quickly went over to resident's room for further assessment. Head to toe assessment was done, findings from this writer's skin assessment confirmed the CNA's earlier report. When asked what happened, resident kept saying 'I am fine, leave me alone.' Alert and oriented, tolerated all scheduled medications and treatments well. Remains in stable condition, range of motion in all lower extremities. Vital signs obtained as follows- BP (blood pressure)-129/73/ Pulse-75, Temp (temperature)-97.4, Resp (respirations)-18, 02sat (oxygen level)-98% at Room Air. MD (medical doctor) notified, no new order given. Lung sound clear to auscultation bilaterally, no wheezing or rhonchi observed. Respiration even and unlabored. Abdomen soft, non tender, and non-distended. Bowel sounds present at all four quadrants. Head of bed elevated, call light bell and frequently used items placed within reach. In no acute distress, nursing staff will continue to monitor." Further review of Resident #107's clinical record failed to reveal documentation of the cause of the bruises and failed to reveal documentation that these injuries of unknown origin were reported to the state agency.	F 610	on 03/30/22 educated the Administrative Staff Member (ASM) #1 & #2 on the importance of investigating and reporting injuries of unknown origin to the state agency within the required timeframe. The ASM #1 would thereafter, educate all Department Heads and Unit Managers who are responsible for reporting/investigating cases of potential abuse on the importance of investigating/reporting any form of abuse in a timely manner. 4. The facility□s Administrator/Designee will include investigating/reporting abuse to the morning meeting sheet and follow up daily with the team to ensure all incidents of injuries of unknown origin/abuse are investigated and reported. The Administrator will also update the weekend Manager on Duty (MOD) form to ensure all incidents of abuse/injuries of unknown origins are investigated/reported to the state agency in a timely manner on the weekends. Findings of the daily morning meeting sheets and weekend MOD forms will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance. 5. April 20, 2022	

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F 610	Continued From page 7	F 610		

On 3/16/22 at 2:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4 (the nurse who documented the above note). LPN #4 stated he was about to leave when Resident #107's bruises were observed. LPN #4 stated he believed the previous shift could have seen Resident #107's bruises and could have done something about them. LPN #4 stated he reported the bruises to the oncoming nurse and the unit manager. LPN #4 stated he also asked the night shift staff and oncoming staff about the bruises and other staff stated they did not know about them.

On 3/16/22 at 3:25 p.m., ASM (administrative staff member) #1 (the administrator) stated she did not have an investigation regarding Resident #107's bruises but the unit manager said he was working on one.

On 3/16/22 at 2:55 p.m., ASM #2 (the director of nursing) presented a typed document that documented, "[Resident #107] - STAFF STATEMENT ON 3/9/22 BY THE CHARGE NURSE- "This writer quickly went over to resident's room for further assessment. Head to toe assessment was done, findings from this writer's skin assessment confirmed the CNA's earlier report. When asked what happened, resident kept saying 'I am fine, leave me alone.' Alert and oriented, tolerated all scheduled medications and treatments well. Remains in stable condition. Vital signs obtained as follows- BP (blood pressure)-129/73/ Pulse-75, Temp (temperature)-97.4, Resp (respirations)-18, 02sat (oxygen level)-98% at Room Air. MD (medical doctor) notified, no new order given. Lung sound clear to auscultation bilaterally, no wheezing or

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F 610	Continued From page 8	F 610		

rhonchi observed. Respiration even and unlabored. Abdomen soft, non tender, and non-distended. Bowel sounds present at all four quadrants. Head of bed elevated, call light bell and frequently used items placed within reach." The documented was signed by RN (registered nurse) #1 (unit manager).

On 3/16/22 at 3:37 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated he was made aware of Resident #107's bruises during the early morning on 3/9/22. RN #1 stated he reported this to the administrator and the director of nursing that same morning during the morning meeting. RN #1 stated an injury of unknown origin investigation should consist of talking to staff who cared for the resident during multiple previous shifts, if possible interviewing the resident, completing an incident report and reporting the injury to the director of nursing and administrator so they can complete their own investigation. RN #1 stated he did not personally complete an investigation regarding Resident #107's bruises and did not know the cause. RN #1 stated the above document, signed by him was completed on this day.

On 3/16/22 at 4:39 p.m., an interview was conducted with ASM #1 and ASM #2. ASM #1 stated an injury of unknown origin is an injury that staff cannot identify the root cause of and includes bruises. ASM #1 stated an injury of unknown origin investigation should consist of a body audit, witness statements from other residents and interviews with staff. ASM #1 stated she was not aware of Resident #107's injuries of unknown origin that were identified on 3/9/22.

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F 610	Continued From page 9 On 3/16/22 at approximately 5:50 p.m., ASM #1and ASM #2 were made aware of the above concern. The facility policy titled, "Prohibition of Abuse" failed to document information regarding injuries of unknown origin. The facility grievance policy documented, "6. The following grievances are reported to Department of Health (DOH): Abuse and neglect, Misappropriation of items, Injury of Unknown Origin. 7. The facility must ensure that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions..." No further information was presented prior to exit.	F 610		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered;	F 622		4/20/22

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F 622	Continued From page 10	F 622		

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 622	Continued From page 11 section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that all required information was provided to the hospital staff when five out of 47 residents in the survey sample were transferred to the hospital; Residents #101, #85, #71, #2 and #74. The findings include:	F 622	1. No residents were adversely affected by this deficient practice. This deficiency cannot be retroactively corrected as residents #101, #85, #71, #2 & #74 are no longer in the hospital. 2. All residents who are transferred and discharged from the facility have the potential to be affected by this deficient practice. This deficient practice cannot be retroactively corrected, however a new	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 622	Continued From page 12	F 622		

Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to evidence that all required information was provided to the hospital staff when five of 47 residents in the survey sample were transferred to the hospital, Residents #101, #85, #71, #2 and #74.

The findings include:

1. The facility staff failed to provide evidence that care plan goals were provided to the hospital staff when Resident #101 was transferred to the hospital on 2/19/22.

Resident #101 was admitted to the facility on 2/17/22. Resident #101's diagnoses included but were not limited to: cerebral vascular accident, bladder neck obstruction and urinary tract infection. Resident #101's most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/2/22, coded the resident as scoring 7 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired.

Review of Resident #101's nursing progress note dated 2/19/22 at 3:02 PM revealed the following, "[Resident #101] Out of bed in wheelchair, noted progressing weakness, unable to sit up straight. Slow respond to verbal and tactile stimuli. Transferred back in bed due to weakness. At lunch writer attempted to feed the resident, unable to open mouth, change in mental status, unable to respond to verbal stimuli ...Notified nurse practitioner- send the resident to Emergency room (ER) for further evaluation due to change in mental status and unable to respond

tool (Transfer/Discharge Checklist Verification Tool) which requires the signature of two licensed nurses to ensure verification that all required information is provided to the hospital staff including residents care plan goals have been developed. The new Transfer/Discharge Checklist Verification Tool form will ensure all required information including care plan goals is provided to the hospital and the checklist form will be uploaded to the resident clinical record as evidence that the facility provided the hospital with all required information including care plan goals.
3. The Director of Staff Development/Designee will educate all licensed and registered nurses responsible for resident's transfer and discharge on the importance of ensuring all required information including care plan goals is provided to the hospital during resident's discharge and transfers. The Director of Staff Development/Designee will also educate all licensed nurses and registered nurses responsible for resident's discharge and transfers on the facility's Transfer/Discharge Checklist Verification Tool as well as the Transfer/Discharge Envelope. The education will include importance of having two nurses verifying that all required information were sent to the hospital and uploading the Checklist Form into the resident's clinical record.
4. The Director of Nursing/designee will audit weekly all resident's transfers and discharge to the hospital to ensure all required information including care plan

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F 622	Continued From page 13 to verbal stimuli. RP (responsible party) notified and given the change of status update. Resident was sent to the ER via 911 at 2:15 pm and given report to hospital." On 3/15/22 at approximately 5:00 PM a request was made for the evidence of information provided to the receiving facility when Resident #101 was transferred to the hospital. On 3/16/22 at 12:16 PM, an interview was conducted with ASM (administrative staff member) #1, the administrator and ASM #2 the director of nursing. ASM #1 provided a blank envelope "compliance checklist: transfer/discharge requirements," which lists required documents. ASM #1 then stated, "We recognized that the nurses are not making copies of the envelope of what is sent to the hospital for the residents going to the hospital. We have started whole house staff education for our nurses and going forward we will be making copies of this checklist and placing in the resident's record." ASM #2 then stated, "We need to make sure the nurses are complying. From this point forward we will be checking on this." On 3/16/22 at 5:25 PM, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the administrator at sister facility and RN #3, staff development coordinator were informed of the above concern. According to the facility's "Transfer or Discharge Requirements" policy: "Facility staff will ensure the following is provided when a resident is transferring or discharging from the facility. This	F 622	goals were provided to the hospital. The weekly audit will include verification that the Transfer/Discharge Checklist form is signed by two nurses and uploaded to the resident's clinical record. Findings of the weekly audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement (QAPI) Committee to ensure compliance. 5. April 20, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 622	Continued From page 14	F 622		

is important for ensuring a safe and appropriate discharge which promotes continuity of care. List includes: face sheet, physician orders, diagnosis/allergies, advance directives, care plan goals, recent labs, isolation information, recent medications, recent nurse's notes, resident status, special instructions and copy of bed hold notice."

No further information was provided prior to exit.

2. The facility staff failed to provide evidence that care plan goals were provided to the hospital staff when Resident #85 was transferred to the hospital on 2/3/22.

Resident #85 was admitted to the facility with diagnoses including congestive heart failure, diabetes mellitus and bradycardia. Resident #85's most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 1/19/22, coded the resident as scoring 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired.

Review of Resident #85's nursing progress note dated 2/3/22 at 11:23 AM, revealed the following, "About 11 AM resident stated that 'I am not doing good. I feel like passing out,' Checked resident's vital signs ...Physician notified and new order given to send the resident to nearest ER (emergency room) for further evaluation and treatment. Resident left with ambulance."

On 3/15/22 at approximately 5:00 PM a request was made for evidence of information provided to the receiving facility when Resident #85 was transferred to the hospital on 2/3/22.

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	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 622	Continued From page 15	F 622		

On 3/16/22 at 12:16 PM, an interview was conducted with ASM (administrative staff member) #1, the administrator and ASM #2 the director of nursing. ASM #1 provided a blank envelope "compliance checklist: transfer/discharge requirements" which lists required documents. ASM #1 then stated, "We recognized that the nurses are not making copies of the envelope of what is sent to the hospital for the residents going to the hospital. We have started whole house staff education for our nurses and going forward we will be making copies of this checklist and placing in the resident's record." ASM #2 then stated, "We need to make sure the nurses are complying. From this point forward we will be checking on this."

On 3/16/22 at 5:25 PM, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the administrator at sister facility and RN #3, staff development coordinator were informed of the above concern.

No further information was provided prior to exit.

3. The facility staff failed to evidence care plan goals were provided for Resident #71 to the receiving provider for a facility-initiated transfer on 1/29/2022.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 2/9/2022, the resident was assessed as being severely impaired for making daily decisions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 622	Continued From page 16	F 622		

The progress notes for Resident #71 documented in part, "1/29/2022 15:16 (3:16 p.m.) Resident observed in bed at beginning of shift with eyes closed and breathing through the mouth. O2 (oxygen) at 2L (two liters)/min (per minute) via nc (nasal cannula). BS (blood sugar) checked. Unable to get reading because BS was high ...Resident continued with lip breathing with a lot of mucus from mouth. MD (medical doctor) notified. Order: Transfer resident to [Name of hospital] ER (emergency room) for further eval (evaluation) and treat. R/P (responsible party) notified. Resident pick up at 9:15 am via 911."

The clinical record failed to evidence documentation of information provided to the hospital on 1/29/2022.

On 3/16/2022 at 12:08 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that they sent an envelope containing documents with residents to the hospital when the resident is transferred out. LPN #5 stated that the envelope had a checklist on it that they followed. LPN #5 stated that they sent a face sheet, the history and physical, the progress notes, the care plan, the change in condition form, and labs in the envelope and called a report to the hospital. LPN #5 stated that they should document what was sent in the progress notes because they do not copy the envelope that was sent. LPN #5 stated that some of the nurses were good about making the notes and some were not.

On 3/16/2022 at 12:16 p.m., ASM (administrative staff member) #1, the administrator stated that they did not have evidence of transfer documents sent to the hospital and that the nurses were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 622	Continued From page 17	F 622		

making copies of the envelope sent with the resident to the hospital containing the documents. ASM #1 stated that that going forward they planned to make copies of the envelopes.

On 3/16/2022 at 5:20 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, administrator of a sister facility and RN (registered nurse) #3, staff development were notified of the findings.

No further information was provided prior to exit.

4. The facility staff failed to evidence care plan goals were provided for Resident #2 to the receiving provider for a facility-initiated transfer on 3/9/2022.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/23/2022, the resident scored a 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact.

The progress notes for Resident #2 documented in part, "3/9/2022 17:50 (5:50 p.m.) Resident was in bed on 2 iitters [sic] of oxygen via nasal canula [sic] at 8:40 am ...Circa 9 am CNA (certified nursing assistant) caring for resident informed me that she was unable to eat her breakfast. Upon approaching her bedside, color appeared slightly cyanotic, skin cool to touch, resident was breathing without any difficulty, with oxygen @ 2L (liters) nasal cannula in use ... was with definite change in mental status. Unable to respond verbally, no congestion observed. [Name of physician] was in house at the time and informed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 622	Continued From page 18	F 622		

him of residents change in status. He ordered resident sent out 911. EMS (emergency medical services) was called..." The progress notes further documented, "3/9/2022 22:34 (10:34 p.m.) Resident returned from the hospital at 8:45 pm."

The clinical record failed to evidence documentation of information provided to the hospital on 3/9/2022.

On 3/16/2022 at 12:08 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that they sent an envelope containing documents with residents to the hospital when transferred out. LPN #5 stated that the envelope had a checklist on it that they followed. LPN #5 stated that they sent a face sheet, the history and physical, the progress notes, the care plan, the change in condition form, and labs in the envelope and called a report to the hospital. LPN #5 stated that they should document what was sent in the progress notes because they do not copy the envelope that was sent. LPN #5 stated that some of the nurses were good about making the notes and some were not.

On 3/16/2022 at 12:16 p.m., ASM (administrative staff member) #1, the administrator stated that they did not have evidence of transfer documents sent to the hospital and that the nurses were not making copies of the envelope sent with the resident to the hospital containing the documents. ASM #1 stated that that going forward they planned to make copies of the envelopes.

On 3/16/2022 at 5:20 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 622	Continued From page 19	F 622		

#4, administrator of a sister facility and RN (registered nurse) #3, staff development were notified of the findings.

No further information was provided prior to exit.

5. The facility staff failed to evidence care plan goals were provided to the receiving facility for a facility initiated transfer for Resident #74 on 1/31/2022.

Resident #74 was admitted to the facility on 1/26/2022. On the most recent MDS (minimum data set) assessment, a significant change Medicare five day assessment, with an ARD (assessment reference date) of 2/11/2022, the resident scored a one on the BIMS (brief interview for mental status) score, indicating the resident is severely cognitively impaired for making daily decisions.

The nurse's note dated 1/31/2022 at 2:42 p.m. documented, "Patient alert and restlessness with tachypnea and tachycardia ...Patient stated, 'I am not feeding (sic) good,' moving all-around in bed, very irritable. MD (medical doctor) notified, new order given to give nebulizer treatment was given one time. Patient still noticed restlessness and fast breathing. Called 911 and sent to ER (emergency room) for further evaluation and treatment. MD made aware and responsible party, son [name of son] notified. Report is given to [Name of hospital] ER nurse. All paper work with med (medications) were given to 911 staff."

