	-	ID HUMAN SERVICES			FOR	M APPROVED
		MEDICAID SERVICES	1			<u>D. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMF	E SURVEY PLETED
		495337	B. WING			C / <b>17/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AUQUOT		000	71	20 BRADDOCK ROAD		
AUGUSTI	HEALTHCARE AT LEEW		A	NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	Survey was conducte The facility was in sul	ergency Preparedness of 3/15/22 through 3/17/22. ostantial compliance with 42 quirement for Long-Term	F 000			
	survey was conducte One complaint (VA00 investigated during th required for complian	dicare/Medicaid standard d 3/15/22 through 3/17/22. 053940-substantiated) was le survey. Corrections are ce with 42 CFR Part 483 are requirements. The Life eport will follow.				
F 609 SS=D	106 at the time of the consisted of 42 curre closed record reviews Reporting of Alleged	Violations	F 609			4/20/22
		se to allegations of abuse, or mistreatment, the facility				
	involving abuse, negl mistreatment, includir source and misappro are reported immedia hours after the allega that cause the allega serious bodily injury, the events that cause abuse and do not res the administrator of th	ng injuries of unknown priation of resident property, itely, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to he facility and to other		TITI E		(X6) DATE
		SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		
Electroni	cally Signed					04/05/2022

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 05/02/2022

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONST		(X3) DATE COMF	E SURVEY PLETED	
		495337	B. WING				C / <b>17/2022</b>	
NAME OF P	ROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	1		
				7120 BRA	ADDOCK ROAD			
AUGUST	HEALTHCARE AT LEEW	OOD			DALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 609	officials (including to f adult protective servic for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the a designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on observatio document review and was determined that f report injuries of unkr agency for one of 47 sample, Resident #10 On 3/9/22, the facility unknown origin (bruis and left hand. The fa injuries of unknown o The findings include: Resident #107 was ar 4/27/21. Resident #1 were not limited to de the most recent MDS quarterly assessment reference date) of 2/2 out of 15 on the BIMS status), indicating the	the State Survey Agency and bes where state law provides term care facilities) in a law through established the results of all administrator or his or her ative and to other officials in a law, including to the State on 5 working days of the eged violation is verified a action must be taken. T is not met as evidenced on, staff interview, facility clinical record review, it the facility staff failed to lown origin to the state residents in the survey 07. staff observed injuries of es) on Resident #107's face cility staff failed to report the rigin to the state agency. dmitted to the facility on 07's diagnoses included but mentia and paralysis. On (minimum data set), a with an ARD (assessment 2/22, the resident scored 1 b (brief interview for mental	F	1. origi the s facili upda infor origi 2. pote prac audi 03/2 any inve ager 3. on 0 Staff impo injur ager ASM Dep	All residents in the facility have the ential to be affected by this deficient stice. The facility completed a skin t for all residents in the facility on 22/2022 to identify if any resident h injuries of unknown origin requiring stigation and reporting to the state	o was own he nt nad lg e ins ive ing The		

Facility ID: VA0142

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TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		495337	B. WING		С		
	ROVIDER OR SUPPLIER	435557		STREET ADDRESS, CITY, STATE, ZIP CODE	03/17/2022		
	NOVIDER OR SOLT EIER			7120 BRADDOCK ROAD			
AUGUST	HEALTHCARE AT LEEW	VOOD		ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETI		
F 609	Continued From pag	e 2	F 609				
	Review of Resident a revealed a nurse's m documented, "At exa (certified nursing ass that she has observe side of resident's fac quickly went over to assessment. Head to findings from this wri confirmed the CNA's what happened, resi- leave me alone.' Ale scheduled medication Remains in stable co- lower extremities. Vi- BP (blood pressure)- (temperature)-97.4, I (oxygen level)-98% a doctor) notified, no n clear to auscultation rhonchi observed. Re- unlabored. Abdomer non-distended. Bowe quadrants. Head of the and frequently used no acute distress, nu- monitor." Further re- clinical record failed the cause of the brui	#107's clinical record ote dated 3/9/22 that actly 0630 (6:30 a.m.), CNA sistant) informed this writer ed some bruises to the left are and left hand. This writer resident's room for further the and left hand. This writer resident's room for further to toe assessment was done, iter's skin assessment are arlier report. When asked dent kept saying 'I am fine, ert and oriented, tolerated all ins and treatments well. ondition, range of motion in all tal signs obtained as follows- 129/73/ Pulse-75, Temp Resp (respirations)-18, 02sat at Room Air. MD (medical new order given. Lung sound bilaterally, no wheezing or espiration even and n soft, non tender, and el sounds present at all four bed elevated, call light bell items placed within reach. In ursing staff will continue to view of Resident #107's to reveal documentation of ses and failed to reveal hese injuries of unknown		<ul> <li>reporting/investigating cases of por abuse on the importance of investigating/reporting any form of in a timely manner.</li> <li>The facility □ s Administrator/D will include investigating/reporting to the morning meeting sheet and up daily with the team to ensure al incidents of injuries of unknown origin/abuse are investigated and reported. The Administrator will als update the weekend Manager on I (MOD) form to ensure all incidents abuse/injuries of unknown origins investigated/reported to the state at in a timely manner on the weekend Findings of the daily morning meet sheets and weekend MOD forms of presented monthly for three month Quality Assurance Improvement Committee (QAPI) to ensure comp 5. April 20, 2022</li> </ul>	abuse abuse follow l so Duty s of are agency ds. ting will be ns to the		