Review of the clinical record on 3/15/2022 failed evidence documentation that the care plan goals were sent with the Resident # 74 upon transfer to the hospital on 1/31/2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 622	Continued From page 20 An interview was conducted with LPN (licensed practical nurse) #5 on 3/16/2022 at 12:08 p.m. When asked the process for sending a resident to the hospital, LPN #6 stated, "When we transfer a resident to the hospital we send an envelope with them, the envelope has a checklist on it. We send a face sheet, the history and physical, the progress notes, the care plan, the change in condition form, and labs and we call a report to the hospital. We also send a bed hold notice with them. When asked where this should be documented, LPN #5 stated, "We should document this in the progress note, we do not make a copy of anything. Some of the nurses are good about making the notes and some are not." On 3/16/2022 at 12:16 p.m. ASM (administrative staff member) #1, the administrator, stated, "We recognized that the nurses are not making copies of the envelope of what is sent to the hospital for the residents going to the hospital. We have started a whole hospital education for our nurses and going forward will be making copies of this." ASM #2, the director of nursing, stated, "We need to make sure the nurses are complying from this point forward. We will be checking on this." ASM #1, ASM #2, ASM #3, the assistant director of nursing, ASM #4, administrator from a sister facility, and RN (registered nurse) #3, the staff development nurse, were made aware of the above concern on 3/16/2022 at 5:30 p.m. No further information was provided prior to exit.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		4/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 623	Continued From page 21	F 623		

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 22	F 623		

days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 23 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to evidence written documentation to the Resident or RP (responsible party) and ombudsman upon transfer for five of 47 residents in the survey sample were transferred to the hospital; Residents #101, #85, #71, #2 and #74. The findings include: 1. The facility staff failed to evidence written documentation to the Resident or RP and Ombudsman when Resident #101 was transferred to the hospital on 2/19/22. Resident #101 was admitted to the facility on 2/17/22. Resident #101's diagnoses included but were not limited to: cerebral vascular accident, bladder neck obstruction and urinary tract infection. Resident #101's most recent MDS (minimum data set) assessment, a significant	F 623	1. No residents were adversely affected by this deficient practice. On 3/16/2022, the facility□s Social Services Director sent out to the ombudsman notifications for residents #101, #85, #71, #2, and #74 on 3/16/2022. The Facility□s Social Worker or Designee will also be sending a written notification about the hospital transfers to the representatives of residents #101, #35, #71, #2 and #74. 2. All residents who are transferred to the hospital have the potential to be affected by this deficient practice. The facility□s Director of Social Services/Designee will be auditing all transfers to the hospital for the month of February & March 2022 to ensure written notification is provided to the Ombudsman and resident□s representatives. 3. The Administrator/designee will educate the Director of Social Services on the importance of ensuring written	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 623	Continued From page 24 change assessment, with an assessment reference date of 3/2/22, coded the resident as scoring 7 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired Review of Resident #101's nursing progress note dated 2/19/22 at 3:02 PM revealed the following, "[Resident #101] Out of bed in wheelchair, noted progressing weakness, unable to sit up straight. Slow respond to verbal and tactile stimuli. Transferred back in bed due to weakness. At lunch writer attempted to feed the resident, unable to open mouth, change in mental status, unable to respond to verbal stimuli ...Notified nurse practitioner- send the resident to Emergency room (ER) for further evaluation due to change in mental status and unable to respond to verbal stimuli. RP (responsible party) notified and given the change of status update. Resident was sent to the ER via 911 at 2:15 pm and given report to hospital." On 3/15/22 at approximately 5:00 PM, a request was made for the evidence of written documentation to the Resident/RP and Ombudsman when Resident #101 was transferred to the hospital on 2/19/22. On 3/16/22 at 9:32 AM, an interview was conducted with ASM (administrative staff member) #1, the administrator who stated, "We have not been sending notification to the ombudsman on hospital transfers. I have talked with the social worker and we will start doing that today, here is the proof of what we sent to the ombudsman this morning." ASM #1 provided copy of email sent to the	F 623	documentation of hospital transfer to the Ombudsman and resident□s representative. 4. The Director of Social Services/designee will complete a weekly audit for all residents who are transferred to the hospital to ensure written notification is provided to the Ombudsman as well as the resident□s representative. Findings of the audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement (QAPI) Committee to ensure compliance. 5. April 20, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 623	Continued From page 25	F 623		

Ombudsman dated 3/16/22 at 8:16 AM, with Resident #101's name listed.

No evidence of written notification to RP was provided.

An interview was conducted on 3/16/22 at 10:03 AM with OSM (other staff member) #5, the director of social services. When asked about ombudsman notification, OSM #5 stated, "We are to notify the ombudsman, which is new to me. She stated she was just told this week, and are starting it now. "I started at this facility in November. I will do at weekly notification to the ombudsman. I already have a relationship with the ombudsman and he comes in at least once a week."

On 3/16/22 at 5:25 PM, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the administrator at sister facility and RN #3, staff development coordinator were informed of the above concern.

According to the facility's "Transfer & Discharge Notification" policy which reveals, "The facility will notify resident, or their representative as well as the Ombudsman of resident transfers and discharge. The facility will notify resident and the representative of transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility will send a copy of the notice to a representative of the Office of the State Long Term Care Ombudsman."

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 623	Continued From page 26	F 623		

2. The facility staff failed to evidence written documentation to the Resident/RP and Ombudsman when Resident #85 was transferred to the hospital on 2/3/22.

Resident #85 was admitted to the facility with diagnoses including congestive heart failure, diabetes mellitus and bradycardia. Resident #85's most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 1/19/22, coded the resident as scoring 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired.

Review of Resident #85's nursing progress note dated 2/3/22 at 11:23 AM, revealed the following, "About 11 AM resident stated that 'I am not doing good. I feel like passing out,' Checked resident's vital signs ...Physician notified and new order given to send the resident to nearest ER (emergency room) for further evaluation and treatment. Resident left with ambulance."

On 3/15/22 at approximately 5:00 PM a request was made for the evidence of written documentation to the Resident or RP and Ombudsman when Resident #85 was transferred to the hospital on 2/3/22.

On 3/16/22 at 9:32 AM, an interview was conducted with ASM (administrative staff member) #1, the administrator, who stated, "We have not been sending notification to the ombudsman on hospital transfers. I have talked with the social worker and we will start doing that today, here is the proof of what we sent to the ombudsman this morning."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 623	Continued From page 27	F 623		

ASM #1 provided copy of email sent to Ombudsman dated 3/16/22 at 8:16 AM, with Resident #85's name listed. No evidence of written notification to RP was provided.

An interview was conducted on 3/16/22 at 10:03 AM with OSM (other staff member) #5, the director of social services. When asked about ombudsman notification, OSM #5 stated, "We are to notify the ombudsman which is new to me." She stated she was just told this week. We are starting it now. I started at this facility in November. I will do at weekly notification to the ombudsman. I already have a relationship with the ombudsman and he comes in at least once a week."

On 3/16/22 at 5:25 PM, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the administrator at sister facility and RN #3, staff development coordinator were informed of the above concern.

No further information was provided prior to exit.
3. The facility staff failed to evidence written notification of transfer to the resident/RP or notification to the ombudsman for Resident #71's facility-initiated transfer on 1/29/2022.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 2/9/2022, the resident was assessed as being severely impaired for making daily decisions.

The progress notes for Resident #71 documented in part, "1/29/2022 15:16 (3:16 p.m.) Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 623	Continued From page 28	F 623		

observed in bed at beginning of shift with eyes closed and breathing through the mouth. O2 (oxygen) at 2L (two liters)/min (per minute) via nc (nasal cannula). BS (blood sugar) checked. Unable to get reading because BS was high ...Resident continued with lip breathing with a lot of mucus from mouth. MD (medical doctor) notified. Order: Transfer resident to [Name of hospital] ER (emergency room) for further eval (evaluation) and treat. R/P (responsible party) notified. Resident pick up at 9:15 am via 911."

The clinical record failed to evidence documentation of written notification of transfer to the resident/RP or notification to the ombudsman for the facility-initiated transfer on 1/29/2022.

On 3/16/2022 at 12:08 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that they sent bed hold notice and clinical records for facility-initiated transfers but did not send any written notice of transfer to the resident or responsible party.

On 3/16/2022 at 9:32 a.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that they had not been sending notification to the ombudsman for hospital transfers. ASM #1 stated that they had spoken with the social worker and had started doing this that morning.

On 3/16/2022 at 10:03 a.m., an interview was conducted with OSM (other staff member) #5, the director of social work. OSM #5 stated that they only spoke with the responsible parties on the phone regarding the bed hold. OSM #5 stated that they had not been notifying the ombudsman of hospital discharges and that they were just told

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 623	Continued From page 29	F 623		

that they were to send them weekly starting now.

On 3/16/2022 at 5:20 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, administrator of a sister facility and RN (registered nurse) #3, staff development were notified of the findings.

No further information was provided prior to exit.

4. The facility staff failed to evidence written notification of transfer to the resident/RP or notification to the ombudsman for Resident #2's facility-initiated transfer on 3/9/2022.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/23/2022, the resident scored a 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact.

The progress notes for Resident #2 documented in part, "3/9/2022 17:50 (5:50 p.m.) Resident was in bed on 2 iitters [sic] of oxygen via nasal canula [sic] at 8:40 am ...Circa 9 am CNA (certified nursing assistant) caring for resident informed me that she was unable to eat her breakfast. Upon approaching her bedside, color appeared slightly cyanotic, skin cool to touch, resident was breathing without any difficulty, with oxygen @ 2L (liters) nasal cannula in use ... was with definite change in mental status. Unable to respond verbally, no congestion observed. [Name of physician] was in house at the time and informed him of residents change in status. He ordered resident sent out 911. EMS (emergency medical services) was called..." The progress notes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 623	Continued From page 30	F 623		

further documented, "3/9/2022 22:34 (10:34 p.m.) Resident returned from the hospital at 8:45 pm."

The clinical record failed to evidence documentation of written notification of transfer to the resident/RP or notification to the ombudsman for the facility-initiated transfer on 3/9/2022.

On 3/16/2022 at 12:08 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that they sent bed hold notice and clinical records for facility-initiated transfers but did not send any written notice of transfer to the resident or responsible party.

On 3/16/2022 at 9:32 a.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that they had not been sending notification to the ombudsman for hospital transfers. ASM #1 stated that they had spoken with the social worker and had started doing this that morning.

On 3/16/2022 at 10:03 a.m., an interview was conducted with OSM (other staff member) #5, the director of social work. OSM #5 stated that they only spoke with the responsible parties on the phone regarding the bed hold. OSM #5 stated that they had not been notifying the ombudsman of hospital discharges and that they were just told that they were to send them weekly starting now.

On 3/16/2022 at 5:20 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, administrator of a sister facility and RN (registered nurse) #3, staff development were notified of the findings.
5. The facility staff failed to provide written

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 31	F 623		

notification to the resident and/or responsible party for a facility initiated transfer, and failed to notify the ombudsman of a transfer to the hospital for Resident #74.

Resident #74 was admitted to the facility on 1/26/2022. On the most recent MDS (minimum data set) assessment, a significant change Medicare five day assessment, with an ARD (assessment reference date) of 2/11/2022, the resident scored a one on the BIMS (brief interview for mental status) score, indicating the resident is severely cognitively impaired for making daily decisions.

The nurse's note dated 1/31/2022 at 2:42 p.m. documented, "Patient alert and restlessness with tachypnea and tachycardia ...Patient stated, 'I am not feeding (sic) good,' moving all-around in bed, very irritable. MD (medical doctor) notified, new order given to give nebulizer treatment was given one time. Patient still noticed restlessness and fast breathing. Called 911 and sent to ER (emergency room) for further evaluation and treatment. MD made aware and responsible party, son [name of son] notified. Report is given to [Name of hospital] ER nurse. All paper work with med (medications) were given to 911 staff."

Review of the clinical record on 3/16/2022 failed to evidence a written notification for the reason for the transfer to the hospital on 1/31/2022 for Resident #74 was provided to the resident and/or responsible party. And further investigation revealed there was no notification of the ombudsman of the transfer of Resident #74 to the hospital on 1/31/2022.

An interview was conducted with ASM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 32 (administrative staff member) #1, the administrator, on 3/16/2022 at 9:32 a.m. ASM #1 stated, "We have not been sending notification to the ombudsman on hospital transfers. I've talked with the social worker and will start doing that today. Here is the proof of what we sent to the ombudsman this morning." An interview was conducted with OSM (other staff member) #5, the director of social services on 3/16/2022 at 10:03 a.m. When asked about notifying the ombudsman of a resident's transfer to the hospital, OSM #5 stated "Notifying the ombudsman is new to me. I was just told this week about it and am starting it now. I will do it weekly, I already have a relationship with the ombudsman and he comes in at least once a week." Multiple requests were made for the documentation of the written notification to the resident and/or responsible party upon transfer to the hospital. Nothing was provided prior to exit. ASM #1, ASM #2, ASM #3, the assistant director of nursing, ASM #4, administrator from a sister facility, and RN (registered nurse) #3, the staff development nurse, were made aware of the above concern on 3/16/2022 at 5:30 p.m. No further information was provided prior to exit.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or	F 625		4/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 33 the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide a notice of bed hold when the resident was transferred to the hospital for four of 47 residents in the survey sample, Residents #101, #85, #71 and #74. The findings include: 1. The facility staff failed to evidence a bed hold was provided when Resident #101 was transferred to the hospital on 2/19/22.	F 625	1. No residents were adversely affected by this deficient practice. This deficiency cannot be retroactively corrected for residents #101, #85, #71, and #74 as they are no longer in the hospital. Director of Social Services/Designee have sent out written notice of the facility bed hold policy to residents and/or responsible party who are currently in the hospital on 4/1/2022. 2. All residents have the potential to be affected by this deficient practice. All facility transfers and discharged residents will be closely monitored by Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 625	Continued From page 34 Resident #101 was admitted to the facility on 2/17/22. Resident #101's diagnoses included but were not limited to: cerebral vascular accident, bladder neck obstruction and urinary tract infection. Resident #101's most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/2/22, coded the resident as scoring 7 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired Review of Resident #101's nursing progress note dated 2/19/22 at 3:02 PM revealed the following, "[Resident #101] Out of bed in wheelchair, noted progressing weakness, unable to sit up straight. Slow respond to verbal and tactile stimuli. Transferred back in bed due to weakness. At lunch writer attempted to feed the resident, unable to open mouth, change in mental status, unable to respond to verbal stimuli ...Notified nurse practitioner- send the resident to Emergency room (ER) for further evaluation due to change in mental status and unable to respond to verbal stimuli. RP (responsible party) notified and given the change of status update. Resident was sent to the ER via 911 at 2:15 pm and given report to hospital." On 3/15/22 at approximately 5:00 PM a request was made for the evidence of a bed hold notification when Resident #101 was transferred to the hospital on 2/19/22. An interview was conducted on 3/16/22 at 10:03 AM with OSM (other staff member) #5, the director of social services. When asked about the bed hold notification being provided, OSM #5 stated, "I talk with the family about a bed hold and	F 625	Social Services to ensure facility staff provide resident and/or responsible party written notice of the facility bed hold policy. The facility□s Director of Social Services/Designee will be auditing all transfers to the hospital for the month of February & March 2022 to ensure written notification has been sent. 3. The administrator/designee will educate the Director of Social Services on the bed hold policy and importance of ensuring proper documentation of bed hold notices. 4. Director of Social Services/designee will monitor resident transfer/discharges on an ongoing basis to ensure documented Bed hold notices are provided to the resident and/or responsible party. Quality audits for compliance with notification will be conducted 2x a week for 4 weeks, weekly x4 weeks then monthly. Findings of audits will be presented monthly for 3 months to the Quality Assurance Performance Improvement (QAPI) Committee to ensure compliance. 5. April 20, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 35	F 625		

talk with admitting about it. I communicate with the family. I do not know if anything is documented."

An interview was conducted on 3/16/22 at 3:30 PM with OSM #8, the admissions director. When asked if a bed hold notification is provided to residents who are transferred to the hospital, OSM #8 stated, "There is no evidence of documentation of bed hold offered to these residents. We do not give them a copy of the bed hold form. We verbally discussed with the RP. Not sure if it has been documented."

On 3/16/22 at 5:25 PM, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the administrator at sister facility and RN #3, staff development coordinator were informed of the above concern.

According to the facility's "Bed Hold Notice Upon Transfer" policy: "At the time of transfer for the hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed."

No further information was provided prior to exit.

2. The facility staff failed to evidence a bed hold was provided when Resident #85 was transferred to the hospital on 2/3/22.

Resident #85 was admitted to the facility on 7/31/20. Resident #85's diagnoses included but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 36	F 625		

were not limited to: congestive heart failure, diabetes mellitus and bradycardia.

Resident #85 was admitted to the facility with diagnoses including congestive heart failure, diabetes mellitus and bradycardia. Resident #85's most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 1/19/22, coded the resident as scoring 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired.

Review of Resident #85's nursing progress note dated 2/3/22 at 11:23 AM, revealed the following, "About 11 AM resident stated that 'I am not doing good. I feel like passing out,' Checked resident's vital signs ...Physician notified and new order given to send the resident to nearest ER (emergency room) for further evaluation and treatment. Resident left with ambulance."

On 3/15/22 at approximately 5:00 PM a request was made for the evidence of a bed hold notification when Resident #101 was transferred to the hospital on 2/19/22.

An interview was conducted on 3/16/22 at 10:03 AM with OSM (other staff member) #5, the director of social services. When asked about the bed hold being provided, OSM #5 stated, "I talk with the family about a bed hold and talk with admitting about it. I communicate with the family. I do not know if anything is documented."

An interview was conducted on 3/16/22 at 3:30 PM with OSM #8, the admissions director. When asked if a bed hold is provided to residents transferred to the hospital, OSM #8 stated,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 37	F 625		

"There is no evidence of documentation of bed hold offered to these residents. We do not give them a copy of the bed hold form. We verbally discussed with the RP. Not sure if it has been documented."

On 3/16/22 at 5:25 PM, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the administrator at sister facility and RN #3, staff development coordinator were informed of the above concern.

No further information was provided prior to exit.

3. The facility staff failed to provide bed hold notice for Resident #71's facility-initiated transfer on 1/29/2022.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 2/9/2022, the resident was assessed as being severely impaired for making daily decisions.

The progress notes for Resident #71 documented in part, "1/29/2022 15:16 (3:16 p.m.) Resident observed in bed at beginning of shift with eyes closed and breathing through the mouth. O2 (oxygen) at 2L (two liters)/min (per minute) via nc (nasal cannula). BS (blood sugar) checked. Unable to get reading because BS was high ...Resident continued with lip breathing with a lot of mucus from mouth. MD (medical doctor) notified. Order: Transfer resident to [Name of hospital] ER (emergency room) for further eval (evaluation) and treat. R/P (responsible party) notified. Resident pick up at 9:15 am via 911."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 38	F 625		

The clinical record failed to evidence documentation of bed hold notice provided for the facility-initiated transfer on 1/29/2022.

On 3/16/2022 at 12:08 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that they sent an envelope with documents with residents to the hospital with them when transferred out. LPN #5 stated that the envelope had a checklist on it that they followed. LPN #5 stated that the documents they sent to the hospital included a bed hold notice. LPN #5 stated that they should document what was sent in the progress notes because they do not copy the envelope that was sent. LPN #5 stated that some of the nurses were good about making the notes and some were not.

On 3/16/2022 at 10:03 a.m., an interview was conducted with OSM (other staff member) #5, the director of social work. OSM #5 stated that they only spoke with the responsible parties on the phone regarding the bed hold.

On 3/16/2022 at 3:30 p.m., an interview was conducted with OSM (other staff member) #8, the admissions director. OSM #8 stated that they did not have evidence of a bed hold provided to Resident #71. OSM #8 stated that they do not give a copy of the bed hold form, that they verbally discuss the bed hold with the responsible party and was unsure if it was documented.

On 3/16/2022 at 5:20 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, administrator of a sister facility and RN (registered nurse) #3, staff development were notified of the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 39	F 625		

No further information was provided prior to exit.
4. The facility staff failed to provide a written copy of the bed hold policy upon transfer to the hospital on 1/31/2022 for Resident #74.

Resident #74 was admitted to the facility on 1/26/2022. On the most recent MDS (minimum data set) assessment, a significant change Medicare five day assessment, with an ARD (assessment reference date) of 2/11/2022, the resident scored a one on the BIMS (brief interview for mental status) score, indicating the resident is severely cognitively impaired for making daily decisions.

The nurse's note dated 1/31/2022 at 2:42 p.m. documented, "Patient alert and restlessness with tachypnea and tachycardia ...Patient stated, 'I am not feeding (sic) good,' moving all-around in bed, very irritable. MD (medical doctor) notified, new order given to give nebulizer treatment was given one time. Patient still noticed restlessness and fast breathing. Called 911 and sent to ER (emergency room) for further evaluation and treatment. MD made aware and responsible party, son [name of son] notified. Report is given to [Name of hospital] ER nurse. All paper work with med (medications) were given to 911 staff."

An interview was conducted with LPN (licensed practical nurse) #5 on 3/16/2022 at 12:08 p.m. When asked the process for sending a resident to the hospital, LPN #6 stated, "When we transfer a resident to the hospital we send an envelope with them, the envelope has a checklist on it. We send a face sheet, the history and physical, the progress notes, the care plan, the change in condition form, and labs and we call a report to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 40 the hospital. We also send a bed hold notice with them." When asked where this should be documented, LPN #5 stated, "We should document this in the progress note, we do not make a copy of anything. Some of the nurses are good about making the notes and some are not." A request was made for the documentation of the bed hold provided to Resident #74 and/or her responsible party on 3/15/2022 at 5:00 p.m. On 03/16/2022 at 3:31 p.m., OSM #8, the director of admissions stated, "From what I understand, the family did not formally pay for a bed hold." OSM #8 stated she would further investigate this. On 3/16/2022 at 3:36 p.m. OSM #8 stated, "We do not give them a copy of the bed hold form, it's verbally discussed with the RP (responsible party). When asked where the verbal discussion is documented, OSM #8 stated for [Resident #74], it is not documented." ASM #1, ASM #2, ASM #3, the assistant director of nursing, ASM #4, administrator from a sister facility, and RN (registered nurse) #3, the staff development nurse, were made aware of the above concern on 3/16/2022 at 5:30 p.m. No further information was provided prior to exit.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 641	1. Resident #83 had their most recent	4/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 41 interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure a complete and accurate MDS assessment for 2 of 47 residents in the survey sample, Residents #83 and #2. The findings include: 1. For Resident #83 the 2/7/22 quarterly MDS assessment was coded incorrectly for weight, weight loss, and weight gain. The resident was coded as having significant weight loss and significant weight gain, based on a weight obtained approximately one year prior to the MDS. The resident had no weights obtained in approximately a year. Resident #83 was admitted to the facility on 1/30/19 and had the diagnoses of but not limited to cerebral vascular disease, high blood pressure and Alzheimer's disease. On the most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 2/7/22, the resident scored a 0 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. A review of the clinical record revealed the resident's weights. The last weight obtained was on 3/25/21 at 78 pounds. A review of the above MDS dated 2/7/22 documented the following in Section K "Swallowing and Nutritional Status:" Section K0200 Height and Weight....B. Weight (in pounds). Base weight on most recent measure in last 30 days...." The documented weight was 78	F 641	MDS assessment modified to accurately code section K to reflect the resident□s weight or lack thereof. Resident #2 had their most recent MDS assessment modified to accurately code section O to reflect the use of oxygen. 2. All residents in the facility have the potential to be affected by this deficient practice. The MDS Coordinators/Designee will audit all current residents MDS records to ensure all residents have a complete and accurate MDS assessment. 3. The Director of Nursing/Designee will educate the MDS Coordinators on proper MDS coding as defined in the RAI manual. 4. The MDS Coordinators/Designee will perform weekly audits of quarterly MDS on coding accuracy. Findings of the weekly audits will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance. 5. April 20, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 42	F 641		

pounds.

This weight should not have been documented, as this weight was obtained approximately a year prior to the above MDS, and did not meet the parameters of "base weight on most recent measure in last 30 days."

Section K0300 Weight Loss: Loss of 5% or more in the last month or loss of 10% or more in last 6 months.
0. No or unknown.
1. Yes, on physician-prescribed weight-loss regimen.
2. Yes, not on physician-prescribed weight-loss regimen.

This section was marked with a "2" in the box, indicating the resident had a significant weight loss, according to the above documented parameters.

Section K0400 Weight Gain: Gain of 5% or more in the last month or gain of 10% or more in last 6 months.
0. No or unknown.
1. Yes, on physician-prescribed weight-gain regimen.
2. Yes, not on physician-prescribed weight-gain regimen.

This section was marked with a "2" in the box, indicating the resident had a significant weight gain, according to the above documented parameters.

The resident had not had any weights obtained in approximately a year, hence the above parameters of weight loss or gain "of 5% or more

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 43	F 641		

in the last month or 10% or more in last 6 months" would not apply.

On 3/16/22 at 2:20 PM an interview was conducted with LPN #3 (Licensed Practical Nurse) the MDS nurse. When asked if a resident has not had any weights obtained, how the MDS should be coded regarding weight loss / gain. She stated she would follow up on that. When asked what resource is used to complete the MDS, she stated the RAI manual (Resident Assessment Instrument).

On 3/16/22 04:25 PM a follow up interview was conducted with LPN #3. She stated that if there has not been any weights to determine if there had been a weight loss or gain, the MDS should be coded as a 0 (for "No or Unknown" for significant weight loss or gain) "because you don't know."

On 3/16/22 at 5:06 PM another follow up interview was conducted with LPN #3. She stated the MDS was miscoded. She stated the weight from a year ago should not have been used.

On 3/16/22 at 5:19 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Assistant Director of Nursing, ASM #4 Administrator of sister facility, and RN #3 (Registered Nurse) Staff Development, were made aware of the findings.

No further information was provided by the end of the survey.

According to the RAI Manual 3.0 dated October 2019:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 44 Steps for Assessment for K0200B, Weight 1. Base weight on the most recent measure in the last 30 days. 2. Measure weight consistently over time in accordance with facility policy and procedure, which should reflect current standards of practice (shoes off, etc.). 3. For subsequent assessments, check the medical record and enter the weight taken within 30 days of the ARD of this assessment. 4. If the last recorded weight was taken more than 30 days prior to the ARD of this assessment or previous weight is not available, weigh the resident again. 5. If the resident's weight was taken more than once during the preceding month, record the most recent weight. " If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-) and document rationale on the resident's medical record. K0300 Weight Loss... Coding Instructions: Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available. · Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician ' s order. In cases where a resident has a weight loss of 5% or more in 30 days or	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 45	F 641		

10% or more in 180 days as a result of any physician ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics, K0300 can be coded as 1.
Code 2, yes, not on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was not planned and prescribed by a physician.

K0310 Weight Gain...
Coding Instructions:
Code 0, no or unknown: if the resident has not experienced weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available.
· Code 1, yes on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was planned and pursuant to a physician ' s order. In cases where a resident has a weight gain of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan, K0310 can be coded as 1.
· Code 2, yes, not on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician.

2. The facility staff failed to maintain an accurate MDS (minimum data set) for the use of oxygen for Resident #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 46	F 641		

Resident #2 was admitted to the facility with diagnoses that included but were not limited to acute respiratory failure with hypoxia and heart failure. On the most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 2/23/2022, the resident scored a 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact. Section O of the assessment failed to evidence the use of oxygen while a resident.

On 3/15/2022 at 12:19 p.m., an observation was made of Resident #2 in their room. Resident #2 was observed receiving oxygen via a nasal cannula attached to an oxygen concentrator. At this time an interview was conducted with Resident #2, who stated that they wore the oxygen all the time and had used oxygen for "a long time."

The physician orders for Resident #2 documented in part, "Oxygen at 1 liter per min (minute) via nasal cannula to maintain sats (saturations) above 92%. Order Date: 8/16/2021."

The comprehensive care plan failed to evidence documentation for the use of oxygen.

The eTAR (electronic treatment administration record) for Resident #2 dated 2/1/2022-2/28/2022 and 3/1/2022-3/31/2022 documented Resident #2 receiving oxygen at 1 liter per minute via nasal cannula every shift.

On 3/16/2022 at approximately 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3, MDS coordinator. LPN #3 stated that they followed the RAI (resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 47	F 641		

assessment instrument) when completing the MDS assessments.

On 3/17/2022 at 9:00 a.m., an interview was conducted with LPN #3. LPN #3 stated that they reviewed the physician orders, MARs (medication administration record) and TARs (treatment administration record) when completing the MDS. LPN #3 stated that they would look at Resident #2's quarterly MDS with the ARD of 2/23/2022 to see if oxygen was coded.

On 3/17/2022 at approximately 9:15 a.m., LPN #3 stated that they had reviewed Resident #2's record and they did receive oxygen during the look back period. LPN #3 stated that oxygen was not coded on the quarterly MDS with the ARD of 2/23/2022, and it should have been on there.

According to the RAI manual, Section O0100: Special Treatments, Procedures, and Programs, it documented in part, "...O0100C, Oxygen therapy, Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item..."

The facility policy "Clinical Documentation/Accuracy of Documentation & Coding" documented in part, "...The clinical record facilitates...Accurate coding of MDS to promote adequate plan of care interventions..."

On 3/17/2022 at 9:30 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, administrator of a sister facility and RN (registered nurse) #3, staff development were notified of the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 48 No further information was provided prior to exit.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under	F 645		4/20/22

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F 645	Continued From page 49 paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined that the facility staff failed to evidence completion of a level 1 PASRR (preadmission screening and resident review) for 1 of 47 residents in the survey sample, Resident #30. The facility staff failed to complete a level 1 PASRR for Resident #30 who was admitted to the	F 645	1. Resident #30 had a PASARR (Preadmission Screening and Resident Review) completed on 3/16/22 by Social Service Director/Designee. 2. All residents in the facility have a potential to be affected by this deficient practice. The Social Service Director has	

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F 645	Continued From page 50 facility on 4/24/2021. The findings include: Resident #30 was admitted to the facility on 4/24/21 with diagnoses that included delusional disorders, hallucinations and unspecified dementia with behavioral disturbance. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/26/2021, the resident scored 10 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired for making daily decisions. Review of Resident #30's clinical record failed to evidence a level 1 PASRR. On 3/16/2022 at approximately 9:26 a.m., a request was made to ASM (administrative staff member) #1, the administrator for the Level 1 PASRR for Resident #30. On 3/16/2022 at approximately 2:30 p.m., ASM #1 provided a Level 1 PASRR for Resident #30 with a completion date of 3/16/2022. On 3/17/2022 at 8:00 a.m., an interview was conducted with OSM (other staff member) #5, the director of social services. OSM #5 stated that the level 1 PASRR normally came with the admission documents for residents. OSM #5 stated that when they began working at the facility their expectation was that all of the residents at the facility at that time already had a Level 1 PASRR. OSM #5 stated that they did not realize that Resident #30 did not have a Level 1 PASRR until the request was made on 3/15/2022. OSM #5 stated that they had completed the level 1	F 645	completed an audit of PASARR completion for all current residents on 3/29/2022. 3. The Administrator/Designee will educate Admission Coordinators and Social Services Director on PASARR regulations and facility policies. 4. The Admissions Director/Designee will perform weekly audits on all new admission charts to ensure completion of the PASARR Level 1. Findings of weekly audits will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance. 5. April 20, 2022	

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F 645	Continued From page 51	F 645		

PASRR on 3/16/2022 and that one should have been done prior to this date.

The facility policy, "Preadmission Screening and Annual Resident Review (PASRR) Policy" documented in part, "...As part of the preadmission process, the facility participates in the Preadmission Screening and Resident Review (PASRR) screening process (Level I) for all new and readmissions per requirement to determine if the individual meets the criterion for mental disorder (SMI/SMD), intellectual disability (ID) or related condition. Based upon the Level I screen, the facility will not admit an individual with a mental disorder or intellectual disability until the Level II screening process has been completed and the recommendations allow for a nursing facility admission and the facility's ability to provide the specialized services determined in the Level II screen. If a provisional admission to the facility is approved via the Level II screen process, the facility will coordinate with the State PASRR representative related to the individual needs of the resident as indicated..."

The document, "COVID-19 Emergency Declaration Waivers" updated 11/29/2021, documented in part on page 16, "Waive Pre-Admission Screening and Annual Resident Review (PASARR). CMS (Centers for Medicare and Medicaid Services) is waiving 42CFR 483.20(k), allowing nursing homes to admit new residents who have not received Level 1 or Level 2 Preadmission Screening. Level 1 assessments may be performed post-admission. On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness (MI) or intellectual disability (ID) should be referred promptly by the nursing home to State PASARR

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F 645	Continued From page 52 program for Level 2 Resident Review..." This information was obtained from the website: https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf On 3/17/2022 at 9:30 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the administrator at sister facility and RN (registered nurse) #3, staff development were made aware of the findings. No further information was provided prior to exit.	F 645		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a	F 655		4/20/22

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F 655	Continued From page 53 comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a complete baseline care plan for 1 of 47 residents in the survey sample, Resident #315. The facility staff failed to develop Resident #315's baseline care plan to include the use of an incentive spirometer. The findings include: Resident #315 was admitted to the facility on 3/7/22. Resident #315's diagnosis included but was not limited to a heart attack. Resident #315's admission minimum data set was not completed.	F 655	1. Resident #315 suffered no adverse effects related to this deficient practice. Facility nurse reached out to the physician on 3/16/22 with a request for an order for incentive spirometer but request was denied; MD stated that resident did not need this device. Care Plan was not updated. 2. All residents with a need for incentive spirometer have the potential to be affected by this deficient practice. The Unit Manager/Designee will complete an audit of all current resident Care Plans for person-centered, complete, and accurate information. 3. Education completed with all nursing staff and Department Heads on Care	

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F 655	Continued From page 54 An admission assessment dated 3/7/22 documented Resident #315 was alert and oriented to person, place, time and situation. A review of Resident #315's March 2022 physician's orders failed to reveal a physician's order for an incentive spirometer. A review of Resident #315's baseline care plan initiated on 3/7/22 failed to reveal documentation regarding an incentive spirometer. On 3/15/22 at 1:15 p.m. and 3/16/22 at 8:34 a.m., Resident #315 was observed sitting in a chair in the bedroom. An incentive spirometer was on the resident's over bed table. At this time, an interview was conducted with the resident. Resident #315 stated, "They told me to inhale 10 times." The resident did not specify who "they" were. On 3/16/22 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the minimum data set coordinator). LPN #3 stated the purpose of the care plan is to coordinate resident care and work out a plan of care for that resident. LPN #3 stated an incentive spirometer is a respiratory device used for the lungs and has to be on the baseline care plan so staff can monitor it. On 3/16/22 at approximately 5:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Care Plan/Care Plan Meeting/Baseline Care Plan" documented, "The facility must develop and implement a baseline person-centered care plan within 48 hours for	F 655	Plan/Care Plan Meetings/Baseline Care Plan policy and identifying new residents admitting with the need for incentive spirometer. 4. The Unit Manager/Designee will perform weekly audits of all new admits□ hospital records, hospital discharge summary and resident inventory for incentive spirometer need/use. Audits will include monitoring for a complete and accurate baseline/comprehensive care plan. Weekly audit reports will be presented to the Quality Assurance Improvement Committee (QAPI) monthly for three months to ensure compliance. 5. April 20, 2022	

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F 655	Continued From page 55 each patient that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality of care." No further information was presented prior to exit.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		4/20/22

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F 656	Continued From page 56 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to develop and implement the comprehensive care plan for six of 47 residents in the survey sample, Residents #56, #28, #39 , #11, #71 and #2 . The findings include: 1. The facility staff failed to develop a comprehensive care plan to address Resident # 56's pain. Resident # 56 was admitted to the facility with a diagnosis that included by not limited to chronic pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/27/2022, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section J coded Resident # 56 as not having any pain in the past 5 (five) days. The physician's order sheet for Resident # 35 dated February 2022 documented in part: "Oxycodone-Acetaminophen (1) 10-325 MG	F 656	1. Resident #56□s Comprehensive Care Plan updated (developed) to reflect person-centered pain management including both non-pharmacological and pharmacological interventions. Care plan includes implementation of pain monitoring every shift with specific non-pharmacological interventions for licensed/registered nurses and CNAs to attempt when resident reports or is displaying signs of pain (specific signs of pain to observe for is also included in the care plan). Resident #28□s Comprehensive Care Plan updated (developed) to reflect fall mat to be placed at bedside when resident is in bed for safety. Care plan implementation includes CNAs re-educated on fall risks/fall interventions (fall mats) and need to follow plan of care for resident safety. Fall mat placement now added to CNA charting tasks for all residents with fall mat orders. Resident #39□s Comprehensive Care Plan updated (developed) to reflect pressure ulcer to heel and interventions to	