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(X2) MULTIPLE			0. 0938-0391
	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
B. WING			C 17/2022
ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
71	120 BRADDOCK ROAD		
Α	NNANDALE, VA 22003		
ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
F 609			
	A. BUILDING	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003 ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	A. BUILDING COMF B. WING 03/ B. WING 03/ STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

Facility ID: VA0142

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/02/2022 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495337	B. WING		_		C 17/2022
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
AUGUST	HEALTHCARE AT LEEW	DOD		120 BRADDOCK ROAD	6		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION DTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	stated he was made a bruises during the ear #1 stated he reported administrator and the same morning during On 3/16/22 at 4:39 p.1 conducted with ASM a stated an injury of unk staff cannot identify th includes bruises. ASI supposed to immedia unknown origin to the supposed to immedia stated she is suppose unknown origin to the hours then complete a stated she was not av injuries of unknown or 3/9/22. On 3/16/22 at approxi #1and ASM #2 were r concern. The facility policy title failed to document inf of unknown origin. Th documented, "6. The reported to Departme and neglect, Misappro Unknown Origin."	ger). m., an interview was egistered nurse) #1. RN #1 aware of Resident #107's rly morning on 3/9/22. RN the bruises to the director of nursing that the morning meeting. m., an interview was #1 and ASM #2. ASM #1 known origin is an injury that he root cause of and M #1 stated staff is tely report injuries of department head who is tely report to her. ASM #1	F 609				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 05/02/2022 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	SURVEY PLETED
		495337	B. WING				(17/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	Continued From page	e 5	F	610			
F 610 SS=D	-	Correct Alleged Violation -(4)	F	610			4/20/22
		se to allegations of abuse, or mistreatment, the facility					
	§483.12(c)(2) Have e violations are thoroug	vidence that all alleged hly investigated.					
		t further potential abuse, or mistreatment while the gress.					
	investigations to the a designated represent accordance with Stat Survey Agency, withi incident, and if the all appropriate corrective This REQUIREMENT	(4) Report the results of all ons to the administrator or his or her representative and to other officials in e with State law, including to the State ency, within 5 working days of the nd if the alleged violation is verified e corrective action must be taken. JIREMENT is not met as evidenced					
	document review and was determined that investigate injuries of	n, staff interview, facility l clinical record review, it the facility staff failed to unknown origin for one of urvey sample, Resident			1. Resident #107 injuries of unknow origin was investigated and reported to the state agency on 03/18/2022. The facility ☐s Prohibition of Abuse policy w updated on 03/18/2022 to include information regarding injuries of unknow origin.	o vas	
	unknown origin (bruis and left hand. The fa	staff observed injuries of ses) on Resident #107's face icility staff failed to ries of unknown origin.			<ol> <li>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 here.</li> </ol>	nt	
		dmitted to the facility on			any injuries of unknown origin requirin investigation and reporting to the state agency.	e	
	4/27/21. Resident #1	07's diagnoses included but			3. The Regional Director of operatio	ns	