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F 656	Continued From page 57 (milligram) Tablet. Give one tablet by mouth twice daily as needed. Order Date: 04/23/2021." Resident #56's eMAR (electronic medication administration record) for March 2022 documented the administration of the Oxycodone-Acetaminophen as documented above on the following dates and times, with no evidence of non-pharmacological interventions being attempted: 03/01/2022 at 4:31 p.m., 03/02/2022 at 7:23 a.m., 03/03/2022 at 4:54 p.m., 03/04/2022 at 5:42 p.m., 03/07/2022 at 7:00 p.m., 03/09/2022 at 9:19 p.m., 03/13/2022 at 5:22 a.m. and on 03/15/2022 at 4:44 p.m. The comprehensive care plan for Resident # 56 dated 04/29/2021 failed to evidence information related to pain. On 03/17/22 at approximately 10:52 a.m., an interview was conducted with Resident # 56. When asked if they receive pain medication as needed Resident # 56 stated, "Sometimes." When asked if the staff try to alleviate their pain before giving them pain medication Resident # 56 stated "Sometimes." On 03/16/2022 at approximately 2:20 p.m. an interview was conducted with LPN [licensed practical nurse] # 3, MDS coordinator regarding the comprehensive care plan for Resident # 56. When asked to describe the purpose for a care plan LPN # 3 stated, "To coordinate resident care and work out a plan of care for the resident." When asked how the comprehensive care plan is developed for a resident LPN # 3 stated, "Go with the triggers from the comprehensive assessment and develop the care plan and we follow the RAI (resident assessment instrument) manual" When	F 656	promote healing/decrease risks for further skin breakdown. Wound measurements and treatment in place. Implementation of frequent repositioning, reporting skin redness/breakdown promptly, changing of incontinence promptly and importance of nutrition/fluids to promote healing in place. Nursing and CNAs re-educated on identifying residents at risk for skin breakdown/pressure ulcer formation, interventions to decrease skin breakdown and pressure ulcer care/documentation. Wound nurse to provide wound treatment in TAR and weekly wound measurements in PCC Weekly Pressure Wound Observation Tool. Braden Scale assessment completed on all residents to assess for skin risk breakdown. Dietician completes PCC Nutrition assessment of all residents upon admission, quarterly and with change of status. Resident #11□s Comprehensive Care Plan updated (developed) to reflect compression stockings, their cleaning care and resident preference to remove them when taking afternoon rest. Implementation includes CNA daily schedule of placing and removing ted hose, daily cleaning of these and interventions to encourage use of wearing ted hose per orders. Nurses monitor for compliance in TAR. Resident #71□s Comprehensive Care Plan updated (developed) to reflect therapeutic bilateral hand splints and instructions for use. Implementation includes daily schedule to place and remove splints, staff encouragement to wear splints per orders and skin check	

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F 656	Continued From page 58 informed of a missing care plan to address Resident # 56's pain, LPN # 3 stated, "I'll check the care plan." At approximately 4:18 p.m., LPN # 3 stated, "There's no care plan for [Name of Resident # 56's] pain and there should be." The facility's policy "Care Plans, Comprehensive Person-Centered" documented in part, "8. The comprehensive, person-centered care plan will: a. Include e measurable objectives and time frames; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ..." The Resident Assessment Instrument (RAI) User's Manual. 4.7 The RAI and Care Planning documented in part, "As required at 42 CFR 483.21(b), the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. Refer to 42 CFR 483.20(d), which notes that a nursing home must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review, and revise the resident's comprehensive plan of care." On 03/16/2022 at approximately 5:00 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, assistant director of nursing, ASM # 4, administrator from	F 656	schedule to ensure no breakdown is occurring under splint. Therapy to re assess for continued need due to frequent refusals of resident to wear this device. Re-education with CNAs and nursing staff on following orders for splint placement, need for skin monitoring under splints, reporting to therapy services and Physician of frequent refusals to wear ordered splints. Education included resident□s right to refuse wearing splint. Resident #2□s Comprehensive Care Plan updated (developed) to reflect use of oxygen and skin impairment risks (pressure ulcers resolved on 3/25/22 by wound nurse practitioner). Implementation includes nursing to monitor respiratory status to ensure effective treatment/use of oxygen, oxygen in use sign to be placed on door of residents using oxygen, and oxygen canisters to be placed in a holder for safety. CNAs and nursing re-educated on proper flow rates of oxygen, reporting of signs of shortness of breath, and general oxygen use/protocols. Implementation of pressure ulcer care/risks include frequent repositioning, keeping skin clean and dry, importance of adequate nutrition/fluids to promote wound healing/prevention of skin breakdown. Oxygen use documented in MAR by nursing. Braden Scale assessment completed by nursing to determine risk of skin breakdown. Wound nurse documents wound care in TAR and weekly pressure ulcer assessments in PCC Weekly Pressure Wound Observation Tool. Interdisciplinary team meets weekly to discuss pressure ulcers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 59 sister facility and RN # 4, staff development, were made aware of the findings. No further information was provided prior to exit. References: (1) Indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f2137f1a-b49a-40bd-97ac-cd6b36e295f4. 2. The facility staff failed to implement Resident # 28's comprehensive care plan for the use of a fall mat. Resident # 28 was admitted to the facility with a diagnosis that included but was not limited to: muscle weakness and a history of falls. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 12/30/2021, the resident scored 4 (four) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. On the following dates a times, Resident #28 was observed to bed, with no fall mat in place on the floor next to the bed: 03/15/22 at 12:40 p.m., 03/15/22 at 4:55 p.m., 03/16/22 at 8:05 a.m., and 03/16/22 at 12:00 p.m. At each observation, a fall mat was leaning against the wall at the foot of Resident #28's bed. The facility's fall investigation for Resident # 28	F 656	and healing process. 2. All residents in the facility have the potential to be affected by this deficient practice. The Unit Manager/Designee will complete an audit of all current resident Comprehensive Care Plans for person-centered, complete, timely, accurate development and implementation of care plans. 3. Education completed with all nursing staff on Care Plan/Care Plan Meetings/Baseline Care Plan policy and development/implementation of resident care plans. Education completed with nursing and CNAs on individual residents listed above as well as all residents with same areas of concern. 4. The Unit Manager/Designee will perform weekly audits of quarterly comprehensive and new admit baseline/comprehensive care plans and implementation of these care plans. Weekly audit reports will be presented to the Quality Assurance Improvement Committee (QAPI) monthly for three months to ensure compliance. 5. April 20, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 60	F 656		

dated 11/27/2021 documented in part, "Resident c/o (complaint of) chest pain bout 6:30 am. (a.m.). Chest pain protocol initiated - O2, (oxygen), 3 (three) doses of Nitro, Aspirin given in am (a.m.). Unresolved. Resident rolled out of bed inspite [sic] of being placed at the middle and low bed position. No injuries sustained."

The comprehensive care plan for Resident # 28 with a revision date of 11/27/2021 documented in part, "Focus: The resident has had an actual fall related to sudden chest pains, dizziness, and shortness of breath. Date Initiated: 11/27/2021. Revision on: 11/29/2021 ...Safety fall protocol in place- ...fall mats in place... Date Initiated: 11/27/2021. Revision on: 11/29/2021."

On 03/16/2022 at approximately 12:20 p.m. an interview was conducted with LPN [licensed practical nurse] # 2. When asked if Resident # 28 needed a fall mat next to their bed LPN # 2 stated, "No because he's not a fall risk." After informed of the above observations and reviewing the comprehensive care plan dated 11/27/2021 LPN # 2 was asked again if Resident # 28 needed a fall mat. LPN # 2 stated, "Yes, it should be down next to his bed." When asked to describe the purpose of a care plan LPN # 2 stated, "What kind of care to provide to the resident." When asked if the care plan was being followed if the fall mat was not on the floor next to the resident's bed LPN # 2 stated, "No."

On 03/16/2022 at approximately 12:25 p.m. an interview was conducted with RN [registered nurse] # 2, unit manager. When asked if a fall mat should be on the floor next to Resident # 28's bed when they are in bed RN # 2 stated, "Yes." When informed of the above observations RN # 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 656	Continued From page 61	F 656		

stated, "It should have been in place." When asked to describe the purpose of a care plan RN # 2 stated, "Tells how to take care of the resident." When asked if the care plan was being followed if the fall mat was not on the floor next to the resident's bed RN # 2 stated, "Not at this time."

On 03/16/2022 at approximately 5:00 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, assistant director of nursing, ASM # 4, administrator from sister facility and RN # 4, staff development, were made aware of the findings.

No further information was provided prior to exit.
3. The facility staff failed to implement the comprehensive care plan to measure and observe the pressure injury for Resident #39.

On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/6/2022, Resident #39 was coded as having both short and long term memory difficulties and was coded as being severely cognitively impaired for making daily decisions. In Section M, the resident was coded as having no unhealed pressure injuries.

The comprehensive care plan dated 12/19/2021, and reviewed on 3/16/2022, documented in part, "Focus: The resident has non rupture blister on right inner heel ...Weekly treatment documentation to include measurement of each are of skin breakdown's width, length, depth, type of tissue and exudate and any other notable change or observations."

The nurse's note dated 12/19/2021 at 3:39 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 62	F 656		

documented in part, "Resident has non ruptured blister noted to her rt (right) inner heel. Measured 4x4. Elevated heel on pillow. Apply skin prep bid (twice a day) and monitor any change. In house wound consult...No sign and symptoms of verbal or non verbal pain or discomfort noted."

The "Weekly Non-Pressure Wound Observation Tool" dated 12/19/2021 at 12:01 p.m. documented in part, "Type of Wound - Other; Location - blister on the right heel, Describe the wound - non punctured blister, no infectious process. Date wound noted: 12/19/2021...Comments: Blister not punctured. Drainage: none. Odor: none. Wound measurements: Length: 2 cm (centimeters), Width: 3 cm, Depth: blank. Describe wound edges and shape: Well defined. Treatment: placed skin prep applied, heels were floated. Evaluation: First observation. Comments: Wound care to treat and evaluate for healing."
The "Weekly Skin Review" dated 12/27/2022 documented in part, "Skin Condition: Open area - pre-existing - no site documented."
The "Weekly Skin Review" dated 12/30/2021 documented in part, "Skin Condition: Open area - pre-existing - no site documented."
The "Weekly Skin Review" dated 1/3/2022 documented in part, "Skin Condition: Open area - pre-existing - no site documented."
The "Weekly Skin Review" dated 1/6/2022 documented in part, "Skin Condition: Open area - pre-existing - no site documented."
The "Weekly Skin Review" dated 1/10/2022 documented in part, "Skin Condition: Open area - pre-existing - no site documented."
The "Weekly Skin Review" dated 1/17/2022 documented in part, "Skin Condition: Open area - pre-existing - RT (right) heel remains."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 656	Continued From page 63	F 656		

The "Weekly Skin Review" dated 1/20/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx (treatment) to right heel remains."
The "Weekly Skin Review" dated 1/24/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx continues to right heel."
The "Weekly Skin Review" dated 1/27/2022 documented in part, "Skin Condition: Open area - pre-existing - tx continues to right heel."
The "Weekly Skin Review" dated 1/31/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx in progress to right heel."
The "Weekly Skin Review" dated 2/7/2022 documented in part, "Skin Condition: Open area - pre-existing- Tx in progress to right heel with skin prep."
The "Weekly Skin Review" dated 2/14/2022 documented in part, "Skin Condition: Open area - Pre-existing- no site documented."
The "Weekly Skin Review" dated 2/21/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx continues to right heel with skin prep."
The "Weekly Skin Review" dated 2/28/2022 documented in part, "Skin Condition: Open area - pre-existing - right heel - tx in progress."
The "Weekly Skin Review" dated 3/7/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx in progress to right heel."
The "Weekly Skin Review" dated 3/14/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx in progress to right heel."
On all of the above documents, there were no measurements of the heel wound.

Review of the nurse's note from 1/1/2022 through 3/2/2022 revealed no documentation of the right heel wound measurements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 64	F 656		

The NP wound specialist note, dated 3/2/2022, documented in part, "Opened DTI (deep tissue injury), now devolved into an unstageable pressure wound. Measurements: length - 0.95 cm (centimeters), width - 1.13 cm, depth - 0.2 cm."

An interview was conducted with LPN #3, the MDS nurse, on 3/16/2022 at 2:22 p.m. When asked the purpose of the care plan, LPN #3 stated it was the plan of how to care for the resident. When asked if it should be followed, LPN #3 stated, "Yes."

An interview was conducted with LPN #1 on 3/16/2022 at 2:25 p.m. When asked if she was aware of the wound on Resident #39's right inner heel, LPN #1 stated, "In late January." When asked when it was determined to be a deep tissue injury and no longer a blister, LPN #1 stated, "In late January." When asked if there were any measurements of this wound prior to 3/2/2022, LPN #1 stated, "No." When asked why there were no measurements prior to 3/2/2022, LPN #1 stated, "I don't know." LPN #1 further stated the normal process when the nurse tells her about an area is for both of them to go in to look at the area of concern. The unit manager also goes with them to assess the area and put a treatment in place.

ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the director of nursing, ASM #4, the administrator from a sister facility, and RN #3, the staff development nurse, were made aware of the above concerns on 3/16/2022 at 5:30 p.m.

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 65	F 656		

4. The facility staff failed to develop a comprehensive care plan for the use of compression stockings for Resident #11.

Resident #11 was admitted to the facility with the diagnoses including cerebral vascular disease and chronic obstructive pulmonary disease. On the most recent MDS (Minimum Data Set), an admission assessment with an ARD (Assessment Reference Date) of 12/9/21, the resident scored a 5 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions.

A review of the physician's orders revealed the following order dated 12/2/21: "Apply TED Hose/Compression Stockings (1) in the AM (morning) as resident tolerates."

On 3/16/22 at 1:00 PM the resident was observed in bed without the stockings on.

On 3/16/22 at 1:02 PM, an interview was conducted with LPN #10 (Licensed Practical Nurse). She stated that the resident had them on this morning when she was up, but that she wants them off when she is in bed.

A review of the comprehensive care plan revealed no information regarding the use of compression stockings.

On 3/16/22 at 2:20 PM an interview was conducted with LPN #3, the MDS nurse. She stated that the purpose of the care plan was, "To coordinate the resident care, work out a plan of care for that resident." When asked if compression stockings should have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 66	F 656		

included in the care plan if there was an order at the time of admission for them, she stated it should have been. When asked who is responsible to develop the comprehensive care plan, she stated, "MDS is responsible for the development of the care plan."

A review of the facility policy, "Care Plans, Comprehensive Person-Centered" was reviewed. This policy documented, "8. The comprehensive, person-centered care plan will:...b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment..."

On 3/16/22 at 5:19 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Assistant Director of Nursing, ASM #4 Administrator of sister facility, and RN #3 (Registered Nurse) Staff Development, were made aware of the findings.

No further information was provided by the end of the survey.

References:
(1) Compression stockings - "You wear compression stockings to improve blood flow in the veins of your legs. Compression stockings gently squeeze your legs to move blood up your legs. This helps prevent leg swelling and, to a lesser extent, blood clots. If you have varicose veins, spider veins, or have just had surgery, your health care provider may prescribe compression stockings. Wearing stockings helps with: Aching

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 67	F 656		

and heavy feeling in legs; Swelling in legs; Preventing blood clots, primarily after surgery or injury when you are less active; Preventing complications of blood clots in the legs, such as post-phlebitic syndrome (pain and swelling in the leg)..."
Information obtained from https://medlineplus.gov/ency/patientinstructions/000597.htm

5. The facility staff failed to develop a care plan for use of a hand splint for Resident #71.

On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 2/9/2022, the resident was assessed as being severely impaired for making daily decisions. Section G documented Resident #71 as being totally dependent on two or more staff for bed mobility, transfers, dressing and personal hygiene. Section O documented Resident #71 using a splint or brace.

On 3/15/2022 at approximately 12:45 p.m., an observation of Resident #71 was made in their room. Resident #71 was observed in bed wearing a hand splint on the right hand.

The ADL (activities of daily living) documentation survey report for 3/1/2022-3/31/2022 documented in part, "Restorative: Splint- Apply Bilateral upper hand resting splint x 2 hrs a day on at 11am, off at 1pm or as tolerated."

The comprehensive care plan for Resident #71 failed to evidence use of a hand splint.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 68	F 656		

On 3/16/2022 at 12:15 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that the care plans were the responsibility of the unit manager, the MDS staff, and the nurses. LPN #5 stated that the care plan was to show a progression of care and to guide them in patient care. LPN #5 stated that splints should be documented on the care plan.

On 3/16/2022 at 2:19 p.m., an interview was conducted with LPN #3, MDS coordinator. LPN #3 stated that the purpose of the care plan was to coordinate resident care and work out a plan of care for the resident. LPN #3 stated that they go over the triggers after completing the comprehensive assessment and completed the care plan. LPN #3 stated that the nurses completed the care plans for changes in condition or specific incidents. LPN #3 stated that they would review Resident #71's record and see if the splint was addressed on the care plan.

On 3/16/2022 at 4:18 p.m., LPN #3 stated that she had reviewed the record and there was an old care plan from the previous facility owners but it had not been carried over with the new company. LPN #3 stated that the splint should be on the current care plan.

On 3/16/2022 at 5:20 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, administrator of a sister facility and RN (registered nurse) #3, staff development were notified of the findings.

No further information was provided prior to exit.

6. For Resident #2, the facility staff failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 69	F 656		

develop a care plan for the use of oxygen (A), and for skin integrity concerns (B).

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/23/2022, the resident scored a 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact. Section M documented Resident #2 having 1 Stage 3 pressure ulcer. Section O failed to evidence documentation of oxygen use.

A.

Resident #2 was admitted to the facility with diagnoses that included but were not limited to acute respiratory failure with hypoxia and heart failure.

On 3/15/2022 at 12:19 p.m., an observation was made of Resident #2 in their room. Resident #2 was observed receiving oxygen via a nasal cannula attached to an oxygen concentrator. At this time an interview was conducted with Resident #2 who stated that they wore the oxygen all the time and had used oxygen for "a long time."

The physician orders for Resident #2 documented in part, "Oxygen at 1 liter per min (minute) via nasal cannula to maintain sats (saturations) above 92%. Order Date: 8/16/2021."

The comprehensive care plan for Resident #2 failed to evidence use of oxygen.

On 3/16/2022 at 12:15 p.m., an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 70	F 656		

conducted with LPN (licensed practical nurse) #5. LPN #5 stated that the care plans were the responsibility of the unit manager, the MDS staff, and the nurses. LPN #5 stated that the care plan was to show a progression of care and to guide them in patient care. LPN #5 stated that the care plan was to be updated when there was any new treatment, infection or change in condition. LPN #5 stated that oxygen should be documented on the care plan.

On 3/16/2022 at 2:19 p.m., an interview was conducted with LPN #3, MDS coordinator. LPN #3 stated that the purpose of the care plan was to coordinate resident care and work out a plan of care for the resident. LPN #3 stated that they go over the triggers after completing the comprehensive assessment and completed the care plan. LPN #3 stated that the nurses completed the care plans for changes in condition or specific incidents. LPN #3 stated that they would review Resident #2's record and see if the oxygen was addressed on the care plan.

On 3/16/2022 at 4:18 p.m., LPN #3 stated that she had reviewed the record and oxygen was not on the care plan. LPN #3 stated that there should be a care plan for oxygen for Resident #2.

On 3/16/2022 at 5:20 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, administrator of a sister facility and RN (registered nurse) #3, staff development were notified of the findings.

B.

The wound evaluation note dated 3/2/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 71	F 656		

documented in part, "Left lateral leg, Length: 1.36cm (centimeter), Width: 0.80cm, Depth: 0.00cm...Date Wound Acquired: 3/2/22; Nonblanchable erythema (redness) surrounding a subcentimeter site of desquamation. Zinc oxide paste to wound and peri-wound Q (every) shift. Wound status: New; Acquired in house? Yes; Etiology: Pressure Ulcer- Stage 2..."

The wound evaluation note dated 3/2/2022 documented in part, "Sacrum, Length: 2.49cm, Width: 2.97cm, Depth 0.00cm...Date Wound Acquired: 3/2/22; Recurrent stage 3 pressure injury. Barrier cream to sacrum q shift. Wound status: New; Acquired in house? Yes; Etiology: Pressure Ulcer- Stage 3..."

The comprehensive care plan for Resident #2 failed to evidence a care plan regarding pressure injuries or skin integrity.

On 3/16/2022 at 12:15 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that the care plans were the responsibility of the unit manager, the MDS staff, and the nurses. LPN #5 stated that the care plan was to show a progression of care and to guide them in patient care. LPN #5 stated that almost all residents had the potential for skin integrity issues and were care planned for them. LPN #5 stated that Resident #5 should have a care plan for pressure injuries because there was a history of them.

On 3/16/2022 at 2:19 p.m., an interview was conducted with LPN #3, MDS coordinator. LPN #3 stated that the purpose of the care plan was to coordinate resident care and work out a plan of care for the resident. LPN #3 stated that they go

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 72 over the triggers after completing the comprehensive assessment and completed the care plan. LPN #3 stated that the nurses completed the care plans for skin conditions. LPN #3 stated that they would review Resident #2's record and see if pressure injuries/skin integrity was addressed on the care plan. On 3/16/2022 at 4:18 p.m., LPN #3 stated that she had reviewed the record and Resident #2 did not have a care plan for skin integrity and should have one. On 3/16/2022 at 5:20 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, administrator of a sister facility and RN (registered nurse) #3, staff development were notified of the findings. No further information was provided prior to exit.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		4/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 73	F 657		

the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to review and/or revise the comprehensive care plan for 6 of 47 residents in the survey sample, Residents #33, #34, #86, #11, #101, and #81.

The findings include:

1. The facility staff failed to review and revise Resident #33's comprehensive care plan for the use of grab bar bed rails.

Resident #33 was admitted to the facility on 9/23/21. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/30/21, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions.

A physical therapy progress note dated 9/23/21

1. Resident #33□s comprehensive care plan updated to reflect use of bilateral grab bars/bed rails to act as enablers to maintain independence with bed mobility. Orders were obtained for use of grab bars/bed rails.
Resident #34□s comprehensive care plan updated to reflect use of bilateral grab bars/bed rails to act as enablers to maintain independence with bed mobility. Orders were obtained for use of grab bars/bed rails.
Resident #86□s comprehensive care plan updated with compression stockings and right hand splint as well as right to refuse. Therapy services department to review for continued need for splint.
Resident #11□s comprehensive care plan updated to reflect risk/actual weight loss.
Resident #101□s comprehensive care plan updated to reflect use of grab bar/bed rail to act as an enabler to maintain independence with bed mobility. Orders were obtained for use of grab

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 74 documented Resident #33 used bed rails for bed mobility. A review of Resident #33's comprehensive care plan dated 10/5/21 failed to reveal documentation regarding grab bar bed rails. A review of Resident #33's March 2022 physician's orders failed to reveal a physician's order for grab bar bed rails. On 3/15/22 at 1:07 p.m., Resident #33 was observed in bed with bilateral grab bar bed rails in the upright position. On 3/16/22 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the minimum data set coordinator). LPN #3 stated the purpose of the care plan is to coordinate resident care and work out a plan of care for that resident. LPN #3 stated she believed residents' care plans should be reviewed and revised to include the use of grab bars because grab bars can cause injury so staff has to review the care plan to see if residents still need grab bars. On 3/16/22 at approximately 5:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Care Plan/Care Plan Meeting/Baseline Care Plan" failed to document specific information regarding reviewing and revising the comprehensive care plan. No further information was presented prior to exit. 2. The facility staff failed to review and revise Resident #34's comprehensive care plan for the use of grab bar bed rails.	F 657	bar/bed rail. Resident #81□s comprehensive care plan updated to reflect use of grab bar/bed rail to act as an enabler to maintain independence with bed mobility. Orders were obtained for use of grab bar/bed rail. Lumbar support back brace added to comprehensive care plan as well as skin breakdown risks associated with brace. 2. All residents in the facility have the potential to be affected by this deficient practice. The Unit Managers/Designee will complete an audit of all current resident Care Plans for person-centered, complete, timely, and accurate information. Therapy Department will complete an audit of all current residents with grab bars/bed rails to ensure continued need for these devices. 3. Education completed with all nursing staff and Department Heads on Care Plan/Care Plan Meetings/Baseline Care Plan Policy and State/Federal regulations regarding review/revision of care plans and use of grab bars/bed rails. 4. The Unit Manager/Designee will perform weekly audits of quarterly and new admit baseline/comprehensive care plans. Weekly audit reports will be presented to the Quality Assurance Improvement Committee (QAPI) monthly for three months to ensure compliance. 5. April 20, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 75	F 657		

Resident #34 was admitted to the facility on 12/29/20. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 12/28/21, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions.

An occupational therapy discharge summary dated 1/12/21 documented a recommendation for grab bars. A review of Resident #34's comprehensive care plan dated 10/15/2 failed to revealed documentation regarding grab bar bed rails. A review of Resident #34's March 2022 physician's orders failed to reveal a physician's order for grab bar bed rails.

On 3/15/22 at 1:36 p.m., Resident #34 was observed in bed with bilateral grab bar bed rails in the upright position.

On 3/16/22 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the minimum data set coordinator). LPN #3 stated the purpose of the care plan is to coordinate resident care and work out a plan of care for that resident. LPN #3 stated she believed residents' care plans should be reviewed and revised to include the use of grab bars because grab bars can cause injury so staff has to review the care plan to see if residents still need grab bars.

On 3/16/22 at approximately 5:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 76	F 657		

No further information was presented prior to exit.

3. The facility staff failed to revise the comprehensive care plan for the use of compression stockings and a hand splint for Resident #86.

On the most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 2/9/22, Resident #86 was scored as having short term and long term memory problems and being moderately impaired in cognitive skills for daily decision making. The resident was coded as requiring supervision for eating and extensive assistance for all other areas of activities of daily living.

A review of the clinical record revealed a physician's order dated 7/26/21 for "Apply compression stockings (1) in am (morning) and remove at night."

A review of the clinical record revealed a physician's order dated 12/30/21 for "Apply right hand splint (2) every morning and remove at bedtime."

On 3/16/22 at 12:06 PM, Resident #86 was observed up in her recliner, dressed. She did not have compression stockings or a hand splint on.

03/16/22 12:08 PM an interview was conducted with CNA #3 (Certified Nursing Assistant) and LPN #10 (Licensed Practical Nurse). They stated that the resident frequently refuses the stockings or wants them removed after they have been on a while. They stated that she does not like to wear them. Regarding the hand splint, they stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 77	F 657		

they will put it on in the morning and then the resident will remove it at some point and won't wear it.

A review of the comprehensive care plan failed to reveal any evidence of the compression stockings or hand splint being care planned for use.

On 3/16/22 at 2:20 PM an interview was conducted with LPN #3, the MDS nurse. She stated that the purpose of the care plan was "To coordinate the resident care, work out a plan of care for that resident." When asked if the comprehensive care plan should have been revised to include these items, she stated it should have been. When asked who is responsible for reviewing and revising the comprehensive care plan, she stated, "The nurse caring for the resident."

On 3/16/22 at 5:19 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Assistant Director of Nursing, ASM #4 Administrator of sister facility, and RN #3 (Registered Nurse) Staff Development, were made aware of the findings.

No further information was provided by the end of the survey.

References:
(1) Compression stockings - "You wear compression stockings to improve blood flow in the veins of your legs. Compression stockings gently squeeze your legs to move blood up your legs. This helps prevent leg swelling and, to a lesser extent, blood clots. If you have varicose veins, spider veins, or have just had surgery, your health care provider may prescribe compression

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 78	F 657		

stockings. Wearing stockings helps with: Aching and heavy feeling in legs; Swelling in legs; Preventing blood clots, primarily after surgery or injury when you are less active; Preventing complications of blood clots in the legs, such as post-phlebitic syndrome (pain and swelling in the leg)..."
Information obtained from https://medlineplus.gov/ency/patientinstructions/000597.htm

(2) Splint - A splint is a rigid or flexible device that maintains in position a displaced or movable part, also used to keep in place and protect an injured part to support healing and to prevent further damage....Purpose of Splinting: Immobilization; Support to promote healing; Positioning or supporting during function; Pain relief; Substitute for weak muscles; Correction and prevention of contracture & deformity; Restoring or maintaining of range of motion; Edema control..."
Information obtained from https://www.physio-pedia.com/Splint

4. The facility staff failed to revise the comprehensive care plan for nutritional needs related to weight loss for Resident #11.

On the most recent MDS (Minimum Data Set), an admission assessment with an ARD (Assessment Reference Date) of 12/9/21, Resident #11 scored a 5 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. The resident was coded as requiring limited assistance for eating.

A review of the clinical record revealed the following weights: 3/3/2022 - 125.0 pounds,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 79	F 657		

2/3/2022 - 125.9 pounds, 1/4/2022 - 126.4 pounds, 12/30/2021 - 127.4 pounds, 12/16/2021 - 129.0 pounds, and 12/2/2021 - 129.4 pounds.

This reflected a 4.4 pound weight loss in the approximately 90 day period since the resident was admitted and the weight that was obtained on 3/3/22.

Further review of the clinical record revealed a dietary note dated 12/30/21 that documented, "....current weight: 127.4 lbs (pounds), down from weight on admission: 129.4 lbs. BMI (body mass index): 19.4, below healthy range for age. Diet: regular/regular/no added salt. Intake for the past 7 days 52% average....Current diet is appropriate....Supplement in place fortified foods with meals to help meet needs. Intake of meals not always meeting needs at this time. Met with resident in room, Resident stated she has enough to eat. Asked if she would like ice cream with meals, Resident stated "yes, she would like that" Plan: add ice cream to lunch and dinner meals, continue to monitor on weekly wts x 4 weeks."

A dietary quarterly review dated 3/15/22 documented, "....Recent changes in Weight: Yes. Percent weight change in 30 days: 0.0. Percent weight change in 90 days: -3.40. Percent weight change in 180 days: n/a (not applicable)...."

A review of the comprehensive care plan revealed nutritional related care plans for diabetes, anemia, and vitamin B12 deficiency. However, risk of weight loss and related nutritional needs had not been care planned after the resident exhibited a trend of mild weight loss in the first 90 days after admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 80	F 657		

On 3/16/22 at 2:20 PM an interview was conducted with LPN #3, the MDS nurse. She stated that the purpose of the care plan was "To coordinate the resident care, work out a plan of care for that resident." When asked if the care play should be revised if there was a weight loss since admission, she stated that it should be. When asked who is responsible for reviewing and revising the comprehensive care plan for nutritional and weight needs, she stated the dietician should be doing that.

On 3/17/22 at 8:15 AM an interview was conducted with OSM #10 (Other Staff Member) the dietitian. When asked about a care plan related to the resident's weight loss and related nutritional needs, she stated that care plans are a joint effort and nutrition concerns are something the dietician would be involved in. She stated that the resident consumed 50% to 75% most days and 100% on some days. She stated that it would not have triggered a care plan for actual or significant weight loss as it was not a significant weight loss. When asked if, based on the 12/30/21 note wherein the resident was evidencing a trend of mild post admission weight loss, the weight loss should have been added to the care plan, she agreed.

On 3/16/22 at 5:19 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the Director of Nursing, ASM #3 the Assistant Director of Nursing, ASM #4 Administrator of sister facility, and RN #3 (Registered Nurse) Staff Development, were made aware of the findings.

No further information was provided by the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 81	F 657		

5. The facility failed to revise the comprehensive care plan to include bed rails for Resident #101.

Resident #101's most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/2/22, coded the resident as scoring 7 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. The resident was coded as requiring extensive assistance in bed mobility.

A review of Resident #101's care plan dated 2/17/22 revealed no information related to grab bars.

A review of the physical therapy treatment encounter notes dated 3/2/22 which revealed the following, "Bed mobility cue to use bed rail to roll to side."

The resident was observed in bed with one quarter grab bars on 3/15/22 at 12:53 PM. When asked if he used the grab bars, Resident #101 stated, "Yes, I use them on my one side to move a little."

An interview was conducted on 3/16/22 at 2:20 PM with LPN (licensed practical nurse) #3, the MDS coordinator. When asked the purpose of the care plan, LPN #3 stated, "The purpose is to coordinate the resident care, work out a plan of care for that resident. MDS is responsible for the development of the care plan." When asked if grab bars should be included on the care plan, LPN #3 stated, "Yes I believe so. The care plan should be reviewed and revised to include them." When asked why the care plan should include the grab bars, LPN #3 stated, "The care plan should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 82	F 657		

include the grab bars because the resident could have injury with the grab bar and we need to review the care plan and check if they still need them."

An interview was conducted on 3/16/22 at 3:03 PM with LPN #4. When asked if grab bars should be on the care plan, LPN #4 stated, "Yes, they should be on the care plan. Usually under falls."

On 3/16/22 at 5:25 PM, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the administrator at sister facility and RN #3, staff development coordinator were informed of the above concern.

No further information was provided prior to exit.

6. A. The facility failed to revise the comprehensive care plan to include bed rails for Resident #81.

Resident #81's most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 2/16/22, coded the resident as scoring 9 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. The resident was coded as requiring extensive assistance in bed mobility.

A review of Resident #81's care plan dated 2/9/22 revealed no information related to grab bars.

A review of the physical therapy treatment encounter notes dated 2/11/22 which revealed the following, "Using bedrails to roll side to side."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 657	Continued From page 83	F 657		

The resident was observed in bed with one quarter grab bars on 3/16/22 at 7:53 AM. When asked if he used the grab bars, Resident #81 stated, "Yes, I use them to help move and get up."

An interview was conducted on 3/16/22 at 2:20 PM with LPN (licensed practical nurse) #3, the MDS coordinator. When asked the purpose of the care plan, LPN #3 stated, "The purpose is to coordinate the resident care, work out a plan of care for that resident. MDS is responsible for the development of the care plan." When asked if grab bars should be included on the care plan, LPN #3 stated, "Yes I believe so. The care plan should be reviewed and revised to include them." When asked why the care plan should include the grab bars, LPN #3 stated, "The care plan should include the grab bars because the resident could have injury with the grab bar and we need to review the care plan and check if they still need them."

An interview was conducted on 3/16/22 at 3:03 PM with LPN #4. When asked if grab bars should be on the care plan, LPN #4 stated, "Yes, they should be on the care plan. Usually under falls."

On 3/16/22 at 5:25 PM, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, the administrator at sister facility and RN #3, staff development coordinator were informed of the above concern.

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 657	Continued From page 84	F 657		

6. B. The facility failed to revise the comprehensive care plan to include brace for Resident #81.

A review of Resident #81's care plan dated 2/9/22 revealed no information regarding a thoracic lumbar supporting brace.

A review of the physician orders dated 2/9/22, revealed the following, "To wear the thoracic lumber support brace when out of bed. Can apply himself when sitting on side of bed every shift."

The resident was observed wearing his brace on 3/15/22 at 12:55 PM. When asked how often he wears his brace, Resident #81 stated, "I put it on in the morning and keep it on till I go to bed. It helps with my back and posture."

An interview was conducted on 3/16/22 at 2:20 PM with LPN (licensed practical nurse) #3, the MDS coordinator. When asked the purpose of the care plan, LPN #3 stated, "The purpose is to coordinate the resident care, work out a plan of care for that resident. MDS is responsible for the development of the care plan." When asked if a brace should be included on the care plan, LPN #3 stated, "Yes, a brace should be on the care plan."

An interview was conducted on 3/16/22 at 3:03 PM with LPN #4. When asked if a brace should be on the care plan, LPN #4 stated, "Yes, the brace should be on the care plan."