Facility ID: VA0142

If continuation sheet Page 6 of 127

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) D/	ATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	, <i>i</i>	G	· · · ·	MPLETED
						С
		495337	B. WING			03/17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		
				7120 BRADDOCK ROAD		
AUGUST	HEALTHCARE AT LEEW	OOD		ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 610	Continued From page	- 6	F 61	10		
1 010	-				- A ducinistantin (c	
		ementia and paralysis. On		on 03/30/22 educated the		
	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			Staff Member (ASM) #1 & importance of investigatin		
				injuries of unknown origin		
				agency within the require		
	status), indicating the			ASM #1 would thereafter		
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	for making daily decisions.		Department Heads and L		
		or making daily debisions.		who are responsible for		
	Review of Resident #	107's clinical record		reporting/investigating ca	uses of potential	
	revealed a nurse's no			abuse on the importance		
		ctly 0630 (6:30 a.m.), CNA		investigating/reporting ar		
		istant) informed this writer		in a timely manner.	,	
		d some bruises to the left		4. The facility⊡s Admin	nistrator/Designee	
	side of resident's face	e and left hand. This writer		will include investigating/		
	quickly went over to r	esident's room for further		to the morning meeting s		
	assessment. Head to	toe assessment was done,		up daily with the team to	ensure all	
	findings from this writ	er's skin assessment		incidents of injuries of un	known	
	confirmed the CNA's	earlier report. When asked		origin/abuse are investig	ated and	
	what happened, resid	lent kept saying 'I am fine,		reported. The Administra	tor will also	
	leave me alone.' Ale	rt and oriented, tolerated all		update the weekend Mar	nager on Duty	
	scheduled medication	ns and treatments well.		(MOD) form to ensure all		
		ndition, range of motion in all		abuse/injuries of unknow		
		al signs obtained as follows-		investigated/reported to t		
		129/73/ Pulse-75, Temp		in a timely manner on the		
		Resp (respirations)-18, 02sat		Findings of the daily mor		
		t Room Air. MD (medical		sheets and weekend MO		
		ew order given. Lung sound		presented monthly for the		
		bilaterally, no wheezing or		Quality Assurance Improv		
	rhonchi observed. Re	-		Committee (QAPI) to ens 5. April 20, 2022	sure compliance.	
	unlabored. Abdomen	l sounds present at all four		5. April 20, 2022		
		ed elevated, call light bell				
	1 -	tems placed within reach. In				
		rsing staff will continue to				
		riew of Resident #107's				
		o reveal documentation of				
		ses and failed to reveal				
		nese injuries of unknown				
			1			1

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495337	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 610	Continued From page	27	F	610			
	(the nurse who docum LPN #4 stated he was Resident #107's bruis stated he believed the seen Resident #107's done something about reported the bruises to the unit manager. LP the night shift staff an bruises and other stat about them. On 3/16/22 at 3:25 p. staff member) #1 (the did not have an inves #107's bruises but the working on one. On 3/16/22 at 2:55 p. nursing) presented a documented, "[Reside STATEMENT ON 3/9/ NURSE- "This writer" resident's room for fut toe assessment was writer's skin assessm earlier report. When a resident kept saying ' Alert and oriented, tol medications and treat stable condition. Vital BP (blood pressure) (temperature)-97.4, R (oxygen level)-98% a doctor) notified, no ne	licensed practical nurse) #4 nented the above note). s about to leave when ses were observed. LPN #4 e previous shift could have s bruises and could have to the oncoming nurse and N #4 stated he also asked d oncoming staff about the ff stated they did not know m., ASM (administrative e administrator) stated she tigation regarding Resident e unit manager said he was m., ASM #2 (the director of typed document that ent #107] - STAFF /22 BY THE CHARGE quickly went over to rther assessment. Head to done, findings from this ent confirmed the CNA's asked what happened, I am fine, leave me alone.'					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/02/2022 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495337	B. WING		_		C 17/2022
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
AUGUST	HEALTHCARE AT LEEW	DOD		7120 BRADDOCK ROAD ANNANDALE, VA 22003	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	quadrants. Head of be and frequently used it The documented was nurse) #1 (unit manage On 3/16/22 at 3:37 p.1 conducted with RN (re stated he was made a bruises during the ear #1 stated he reported and the director of nu during the morning m injury of unknown orig consist of talking to st resident during multip interviewing the resider report and reporting th nursing and administr their own investigation personally complete a Resident #107's bruis cause. RN #1 stated signed by him was co On 3/16/22 at 4:39 p.1 conducted with ASM a stated an injury of unk staff cannot identify th includes bruises. ASI unknown origin invest body audit, witness st residents and intervie stated she was not av	spiration even and soft, non tender, and sounds present at all four ed elevated, call light bell ems placed within reach." signed by RN (registered ger). m., an interview was egistered nurse) #1. RN #1 aware of Resident #107's dy morning on 3/9/22. RN this to the administrator rsing that same morning eeting. RN #1 stated an gin investigation should aff who cared for the le previous shifts, if possible ent, completing an incident the injury to the director of ator so they can complete h. RN #1 stated he did not an investigation regarding es and did not know the the above document, mpleted on this day. m., an interview was #1 and ASM #2. ASM #1 known origin is an injury that he root cause of and M #1 stated an injury of igation should consist of a	F 61				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495337	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 610 F 622 SS=E	On 3/16/22 at approx #1and ASM #2 were in concern. The facility policy title failed to document inf of unknown origin. The documented, "6. The reported to Department and neglect, Misapprot Unknown Origin. 7. The all written grievance of the grievance was read statement of the resident taken to investigate the the pertinent findings No further information Transfer and Dischart CFR(s): 483.15(c)(1)( §483.15(c) Transfer at §483.15(c)(1) Facility (i) The facility must per remain in the facility, discharge the resident (A) The transfer or dis resident's welfare and cannot be met in the (B) The transfer or dis because the resident's services provided by (C) The safety of indivi- endangered due to the status of the resident;	d, "Prohibition of Abuse" formation regarding injuries he facility grievance policy following grievances are ent of Health (DOH): Abuse opriation of items, Injury of The facility must ensure that decisions include the date ceived, a summary ent's grievance, the steps ne grievance, a summary of or conclusions" In was presented prior to exit. ge Requirements (i)(ii)(2)(i)-(iii) and discharge- requirements- ermit each resident to and not transfer or it from the facility unless- scharge is necessary for the d the resident's needs facility; scharge is appropriate s health has improved ident no longer needs the the facility; viduals in the facility is le clinical or behavioral ; viduals in the facility would		610			4/20/22