On 3/16/22 at 5:25 PM, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 657	Continued From page 85 #4, the administrator at sister facility and RN #3, staff development coordinator were informed of the above concern. No further information was provided prior to exit.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview and facility document review, it was determined that the facility staff failed to meet professional standards of practice in providing care and services to one of 47 residents in the survey sample, Resident #71. The facility staff failed to completely transcribe a physician order for Resident #71 to include the type of enteral feeding to be administered. The findings include: On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 2/9/2022, the resident was assessed as being severely impaired for making daily decisions. Section K documented Resident #71 as having a feeding tube and receiving 51% or more of their total calories through tube feeding. On 3/15/2022 at approximately 12:45 p.m., an observation of Resident #71 was made in their	F 658	1. Resident #71□s orders were updated on 3/15/22 to include type of enteral feeding to be administered with tube feeding. 2. All residents in the facility have the potential to be affected by this deficient practice. The Unit Managers, MD and/or pharmacist will perform a medication reconciliation of all current resident orders. 3. Education completed with all nursing staff that pass medications on the Medication Administration Policy and 5 Rights of Medication Administration. 4. The Unit Manager/Designee will perform weekly audits of new medication orders to ensure that orders are transcribed accurately and that professional standards of practice are met. The Unit Managers will complete medication pass observation two times weekly on randomly selected nurses on all shifts to ensure medications are	4/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 658	Continued From page 86 room. Resident #71 was observed in bed receiving Glucerna tube feeding at 45 ml/hr (milliliters per hour) via pump. The physician orders for Resident #71 documented in part, "Enteral Feed Order every shift for Nutritional Support Administer 45ml per hr via G-tube (gastrostomy) continuously via pump. Due to dysphagia. Order Date: 03/07/2022." The physician orders failed to evidence the type of enteral feeding to be administered. The comprehensive care plan for Resident #71 documented in part, "The resident requires tube feeding r/t (related to) dysphagia. Date Initiated: 09/03/2020." On 3/16/2022 at 12:15 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that when transcribing orders they verified the frequency, the patient, the medication, the duration and the time. LPN #5 stated that tube feeding orders required the name of the feeding that was ordered to be included. LPN #5 reviewed Resident #71's orders and stated that the order needed to be clarified. LPN #5 stated that the rate of the Glucerna had recently been increased and the feeding type had not changed, however the order should reflect the name of the feeding to be administered. The facility policy "Physician Medication Orders/Transcription" documented in part, "...7. Orders for medications must include: a. Name and strength of the drug;" The policy further documented, "...10. Resident orders must be transcribed accurately as ordered by the prescriber."	F 658	administered according to the 5 Rights of Medication Administration. Weekly audit reports will be presented to the Quality Assurance Improvement Committee (QAPI) monthly for three months to ensure compliance. 5. April 20, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 658	Continued From page 87 On 3/16/2022 at 5:20 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, administrator of a sister facility and RN (registered nurse) #3, staff development were notified of the findings. No further information was provided prior to exit.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services for a pressure injury for two of 47 residents in the survey sample, Residents #39 and #2. The findings included: 1. For Resident #39, the facility staff failed to	F 686	1. Resident #39□s right heel wound began treatment on 3/2/22 and is also being monitored by a Wound Nurse Practitioner weekly. Weekly skin measurements are now in place and being done consistently since 3/2/22. Comprehensive care plan updated with pressure ulcer and interventions to promote healing/decrease further pressure formation/skin breakdown.	4/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 686	Continued From page 88 assess and measure a pressure injury (1) from January 2022 through March 2, 2022. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/6/2022, Resident #39 was coded as having both short and long term memory difficulties and was coded as being severely cognitively impaired for making daily decisions. In Section M, the resident was coded as having no unhealed pressure injuries. The nurse's note dated 12/19/2021 at 3:39 p.m. documented in part, "Resident has non ruptured blister noted to her rt (right) inner heel. Measured 4x4. Elevated heel on pillow. Apply skin prep bid (twice a day) and monitor any change. In house wound consult...No sign and symptoms of verbal or non verbal pain or discomfort noted." The "Weekly Non-Pressure Wound Observation Tool" dated 12/19/2021 at 12:01 p.m. documented in part, "Type of Wound - Other; Location - blister on the right heel, Describe the wound - non punctured blister, no infectious process. Date wound noted: 12/19/2021...Comments: Blister not punctured. Drainage: none. Odor: none. Wound measurements: Length: 2 cm (centimeters), Width: 3 cm, Depth: blank. Describe wound edges and shape: Well defined. Treatment: placed skin prep applied, heels were floated. Evaluation: First observation. Comments: Wound care to treat and evaluate for healing." The "Weekly Skin Review" dated 12/27/2022 documented in part, "Skin Condition: Open area - pre-existing - no site documented." The "Weekly Skin Review" dated 12/30/2021	F 686	Resident #2□s wounds have healed. Care plan updated to reflect skin impairment risks. 2. All residents with skin impairment or risk for skin impairment have a potential to be affected by this deficient practice. The Wound Nurse has completed a skin audit of all residents on 3/22/22. Unit Managers/Designee will audit all current resident□s Weekly Skin Review assessments for accuracy. 3. Education completed with nursing staff on Pressure Injury Surveillance Policy and accurate documentation/reporting and care of wounds. 4. Unit Manager/Designee will complete weekly audits of at least 25% of Weekly Skin Review assessments, Weekly Pressure Wound Observation Tool assessment, and Wound Nurse Practitioner□s documentation. Weekly audit reports will be presented to the monthly Quality Assurance Improvement Committee (QAPI) for three months to ensure compliance. 5. April 20, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 686	Continued From page 89	F 686		

documented in part, "Skin Condition: Open area - pre-existing - no site documented."
The "Weekly Skin Review" dated 1/3/2022 documented in part, "Skin Condition: Open area - pre-existing - no site documented."
The "Weekly Skin Review" dated 1/6/2022 documented in part, "Skin Condition: Open area - pre-existing - no site documented."
The "Weekly Skin Review" dated 1/10/2022 documented in part, "Skin Condition: Open area - pre-existing - no site documented."
The "Weekly Skin Review" dated 1/17/2022 documented in part, "Skin Condition: Open area - pre-existing - RT (right) heel remains."
The "Weekly Skin Review" dated 1/20/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx (treatment) to right heel remains."
The "Weekly Skin Review" dated 1/24/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx continues to right heel."
The "Weekly Skin Review" dated 1/27/2022 documented in part, "Skin Condition: Open area - pre-existing - tx continues to right heel."
The "Weekly Skin Review" dated 1/31/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx in progress to right heel."
The "Weekly Skin Review" dated 2/7/2022 documented in part, "Skin Condition: Open area - pre-existing- Tx in progress to right heel with skin prep."
The "Weekly Skin Review" dated 2/14/2022 documented in part, "Skin Condition: Open area - Pre-existing- no site documented."
The "Weekly Skin Review" dated 2/21/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx continues to right heel with skin prep."
The "Weekly Skin Review" dated 2/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 686	Continued From page 90	F 686		

documented in part, "Skin Condition: Open area - pre-existing - right heel - tx in progress."
The "Weekly Skin Review" dated 3/7/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx in progress to right heel."
The "Weekly Skin Review" dated 3/14/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx in progress to right heel."
On all of the above documents, there were no measurements of the heel wound.

Review of the nurse's note from 1/1/2022 through 3/2/2022 revealed no documentation of the right heel wound measurements.

The physician orders dated 12/19/2021 documented, "Skin prep apply to right inner heel blister bid (twice a day) every day and evening shift." Review of the Treatment Administration Record for December 2021, January 2022, and February 2022, documented the skin prep as having been applied to right inner heel.

The dietician note dated 1/7/2022 documented in part, "Is the resident's skin intact? Yes. Does the resident have a pressure ulcer? No."

The MD (medical doctor) note dated 1/7/2022 documented in part, "Skin: no rashes, lesions, clubbing, cyanosis. No edema."

The MD note dated 1/24/2022 documented in part, "Skin: no rashes, lesions, ulcers."

The MD note dated 2/17/2022 documented in part, "Skin: No rashes, lesions or ulcers."

The NP (nurse practitioner), wound specialist, note dated, 3/2/2022 documented, "Right lateral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 91	F 686		

heels wound...Pressure ulcer of right heel, unstageable. Assessment and Plan: Patient has a pressure injury."

The NP wound specialist note dated 3/2/2022 documented in part, "Opened DTI (deep tissue injury), now devolved into an unstageable pressure wound. Measurements: length - 0.95 cm (centimeters), width - 1.13 cm, depth - 0.2 cm."

The comprehensive care plan dated 12/19/2021, and reviewed on 3/16/2022, documented in part, "Focus: The resident has non rupture blister on right inner heel ...Weekly treatment documentation to include measurement of each are of skin breakdown's width, length, depth, type of tissue and exudate and any other notable change or observations."

On 3/16/2022 at 11:06 a.m. an observation was made of Resident #39's right heel with LPN (licensed practical nurse) #1, the wound care nurse. There was a black necrotic tissue, approximately the size of a dime, on the middle of the area on the right inner heel. The surrounding tissue was pink.

An interview was conducted with LPN #1 on 3/16/2022 at 2:25 p.m. When asked if she was aware of the wound on Resident #39's right inner heel, LPN #1 stated, "In late January." When asked when it was determined to be a deep tissue injury and no longer a blister, LPN #1 stated, "In late January." When asked if there were any measurements of this wound prior to 3/2/2022, LPN #1 stated, "No." When asked why there were no measurements prior to 3/2/2022, LPN #1 stated, "I don't know." LPN #1 further stated the normal process when the nurse tells

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 686	Continued From page 92	F 686		

her about an area is for both of them to go in to look at the area of concern. The unit manager also goes with them to assess the area and put a treatment in place.

An interview was conducted with RN (registered nurse) #5 on 3/16/2022 at 2:29 p.m. When asked if she was trained in wound care, RN #1 stated, "No, but I know a pressure wound." When asked if a blister on the heel qualifies as a pressure injury, RN #1 stated, "It depends on where it is located." When asked about Resident #39's right heel wound on which she discovered a blister on 12/19/2021, RN #1 stated she could not recall that.

An interview was conducted with ASM (administrative staff member) #6, the nurse practitioner wound care specialist, on 3/16/2022 at 2:53 p.m. When asked if a blister on a heel is considered a pressure ulcer, ASM #6 stated "If it's a fluid filled blister, it would be considered a stage 2. If it's open it would still be a stage 2. If it is more than superficial, then it could be a stage 3 or higher." When asked his first observation of Resident #39's right heel, ASM #6 stated, "We did a full house skin sweep on 3/2/2022. It was a DTI (deep tissue injury) on her heel with a small scab." ASM #6 stated he changed the staging to an unstageable area at that time because of the necrotic tissue in the wound. When asked if Resident #39's wound was a pressure wound, ASM #6 stated, "Yes, it's pressure."

The facility policy, "Pressure Injury Surveillance" documented in part, "Policy:
A system of surveillance is utilized for preventing, identifying, reporting, and investigating any new or worsened pressure injuries in the facility. Policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 686	Continued From page 93	F 686		

Explanation and Compliance Guidelines: 1. The Director of Nursing serves as the leader in surveillance activities, maintains/reviews documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee. 2. RNs and LPNs participate in surveillance through Weekly Skin Review, a weekly assessment of residents, and reporting changes in condition to the resident's physicians and management staff, per protocol for notification of changes and in-house reporting of new or worsened pressure injuries...5. Surveillance activities will be monitored facility-wide, and may be broken down by role or unit, depending on the measure being observed. A combination of process and outcome measures will be utilized...7. All pressure injuries will be tracked. A focused review will be completed on pressure injuries that develop or worsen in the facility through the Residents at Risk "Risk" meeting process. Corrective actions will be taken immediately, as needed. 8. Data to be used in the surveillance activities may include, but are not limited to: a. 24 hour shift reports, incident reports, focused incident reviews b. Pressure injury/wound assessments c. Medication and treatment records d. Skills validations for dressing changes, turning/repositioning, perineal care e. Skin assessment data f. Rounding observation data."

ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the director of nursing, ASM #4, the administrator from a sister facility, and RN #3, the staff development nurse, were made aware of the above concerns on 3/16/2022 at 5:30 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 94	F 686		

No further information was provided prior to exit.
2. The facility staff failed to implement care and services for a documented pressure injury for Resident #2.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/23/2022, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section M documented Resident #2 having one Stage 3 pressure ulcer.

On 3/15/2022 at 12:19 p.m., an observation was made of Resident #2 in their room. Resident #2 was observed in bed with her feel elevated on pillows covered with blankets. Resident #2 was observed to have an air mattress in place.

The wound evaluation note dated 3/2/2022 documented in part, "Left lateral leg, Length: 1.36 cm (centimeter), Width: 0.80 cm, Depth: 0.00 cm...Date Wound Acquired: 3/2/22; Nonblanchable erythema (redness) surrounding a subcentimeter site of desquamation. Zinc oxide paste to wound and peri-wound Q (every) shift. Wound status: New; Acquired in house? Yes; Etiology: Pressure Ulcer- Stage 2..."

The progress notes for Resident #2 documented in part, "3/2/2022 12:14 (12:14 p.m.) Skin/Wound Note. ...Chief Complaint: comprehensive skin and wound evaluation...Wound plan of care: Recurrent stage 3 pressure injury to sacrum and stage 2 pressure injury to lateral left lower leg. Please see TA (tissue analytics) for detailed description and treatment recommendations...Wound rounds completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 686	Continued From page 95	F 686		

and reconciled with wound nurse today..."

The physician orders for Resident #2 failed to evidence orders for treatment to the left lateral leg.

The eTAR (electronic treatment administration record) and eMAR (electronic medication administration record) for Resident #2 dated 3/1/2022-3/31/2022 failed to evidence documentation of a treatment to the left lateral leg.

The comprehensive care plan for Resident #2 failed to evidence a care plan regarding pressure injuries.

On 3/16/2022 at 10:35 a.m., an observation of Resident #2 was made with LPN (licensed practical nurse) #1, wound care. Resident #2 was observed to have no open areas to the left lateral leg during the observation.

On 3/16/2022 at 10:45 a.m., an interview was conducted with LPN #1. LPN #1 stated that the wound nurse practitioner was new at the facility and had conducted a whole house skin assessment on 3/2/2022. LPN #1 stated that the process was for them to go with the wound nurse practitioner and enter any new treatment orders and notes at the time of the assessment, however the notes were sometimes entered after the assessment. LPN #1 stated that Resident #2 should have had the order for Zinc oxide entered on 3/2/2022, as documented by the wound nurse practitioner. She stated the order was never put into place. LPN #1 stated that they needed to have an order entered into the medical record for Zinc oxide because it was a medication and had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 686	Continued From page 96 to be applied by the nursing staff. LPN #1 stated that the nursing assistants were only allowed to apply barrier cream. LPN #1 stated that Resident #2 was at high risk for pressure injury due to being very thin and the history of recurring pressure injuries. On 3/16/2022 at 12:15 p.m., an interview was conducted with LPN #5. LPN #5 stated that Resident #2 received barrier cream to the sacral area after receiving incontinence care but was not aware of any treatment orders for a pressure injury. LPN #5 stated that zinc required a physician order because it was a medication. LPN #5 stated that the nurses applied zinc when it was ordered and documented the application on the eTAR. The facility policy "Pressure Injury Surveillance" documented in part, "...All pressure injuries will be tracked. A focused review will be completed on pressure injuries that develop or worsen in the facility through the Resident at Risk "Risk" meeting process. Corrective actions will be taken immediately, as needed..." On 3/16/2022 at 5:20 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, administrator of a sister facility and RN (registered nurse) #3, staff development were notified of the findings. No further information was provided prior to exit.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		4/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 689	Continued From page 97 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to implement interventions to prevent injury from a fall for one of 47 residents in the survey sample, Resident # 28. The facility staff failed to place a fall mat on the floor next to Resident # 28's bed when they are were in bed. The findings include: Resident # 28 was admitted to the facility with a diagnosis that included but was not limited to: muscle weakness and a history of falls. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 12/30/2021, the resident scored 4 (four) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. On the following dates a times, Resident #28 was observed to bed, with no fall mat in place on the floor next to the bed: 03/15/22 at 12:40 p.m, 03/15/22 at 4:55 p.m., 03/16/22 at 8:05 a.m., and 03/16/22 at 12:00 p.m. At each observation, a fall mat was leaning against the wall at the foot of Resident #28's bed. The facility's fall risk assessment titled	F 689	1. Resident # 28 suffered no adverse effect related to this deficient practice. The resident□s fall mat is now placed next to his bed and no longer leaning against the wall at the foot of the resident. 2. All resident at risk for fall have the potential to be affected by this deficient practice. Facility will audit all resident who are at risk for fall to ensure interventions to prevent injury is in place. The audit will include ensuring fall mat orders are implemented including other measures put in place to prevent injury. 3. All Certified Nursing Assistant (C.N. A□s) & Licensed Nurses will be educated by the Director of Staff Development / Designee on the importance of following the facility□s fall prevention policies including implementing fall intervention plan to prevent injury. 4. The facility□s unit managers/ Designee will complete weekly visual audit on all resident who are at risk for fall to ensure the facility is implementing it fall prevention policy. Findings of the facility□s audit of its implementation of interventions to prevent injury will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 689	Continued From page 98	F 689	5. April 20, 2022	

"AHR-MORSE FALL SCALE V2" dated 11/19/2021 for Resident # 28 documented in part, "Low Risk for Falling."

The facility's progress note dated 11/27/2021 for Resident # 28 documented in part, " ...at 6:35 (a.m.) resident was noted on the floor next to bed, full body, neuro [neurological] assessment done while resident lie on the fall, ...[Name of Physician] was notified, case manager was notified, resident was sent to the hospital."

The facility's fall investigation for Resident # 28 dated 11/27/2021 documented in part, "Resident c/o (complaint of) chest pain bout 6:30 am. (a.m.). Chest pain protocol initiated - O2, (oxygen), 3 (three) doses of Nitro, Aspirin given in am (a.m.). Unresolved. Resident rolled out of bed inspite [sic] of being placed at the middle and low bed position. No injuries sustained."

The comprehensive care plan for Resident # 28 with a revision date of 11/27/2021 documented in part, "Focus: The resident has had an actual fall related to sudden chest pains, dizziness, and shortness of breath. Date Initiated: 11/27/2021. Revision on: 11/29/2021 ...Safety fall protocol in place- ...fall mats in place... Date Initiated: 11/27/2021. Revision on: 11/29/2021."

On 03/16/2022 at approximately 12:10 p.m. an interview and observation of Resident # 28's room was conducted with CNA [certified nursing assistant] # 1. When asked if Resident # 28 needed a fall mat next to their bed, CNA # 1 stated, "Yes. He is a fall risk." After entering Resident # 28's room, CNA # 1 reached for the fall mat leaning against the wall at the foot of Resident # 28's bed. When asked if the fall mat

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 689	Continued From page 99	F 689		

should be on the floor next to the bed CNA # 1 stated, "Yes," and placed the mat on the floor next to the bed. When asked who was responsible for placing the fall mat on the floor, CNA # 1 stated, "The CNA or the nurse."

On 03/16/2022 at approximately 12:20 p.m. an interview was conducted with LPN [licensed practical nurse] # 2. When asked if Resident # 28 needed a fall mat next to their bed LPN # 2 stated, "No because he's not a fall risk." After LPN # 2 reviewed the comprehensive care plan dated 11/27/2021, LPN # 2 was asked again if Resident # 28 needed a fall mat. LPN # 2 stated, "Yes, it should be down next to his bed."

On 03/16/2022 at approximately 12:25 p.m., an interview was conducted with RN [registered nurse] # 2, unit manager. When asked if a fall mat should be on the floor next to Resident # 28's bed when they are in bed RN # 2 stated, "Yes." When informed of the above observations RN # 2 stated, "It should have been in place."

The facility's policy "FALLS/FALL WITH INJURY PREVENTION" documented in part, "POLICY STATEMENT: It is the policy of the facility to provide a safe environment for our residents. The facility's Fall Prevention initiative will provide strategies in attempt to decrease the number of falls and minimizes falls with injury. This policy will assure proper assessment and documentation of potential risk for falls, actual occurrence of falls and interventions to prevent future occurrences."

On 03/16/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, ASM # 3, assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 689	Continued From page 100 director of nursing, ASM # 4, administrator from sister facility and RN # 4, staff development, were made aware of the findings. No further information was provided prior to exit.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide respiratory care and services to two of 47 residents in the survey sample, Residents #2 and #315. The findings include: 1. The facility staff failed to provide oxygen at the prescribed rate for Resident #2. Resident #2 was admitted to the facility with diagnoses that included but were not limited to acute respiratory failure with hypoxia and heart failure. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/23/2022, the resident scored 13 out of 15 on the BIMS (brief	F 695	1. Resident # 2 suffered no adverse effect related to this deficient practice. Resident # 2 oxygen had been provided at the prescribed rate while ensuring the flow meter is centered on the line next to the prescribed number. Resident # 315 suffered no adverse effect related to this deficient practice. The physician was contacted on 03/16/2022 and indicated that the resident no longer needs the incentive spirometer, so no order was given. Since no order was given for incentive spirometer, there is no need to store the incentive spirometer in a sanitary manner. 2. All residents who have order for oxygen use are at risk for this deficient practice. The facility will audit all residents who have order for use of oxygen to ensure it	4/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 695	Continued From page 101	F 695		

interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section O failed to evidence oxygen use.

On 3/15/2022 at 12:19 p.m., an observation was made of Resident #2 in their room. Resident #2 was observed receiving oxygen via a nasal cannula attached to an oxygen concentrator. At this time an interview was conducted with Resident #2 who stated that they wore the oxygen all the time and had used oxygen for "a long time." The top of the flowmeter ball was observed to be set below the line for 1 lpm (liter per minute).

Additional observations of Resident #2 on 3/15/2022 at 2:48 p.m., and 4:25 p.m., and on 3/16/2022 at 8:05 a.m. revealed the findings as described above.

The physician orders for Resident #2 documented in part, "Oxygen at 1 liter per min (minute) via nasal cannula to maintain sats (saturations) above 92%. Order Date: 8/16/2021."

The comprehensive care plan for Resident #2 failed to evidence use of oxygen.

On 3/16/2022 at 12:15 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated Resident #2 received 1 liter of oxygen. LPN #5 stated that the oxygen flow rate was set by placing the top of the flowmeter ball at the line of the prescribed rate. LPN #5 observed Resident #2's oxygen with the top of the flowmeter ball set below the line for 1 lpm and stated that this was how they were trained to set

is provided at the prescribed rate and the flow meter ball is centered on the line next to the prescribed number of flow rate.
All residents admitted from the hospital have the potential to be affected by this deficient practice as well as all residents who use the incentive spirometer have the potential to have it stored in a manner that is not sanitary. The facility will audit all new admissions in the last two weeks to ensure they have physician orders for the use of incentive spirometer if deemed appropriate. The facility will complete an audit for all residents using incentive spirometers to ensure they are stored in a sanitary manner by providing a bag or another item to cover the month piece on the incentive spirometer.
3. All licensed / Registered nurses will be educated by the Director of Staff Development / Designee on the importance of providing residents oxygen at the prescribed rate while ensuring the flow meter is centered on the line next to the prescribed number.
The facility□s Director of Staff Development/Designee will provide education to all licensed and registered nurses on the importance of ensuring all new admissions who are appropriate have orders for the use of incentive spirometer. The education will also include the importance of ensuring incentive spirometers are stored in a sanitary manner by providing a bag or another item to cover the month piece on the incentive spirometer is provided.
4. The facility□s unit managers/ Designee will complete weekly audit on all resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 695	Continued From page 102 the oxygen. On 3/16/2022 at approximately 5:15 p.m., RN (registered nurse) #3, staff development, ASM (administrative staff member) #2, the director of nursing and ASM #3, the assistant director of nursing were asked the process for setting the flowmeter ball on the oxygen concentrator. RN #3 stated that the line corresponding to the prescribed oxygen rate should go through the flowmeter ball to deliver the prescribed rate. The manufacturer's instructions for use provided by the facility for Resident #2's concentrator documented in part, "...2. Check the flow meter to make sure that the flow meter ball is centered on the line next to the prescribed number of your flow rate..." The facility policy, "Oxygen Concentrator/Oxygen Utilization" documented in part, "...Oxygen will be administered to the resident per order..." On 3/16/2022 at 5:20 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, administrator of a sister facility and RN (registered nurse) #3, staff development were notified of the findings. No further information was provided prior to exit. 2. The facility staff failed to obtain a physician's order for Resident #315's use of an incentive spirometer, and failed to store the incentive spirometer in a sanitary manner. Resident #315 was admitted to the facility with diagnoses including a heart attack. Resident	F 695	on oxygen to ensuring residents are provided oxygen at the prescribed rate and the flow meter ball is centered on the line next to the prescribed number. The facility□s unit managers/designee will complete a weekly audit of all new admissions to ensure all residents who are appropriate for incentive spirometer orders have it in place. A visual audit will be completed twice weekly to ensure all residents using incentive spirometer have it stored in a sanitary manner by providing a bag or another item to cover the mouthpiece. Findings of the weekly and bi-weekly audit will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance. 5. April 20, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 103	F 695		

#315's admission minimum data set was not completed. An admission assessment dated 3/7/22 documented Resident #315 was alert and oriented to person, place, time and situation.

Review of Resident #315's March 2022 physician's orders failed to reveal a physician's order for an incentive spirometer. Resident #315's baseline care plan initiated on 3/7/22 failed to reveal documentation regarding an incentive spirometer.

On 3/15/22 at 1:15 p.m., Resident #315 was observed sitting in a chair in the bedroom. An incentive spirometer was on the resident's over bed table. The incentive spirometer mouth piece was uncovered and exposed to air. At this time, an interview was conducted with the resident. Resident #315 stated, "They told me to inhale 10 times." The resident did not specify who "they" were. When asked if the facility staff had provided a bag or another item to cover the mouth piece on the incentive spirometer, the resident stated they had not. On 3/16/22 at 8:34 a.m., the incentive spirometer remained uncovered and exposed to air on Resident #315's over bed table.

On 3/16/22 at 2:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated residents should have a physician's order for an incentive spirometer. LPN #4 stated nurses must have orders from doctors. LPN #4 stated nurses can't just guess and need to obtain orders. When asked how an incentive spirometer should be stored, LPN #4 stated he had not cared for a patient with an incentive spirometer in a long time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 695	Continued From page 104 On 3/16/22 at 3:37 p.m., an interview was conducted with RN (registered nurse) #1, regarding the storage on an incentive spirometer. RN #1 stated normally the nurses make sure it is dry, then places it in a zip lock bag to prevent infection. On 3/16/22 at approximately 5:50 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concerns. The facility policy titled, "USE OF INCENTIVE SPIROMETER" documented, "1. Get a physician's order prior to use...4. Ensure device is clean and kept in a sanitary manner." No further information was presented prior to exit.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement a complete pain management program by implementing non-pharmacological interventions prior to the administration of a prn (as needed) pain medications for one of 47 residents in the survey sample, Residents # 56.	F 697	1. Resident # 56 suffered no adverse effect related to this deficient practice. The facility cannot retroactively correct this deficient practice for resident #56. 2. All residents who are on pain medications have the potential to be affected by this deficient practice. The facility will audit for all residents who are	4/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 697	Continued From page 105 The findings include: The facility staff failed to implement non-pharmacological interventions prior to the administration of oxycodone-acetaminophen (1) to Resident #56. Resident # 56 was admitted to the facility with a diagnosis that included by not limited to chronic pain. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/27/2022, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section J coded Resident # 56 as not having any pain in the past 5 (five) days. The physician's order sheet for Resident # 35 dated February 2022 documented in part: "Oxycodone-Acetaminophen 10-325 MG (milligram) Tablet. Give one tablet by mouth twice daily as needed. Order Date: 04/23/2021." Resident #56's eMAR (electronic medication administration record) for March 2022 documented the administration of the Oxycodone-Acetaminophen as documented above on the following dates and times, with no evidence of non-pharmacological interventions being attempted: 03/01/2022 at 4:31 p.m., 03/02/2022 at 7:23 a.m., 03/03/2022 at 4:54 p.m., 03/04/2022 at 5:42 p.m., 03/07/2022 at 7:00 p.m., 03/09/2022 at 9:19 p.m., 03/13/2022 at 5:22 a.m. and on 03/15/2022 at 4:44 p.m. The comprehensive care plan for Resident # 56 dated 04/29/2021 failed to evidence information	F 697	on pain medications to ensure non-pharmacology intervention are implemented prior to the administration of pain medications. 3. All licensed / Registered nurses will be educated by the Director of Staff Development / Designee on the importance of implementing and documenting in the clinical record non -pharmacological interventions prior to the administration of as needed pain medication. 4. The facility□s unit managers/ Designee will complete weekly audit on all residents on pain medications to ensure non-pharmacology intervention are implemented prior to the administration of pain medication. Findings of the facility weekly audit will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance. 5. April 20, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 697	Continued From page 106	F 697		

related to pain.

On 03/17/22 at approximately 10:52 a.m., an interview was conducted with Resident # 56. When asked if they receive pain medication as needed Resident # 56 stated, "Sometimes." When asked if the staff try to alleviate their pain before giving them pain medication Resident # 56 stated "Sometimes."

On 03/16/2022 at approximately 1:55 p.m. an interview was conducted with LPN (licensed practical nurse) # 2 regarding the procedure for administering prn (as needed) pain medication and documentation of non-pharmacological interventions. LPN # 2 stated, "Assess the resident's pain, where the pain is and using a scale one to ten, with ten being the worse pain. Attempt interventions, like repositioning, to alleviate their pain, if it doesn't work administer the pain medication and recheck the resident for effectiveness." When asked how often the non-pharmacological interventions should be attempted LPN # 2 stated, "Before you give the medication, every time." When asked about where the non-pharmacological interventions should be documented, LPN # 2 stated, "It's documented in the nurse's notes." After reviewing the physician's orders, the March 2022 eMAR and the nurse's progress notes dated 03/01/2022 through 03/15/2022 for Resident # 56, LPN # 2 was asked if there was documentation that non-pharmacological interventions were attempted prior to Resident # 56 receiving the physician ordered pain medication of oxycodone on the dates listed above. LPN # 2 stated, "No."

The facility's policy "Policy on Pain Management"

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F 697	Continued From page 107 documented in part, "POLICY STATEMENT: It is the policy of the facility to ensure that our residents are comfortable and free of pain as possible. Pain Management: Provide non pharmacological approach as needed or as requested by the resident." On 03/16/2022 at approximately 5:00 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, assistant director of nursing, ASM # 4, administrator from sister facility and RN # 4, staff development, were made aware of the findings. No further information was provided prior to exit. References: (1) Indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=f2137f1a-b49a-40bd-97ac-cd6b36e295f4.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to	F 698	1. Resident # 44 suffered no adverse effect related to this deficient practice. The deficient practice for resident #44	4/20/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 698	Continued From page 108	F 698		

communicate consistently with the dialysis center for one of 47 residents in the survey sample, Resident #44. For Resident #44, the facility staff failed to evidence consistent communication via the dialysis communication book on multiple dates in 2022.

The findings include:

Resident #44 was admit to the facility on 4/5/2019 with a diagnosis of end stage renal failure requiring hemodialysis. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/11/2022, the resident scored a 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions. In Section O, Resident #74 was coded as receiving dialysis while a resident at the facility.

The physician order dated 10/3/2020 documented, "Dialysis Services [address of dialysis center] on Monday, Wednesday and Friday at 11:00 a.m."

An interview was conducted with Resident #44 on 3/15/2022 at 2:08 p.m. When asked if she takes anything with her to dialysis, Resident #44 stated she takes a book with her to dialysis. She stated the book is kept at the nurse's station.

On 3/16/2022 at 8:15 a.m. Resident #44's dialysis book was reviewed. There was only one page in the book; the page was dated 3/11/2022. The clinical record was reviewed for the months of January 2022 through March 15, 2022. The following dates were not located in the clinical record: 1/17/2022, 1/19/2022, 1/21/2022,

cannot be retroactively corrected as the dialysis dates in question have pasted. The facility cannot create dialysis communication for the multiple missed communication days.
2. All residents on dialysis have the potential to be affected by this deficient practice. The facility will complete an audit to ensure all dialysis residents have dialysis communication book in place to ensure consistent communication with the dialysis center.
3. All licensed / Registered nurses will be educated by the Director of Staff Development / Designee on the importance of ensuring consistent communication with the Dialysis Centre via the dialysis communication form.
4. The facility□s unit managers/ Designee will complete weekly audit on all residents on dialysis to ensure dialysis residents have dialysis communication book in place and dialysis log form completed consistently for communication with the dialysis center. Findings of the weekly audit on all dialysis resident□s communication book and communication form with the dialysis center will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance.
5. April 20, 2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 698	Continued From page 109	F 698		

1/24/2022, 1/26/2022, 1/28/2022, 1/31/2022, 2/1/2022, 2/7/2022, and 2/21/2022.

A request was made on 3/16/2022 at 3:29 p.m. for the missing dates above.

On 3/17/2022 at 8:00 a.m. the following dates of documentation of communication with the dialysis facility was provided: 1/17/2022, 1/19/2022, 1/21/2022, 1/24/2022 and 2/21/2022.

Still missing were the following dates: 1/26/2022, 1/28/2022, 1/31/2022, 2/1/2022, and 2/7/2022.

The nurse's notes dated 1/26/2022 at 8:37 p.m. documented in part, "Resident returned from dialysis." The nurse's note dated 1/28/2022 at 10:49 p.m. documented in part, "Resident returned from dialysis." The nurse's note dated 1/31/2022 at 10:14 p.m. documented in part, "Resident returned from dialysis." The nurse's note dated 2/1/2022 at 5:11 p.m. documented in part, "Resident returned from dialysis." The nurse's note dated, 2/7/2022 at 4:59 p.m. documented in part, "Resident returned from dialysis."

The comprehensive care plan dated, 9/28/2020 and revised on 3/15/2022, documented in part, "Focus: [Resident #74] has renal failure r/t (related to) End Stage Renal Disease/need for dialysis ...Resident goes to Dialysis [name of dialysis center] 3 times a week on Mondays/Wednesdays and Fridays."

An interview was conducted with LPN (licensed practical nurse) #5 on 3/16/2022 at 12:58 p.m. When asked the process for when a resident is sent to dialysis, LPN #5 stated, "When we come

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	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 698	Continued From page 110	F 698		

in the morning that [Resident #44] goes to dialysis, we fill in the paper in the book and send the book with her." When asked if a new sheet is completed each time the resident goes to the dialysis center, LPN #5 stated, "Yes, every time she goes to dialysis." LPN #5 further stated when the resident returns, the nurse has to check the book on a daily basis as sometimes the dialysis center will write recommendations. LPN #5 stated that sometimes the resident accidentally leaves the book at dialysis, so they have a second book to use, just in case. LPN #5 checked the second book and there were no communication papers in it.