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495337	B. WING				C / <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	DOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	(E) The resident has it appropriate notice, to under Medicare or Me Nonpayment applies submit the necessary payment or after the t Medicare or Medicaid resident refuses to pa resident who become admission to a facility resident only allowabl or (F) The facility ceases (ii) The facility may no resident while the app § 431.230 of this chap exercises his or her ri discharge notice from 431.220(a)(3) of this of discharge or transfer or safety of the reside facility. The facility m that failure to transfer §483.15(c)(2) Docum When the facility trans resident under any of in paragraphs (c)(1)(i) section, the facility m or discharge is docum medical record and a communicated to the institution or provider. (i) Documentation in t must include: (A) The basis for the f (i) of this section.	Failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. If the resident does not paperwork for third party hird party, including , denies the claim and the y for his or her stay. For a s eligible for Medicaid after , the facility may charge a e charges under Medicaid; s to operate. ot transfer or discharge the beal is pending, pursuant to oter, when a resident ght to appeal a transfer or the facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the ust document the danger or discharge would pose. entation. sfers or discharges a the circumstances specified 0(A) through (F) of this ust ensure that the transfer nented in the resident's opropriate information is receiving health care	F	622			

Facility ID: VA0142

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/02/2022 MAPPROVED ). 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495337	B. WING			03/	C 17/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE			
				7120 BRADDOCK I	ROAD			
AUGUST	HEALTHCARE AT LEEW	DOD	ANNANDALE, VA 22003					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 622	be met, facility attemp needs, and the servic facility to meet the ner (ii) The documentation (2)(i) of this section m (A) The resident's phy discharge is necessar (A) or (B) of this section (B) A physician when necessary under para this section. (iii) Information provid must include a minimu (A) Contact information (C) Action the ca (B) Resident represen contact information (C) Advance Directive (D) All special instruct ongoing care, as appr (E) Comprehensive ca (F) All other necessa copy of the resident's consistent with §483.2 any other documentat a safe and effective tr This REQUIREMENT by: Based on staff intervi and facility document the facility staff failed required information v	esident need(s) that cannot outs to meet the resident e available at the receiving ed(s). In required by paragraph (c) ust be made by- visician when transfer or y under paragraph (c) (1) on; and transfer or discharge is igraph (c)(1)(i)(C) or (D) of ed to the receiving provider um of the following: on of the practitioner re of the resident. Intative information including e information tions or precautions for ropriate. are plan goals; ry information, including a discharge summary, 21(c)(2) as applicable, and tion, as applicable, to ensure ansition of care. is not met as evidenced ew, clinical record review review, it was determined to provide evidence that all vas provided to the hospital 47 residents in the survey red to the hospital;	F	by this defici cannot be re- residents #1 longer in the 2. All resid discharged f potential to b practice. Thi	dents were adversely affect ient practice. This deficient stroactively corrected as 01, #85, #71, #2 & #74 are hospital. dents who are transferred a from the facility have the be affected by this deficien is deficient practice cannot corrected, however a new	cy ∋ no and t be		