The facility policy, "Coordination of Hemodialysis Services" documented, "Policy: Residents requiring an outside ESRD facility will have services coordinated by the facility. There will be communication between the facility and the ESRD facility regarding the resident. The facility will establish a Dialysis Agreement/Arrangement if there are any residents requiring Dialysis Services. The agreement shall include how the residents care is to be managed. Procedure: 1. The Dialysis Communication form will be initiated by the facility for any resident going to an ESRD center for hemodialysis. 2. Nursing will collect and complete the information regarding the resident to send to the ESRD Center. 3. The ESRD facility is to review the Dialysis Communication form and either: a. Complete the communication form and return with the resident OR b. Provide treatment information to the facility 4. Upon the resident's return to the facility, nursing will review the Dialysis Communication form and information completed by the dialysis center OR the information sent by the dialysis center; communicate with the resident's physician

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	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 698	Continued From page 111 and other ancillary departments as needed, implement interventions as appropriate. 5. Nursing will complete the post dialysis information on the Dialysis Communication form and file the completed form in the Resident's Clinical record." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, ASM #4, administrator from a sister facility and RN (registered nurse) #3, the staff development nurse, were made aware of the above concern on 3/17/2022 at 9:29 a.m. No further information was provided prior to exit.	F 698		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain one of three of the facility dumpsters in a sanitary manner. A trash bag approximately half full of trash was hanging on the outside of the dumpster and approximately twelve pairs of used plastic gloves and numerous pieces of debris were found lying on the ground around and behind the facility's dumpster. The findings include: On 03/15/22 at approximately 11:50 a.m., an observation of the facility's dumpsters was	F 814	1. No resident was affected by this deficient practice. However, on 3/16/22 after the facility was notified of this deficient practice the facility□s Department of Environmental Services ensured the affected dumpster was maintained in a sanitary manner. 2. All three of the facility□s dumpster and its surroundings have the potential to be affected by this deficient practice. On 3/16/22, the Department of Environmental Services ensured all three dumpsters were maintained in a sanitary manner. 3. The Director of Environmental Services/Designee will educate all Environmental Services Staff on the	4/20/22

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	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 814	Continued From page 112 conducted with OSM (other staff member) # 1, dietary manager, OSM # 2, director of maintenance, OSM # 3, director of housekeeping and OSM # 4, housekeeper. The observation revealed that the facility had two trash dumpsters and one cardboard recycling dumpster and one dumpster for trash, next to each other located behind the facility. Observations of the area between and behind the two dumpsters revealed a broken mop handle between the two dumpsters, approximately 12 pairs of used plastic gloves, and numerous pieces of trash - behind the two dumpsters, mixed in and lying on top of decaying leaves and pine needles. Further observation revealed a trash bag, approximately half full of trash, hanging on the outside of the dumpster. When asked who was responsible for ensuring the dumpster area was kept clean, OSM # 2 stated, "We call the company to come and empty the dumpsters and housekeeping is responsible for cleaning up around the dumpsters. The dumpsters were emptied this morning." When asked how often the dumpster area was cleaned and checked OSM # 3 stated, "Every morning." When asked about the trash observed on the ground around the dumpsters OSM # 3 stated, "[Name of OSM # 4] is responsible for cleaning up around the dumpster." OSM # 4 was asked how often they clean up around the dumpster, OSM # 4 stated, "Every morning." When asked if they had come out to clean up around the dumpsters after they were emptied earlier that morning, OSM # 4 stated, "No I was going to come out this afternoon." When asked why it was important to keep the dumpster areas clean and free from debris, OSM # 3 stated, "For sanitary purposes, prevent rats and mice from	F 814	importance of ensuring that the dumpster areas are maintained in a sanitary manner. This education will also include the importance of following the facility□s policy on External Environmental Cleaning by ensuring facility□s environment is maintained in a safe and orderly manner. 4. The Director of Environmental Services/Designee will perform a visual random audit two times weekly for 12 weeks of the facility□s dumpster areas before and after garbage pick up to ensure its surrounding are maintained in a safe and sanitary manner. Findings of the random visual audits completed twice weekly will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance. 5. April 20, 2022.	

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F 814	Continued From page 113 coming around." The facility's policy "External Environmental Cleaning" documented in part, "5. Areas around the buildings (i.e., sidewalks, patios, gardens, dumpster area, etc.) shall be always maintained in a safe and orderly manner." On 03/16/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing, ASM # 3, assistant director of nursing, ASM # 4, administrator from sister facility and RN # 4, staff development, were made aware of the findings. No further information was provided prior to exit.	F 814		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		4/20/22

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	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 842	Continued From page 114 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening	F 842		

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F 842	Continued From page 115 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain a complete and accurate clinical record for one of 47 residents in the survey sample, Resident #39. For Resident #39, the facility staff failed to document any notes related to a pressure injury from the end of January 2022 until March 2, 2022. The findings include: Resident #39 was admitted to the facility on 6/29/2022. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/6/2022, the resident was coded as having both short and long term memory difficulties and was coded as being severely cognitively impaired for making daily decisions. In Section M, the resident was coded as having no unhealed pressure injuries. The nurse's note dated 12/19/2021 at 3:39 p.m. documented in part, "Resident has non ruptured blister noted to her rt (right) inner heel. Measured 4x4. Elevated heel on pillow. Apply skin prep bid (twice a day) and monitor any change. In house wound consult...No sign and symptoms of verbal or non verbal pain or discomfort noted." The "Weekly Non-Pressure Wound Observation	F 842	1. The facility cannot retroactively document pressure injury notes for resident #39 from the period of January 2022 until March 2. The facility□s wound Nurse Practitioner (NP) assessed resident #39 pressure injury on 03/02/2022. The wound NP or facility wound nurse will continue weekly assessment thereafter until resolved. 2. All residents with pressure injury are at potential risk for this deficient practice. The facility□s wound nurse or designee will audit all residents with pressure injuries to ensure the facility is maintaining a complete and accurate clinical record with a minimum of weekly documentation on resident□s pressure injury status. 3. The facility□s Director of Nursing/Designee will educate the facility□s wound nurse on the importance of maintaining a complete and accurate clinical record. This education will also include ensuring all residents with pressure injury having at minimum weekly progress notes on status of their pressure injury. 4. The Wound Nurse/Designee will complete clinical records audit for all residents with pressure injury to ensure weekly progress notes on pressure injury status is in place. This weekly audit will	

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AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 842	Continued From page 116 Tool" dated 12/19/2021 at 12:01 p.m. documented in part, "Type of Wound - Other; Location - blister on the right heel, Describe the wound - non punctured blister, no infectious process. Date wound noted: 12/19/2021...Comments: Blister not punctured. Drainage: none. Odor: none. Wound measurements: Length: 2 cm (centimeters), Width: 3 cm, Depth: blank. Describe wound edges and shape: Well defined. Treatment: placed skin prep applied, heels were floated. Evaluation: First observation. Comments: Wound care to treat and evaluate for healing." Review of the nurse's note from 1/1/2022 through 3/2/2022 revealed no documentation of the right heel wound measurements. The "Weekly Skin Review" dated 12/27/2022 documented in part, "Skin Condition: Open area - pre-existing - no site documented." The "Weekly Skin Review" dated 12/30/2021 documented in part, "Skin Condition: Open area - pre-existing - no site documented." The "Weekly Skin Review" dated 1/3/2022 documented in part, "Skin Condition: Open area - pre-existing - no site documented." The "Weekly Skin Review" dated 1/6/2022 documented in part, "Skin Condition: Open area - pre-existing - no site documented." The "Weekly Skin Review" dated 1/10/2022 documented in part, "Skin Condition: Open area - pre-existing - no site documented." The "Weekly Skin Review" dated 1/17/2022 documented in part, "Skin Condition: Open area - pre-existing - RT (right) heel remains." The "Weekly Skin Review" dated 1/20/2022 documented in part, "Skin Condition: Open area	F 842	ensure a complete and accurate clinical record. Findings of the weekly audits will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance. 5. April 20, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 117 - pre-existing - Tx (treatment) to right heel remains." The "Weekly Skin Review" dated 1/24/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx continues to right heel." The "Weekly Skin Review" dated 1/27/2022 documented in part, "Skin Condition: Open area - pre-existing - tx continues to right heel." The "Weekly Skin Review" dated 1/31/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx in progress to right heel." The "Weekly Skin Review" dated 2/7/2022 documented in part, "Skin Condition: Open area - pre-existing- Tx in progress to right heel with skin prep." The "Weekly Skin Review" dated 2/14/2022 documented in part, "Skin Condition: Open area - Pre-existing- no site documented." The "Weekly Skin Review" dated 2/21/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx continues to right heel with skin prep." The "Weekly Skin Review" dated 2/28/2022 documented in part, "Skin Condition: Open area - pre-existing - right heel - tx in progress." The "Weekly Skin Review" dated 3/7/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx in progress to right heel." The "Weekly Skin Review" dated 3/14/2022 documented in part, "Skin Condition: Open area - pre-existing - Tx in progress to right heel." On all of the above documents, there were no measurements of the heel wound. The physician orders dated 12/19/2021 documented, "Skin prep apply to right inner heel blister bid (twice a day) every day and evening shift." Review of the Treatment Administration	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 842	Continued From page 118	F 842		

Record for December 2021, January 2022, and February 2022, documented the skin prep as having been applied to right inner heel.

The MD (medical doctor) note dated 1/7/2022 documented in part, "Skin: no rashes, lesions, clubbing, cyanosis. No edema."

The MD note dated 1/24/2022 documented in part, "Skin: no rashes, lesions, ulcers."

The MD note dated 2/17/2022 documented in part, "Skin: No rashes, lesions or ulcers."

The NP (nurse practitioner), wound specialist, note dated, 3/2/2022 documented, "Right lateral heels wound...Pressure ulcer of right heel, unstageable. Assessment and Plan: Patient has a pressure injury."

The NP wound specialist note dated 3/2/2022 documented in part, "Opened DTI (deep tissue injury), now devolved into an unstageable pressure wound. Measurements: length - 0.95 cm (centimeters), width - 1.13 cm, depth - 0.2 cm."

The comprehensive care plan dated, 12/19/2021 and reviewed on 3/16/2022, documented in part, "Focus: The resident has non rupture blister on right inner heel ...Weekly treatment documentation to include measurement of each are of skin breakdown's width, length, depth, type of tissue and exudate and any other notable change or observations."

An interview was conducted with LPN #1 on 3/16/2022 at 2:25 p.m. When asked if she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 842	Continued From page 119	F 842		

aware of the wound on Resident #39's right inner heel, LPN #1 stated, "In late January." When asked when it was determined to be a deep tissue injury and no longer a blister, LPN #1 stated, "In late January." When asked if there were any measurements of this wound prior to 3/2/2022, LPN #1 stated, "No." When asked why there were no measurements prior to 3/2/2022, LPN #1 stated, "I don't know." LPN #1 further stated the normal process when the nurse tells her about an area is for both of them to go in to look at the area of concern. The unit manager also goes with them to assess the area and put a treatment in place.

An interview was conducted with ASM (administrative staff member) #6, the nurse practitioner wound care specialist, on 3/16/2022 at 2:53 p.m. When asked if a blister on a heel is considered a pressure ulcer, ASM #6 stated "If it's a fluid filled blister, it would be considered a stage 2. If it's open it would still be a stage 2. If it is more than superficial, then it could be a stage 3 or higher." When asked his first observation of Resident #39's right heel, ASM #6 stated, "We did a full house skin sweep on 3/2/2022. It was a DTI (deep tissue injury) on her heel with a small scab." ASM #6 stated he changed the staging to an unstageable area at that time because of the necrotic tissue in the wound. When asked if Resident #39's wound was a pressure wound, ASM #6 stated, "Yes, it's pressure."

A second interview was conducted with LPN #1 on 3/16/2022 at 3:16 p.m. When asked if she wrote a note when she was made aware of the wound, LPN #1 stated, "No I didn't do a wound note." When asked what the wound looked like when she saw it in late January, LPN #1 stated it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 120	F 842		

was a DTI. LPN #1 stated, "I requested the boot on her foot and offloading. When I reviewed the record at that time I saw there was already an order for skin prep in place." LPN #1 further stated, "We use a camera to measure the wounds." When asked if she took a picture in January of the wound, LPN #1 stated, "No, my ID (identification) doesn't work." When asked if she measured the wound from late January until March 2, 2022, LPN #1 stated, "No." When asked if she saw the wound on Resident #39's heel from January through March, LPN #1 stated, "Yes." When asked if she saw the wound but did not write a note, LPN #1 stated it was correct. When asked if she had the equipment to measure wounds when the camera is not working, or her access to the camera is not working, LPN #1 stated, "Yes." LPN #1 stated the wound was "Shrinking."

A copy of the policy on a complete and accurate clinical record was requested on 3/16/2022 at 5:30 p.m. No policy was received.

The following quotation is found in Lippincott's Fundamentals of Nursing 5th edition (2007, page 237): "The client record serves as a legal document of the client's health status and care received .....Because nurses and other healthcare team members cannot remember specific assessments or interventions involving a client years after the fact, accurate and complete documentation at the time of care is essential. The care may have been excellent, but the documentation must prove it."

ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the director of nursing, ASM #4, the administrator from a sister facility, and RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 842	Continued From page 121 #3, the staff development nurse, were made aware of the above concerns on 3/16/2022 at 5:30 p.m. No further information was provided prior to exit.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		4/20/22

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	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 880	Continued From page 122 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to administer medication in a sanitary manner for 1	F 880	1. Resident #35 suffered no adverse effect related to this deficient practice. Resident #35 was assessed by a Registered Nurse on 03/30/2021 to	

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	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 880	Continued From page 123 of 6 residents in the Medication Administration observation, Resident #35. The facility nurse administered a medication which had been handled in an unsanitary manner to Resident #35. The findings include: Resident #35 was admitted to the facility with diagnoses including alcohol abuse and alcohol related hepatitis. On the most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 3/7/22, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. A review of the clinical record revealed a physician's order dated 9/1/20 for "Vitamin B1 (Thiamine) (1) 50 mg (milligrams)..." On 3/16/22 at 8:17 AM, LPN #9 (Licensed Practical Nurse) was observed to prepare and administer medications for Resident #35. One of the medications prepared and administered was Vitamin B1 (Thiamine). LPN #9 donned gloves, and picked up the unsanitized pill cutter and the unsanitized stock bottle of Vitamin B1, thus contaminating her gloves. She poured a 100 mg pill of Vitamin B1 onto the pill cutter. She then used her contaminated, gloved finger to position the pill on the pill cutter. After cutting the pill in half, she dumped both halves from the pill cutter into the palm of her contaminated, gloved hand. She then picked up one half of the pill with her other contaminated, gloved hand, and placed it in the pill cup to administer to the resident. She	F 880	identify any possible effects related to been administered a contaminated pill. LPN #9 will be educated on the importance of ensuring medications are administered in a sanitary manner. LPN #9 will also be educated on the importance of following the facility□s Medication Pass & Administration Policy. 2. All residents who LPN # 9 administers medication to have the potential to be affected by this deficient practice. Facility will assess all residents on Cardinal 1 Unit which is the primary assignment for LPN # 9 to ensure they have no adverse effect to any potential unsanitary medication pass. The remaining stock pill bottle of Vitamin B1 which LPN #9 placed the other half of contaminated pill was discarded immediately and a new Vitamin B1 bottle was ordered. 3. All licensed/Registered nurses who complete medication pass will be educated by the Director of Staff Development/Designee on the importance of ensuring medications are administered in a sanitary manner to residents. All Licensed/Registered nurses will also be educated by the Director of Staff Development/Designee on the importance of following the facility□s Medication Pass/Administration Policy. 4. The facility□s Unit Managers/Designee will complete medication pass observation two times weekly on randomly selected nurses on all shifts to ensure medications are administered in a sanitary manner and incompliance with the facility□s Medication Pass & Administration Policy.	

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	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 880	Continued From page 124 placed the other half back into the stock pill bottle, contaminating all the other pills that remained in the bottle. On 3/16/22 at 9:12 AM, an interview was conducted with LPN #9. When asked about handling the Vitamin B1 with her hand and putting half of it back in the bottle, she stated that she had gloves on. When asked if she touched anything after putting gloves on, before handling the Vitamin B1 pill directly, such as the unsanitized pill cutter and unsanitized pill bottle, she stated that she should not have touched the pills, and scooped them up with a spoon instead, or poured them directly into a pill cup and then separated them to give the resident half for his ordered dose. She stated that this was an infection control concern. A review of the facility policy, "Medication Pass/Administration" was conducted. This policy documented, "It is the policy of the facility to ensure safe administration of medications to our residents by licensed nurses according to acceptable professional standard....1. Cleanse hand before administering medications, and between resident contacts and after medication administration or resident contact. 2. Wear gloves as appropriate for administering and removing of some medications such as skin patches, eye drops, and ear drops. 3. Cleanse hand after removal of gloves. 4. Remove used gloves after removal of old patch (es), clean hands and wear a clean glove to administer a new patch. 5. Do not touch tablets with bare hands...." On 3/16/22 at 5:19 PM, ASM #1 (Administrative Staff Member) the Administrator, ASM #2 the	F 880	Findings of the sanitary medication pass weekly audits will be presented monthly for three months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance. 5. April 20, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT LEEWOOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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F 880	Continued From page 125	F 880		

Director of Nursing, ASM #3 the Assistant Director of Nursing, ASM #4 Administrator of sister facility, and RN #3 (Registered Nurse) Staff Development, were made aware of the findings.

No further information was provided by the end of the survey.

"Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: ...After touching a patient or the patient's immediate environment ...After contact with blood, body fluids, or contaminated surfaces." This information is taken from the website https://www.cdc.gov/handhygiene/providers/guideline.html

References:
(1) Thiamine (vitamin B1) is used as a dietary supplement when the amount of thiamine in the diet is not enough. People most at risk for thiamine deficiency are older adults, those who are dependent on alcohol, or who have HIV/AIDS, diabetes, malabsorption syndrome (problems absorbing food), or have had bariatric surgery (an operation that helps you lose weight by making changes to your digestive system). Thiamine is used to treat beriberi (tingling and numbness in feet and hands, muscle loss, and poor reflexes caused by a lack of thiamine in the diet) and to treat and prevent Wernicke-Korsakoff syndrome (tingling and numbness in hands and feet, memory loss, confusion caused by a lack of thiamine in the diet). Thiamine is in a class of medications called vitamins. It is needed by the body to turn foods into energy, which is important for the growth, development, and function of cells. Information obtained from

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	495337	A. BUILDING _____ B. WING _____	C 03/17/2022

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F 880	Continued From page 126 https://medlineplus.gov/druginfo/meds/a682586.html	F 880		