Event ID: W82111

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/02/2022 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495337	B. WING				C / <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUOT		005		71	120 BRADDOCK ROAD		
AUGUST	HEALTHCARE AT LEEW			A	NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 622	Based on staff intervi and facility document the facility staff failed information was provi when five of 47 reside were transferred to th #85, #71, #2 and #74 The findings include: 1. The facility staff fai care plan goals were when Resident #101 hospital on 2/19/22. Resident #101 was a 2/17/22. Resident #1 were not limited to: or bladder neck obstruct infection. Resident #1 (minimum data set) a change assessment, reference date of 3/2/ scoring 7 out of 15 or for mental status) sco was severely cognitiv Review of Resident # dated 2/19/22 at 3:02 "[Resident #101] Out progressing weakness Slow respond to verb Transferred back in b lunch writer attempte unable to open moutfunable to respond to nurse practitioner- se Emergency room (EF	ew, clinical record review review, it was determined to evidence that all required ided to the hospital staff ents in the survey sample te hospital, Residents #101,  led to provide evidence that provided to the hospital staff was transferred to the dmitted to the facility on 01's diagnoses included but erebral vascular accident, tion and urinary tract 101's most recent MDS ssessment, a significant with an assessment (22, coded the resident as the BIMS (brief interview ore, indicating the resident rely impaired. et 01's nursing progress note PM revealed the following, of bed in wheelchair, noted is, unable to sit up straight. al and tactile stimuli. ed due to weakness. At d to feed the resident, n, change in mental status, verbal stimuliNotified	F	622	tool (Transfer/Discharge Checklist Verification Tool) which requires the signature of two licensed nurses to everification that all required informatii provided to the hospital staff includin residents care plan goals have been developed. The new Transfer/Dischar Checklist Verification Tool form will e all required information including car plan goals is provided to the hospital the checklist form will be uploaded to resident clinical record as evidence to the facility provided the hospital with required information including care p goals. 3. The Director of Staff Development/Designee will educate licensed and registered nurses responsible for resident's transfer an discharge on the importance of ensua all required information including car plan goals is provided to the hospital during resident's discharge and trans The Director of Staff Development/Designee will also edu all licensed nurses and registered nur- responsible for resident's discharge at transfers on the facility's Transfer/Discharge Checklist Verifica Tool as well as the Transfer/Discharge Envelope. The education will include importance of having two nurses ver that all required information were set the hospital and uploading the Check Form into the resident's clinical recor 4. The Director of Nursing/designe audit weekly all resident's transfers at discharge to the hospital to ensure a required information including care p	on is g urge nsure e and the hat all lan all d ring e ofers. cate rses and tion ge fying nt to klist rd. e will nd ll	

Facility ID: VA0142

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				PLE CONSTRUCTION		NO. 0938-039
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	G		ATE SURVEY OMPLETED
						С
		495337	B. WING			03/17/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
AUGUST	HEALTHCARE AT LEEW	IOOD		7120 BRADDOCK ROAD		
				ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
F 622	Continued From pag	e 13	F 62	22		
	to verbal stimuli. RP	(responsible party) notified		goals were provided to the h	ospital. The	
		e of status update. Resident		weekly audit will include veri		
	was sent to the ER v report to hospital."	ia 911 at 2:15 pm and given		the Transfer/Discharge Cheo signed by two nurses and up		
				resident's clinical record. Fin		
	On 3/15/22 at approx	kimately 5:00 PM a request		weekly audits will be present	•	
	was made for the evi			for 3 months to the Quality A		
	•	ving facility when Resident		Performance Improvement (		
	#101 was transferred	t to the hospital.		Committee to ensure compli 5. April 20, 2022	ance.	
	On 3/16/22 at 12:16	PM, an interview was		5. April 20, 2022		
	conducted with ASM					
		ninistrator and ASM #2 the				
		ASM #1 provided a blank				
	envelope "complianc					
		quirements," which lists ASM #1 then stated, "We				
	•	nurses are not making copies				
		nat is sent to the hospital for				
	0 0	o the hospital. We have				
		staff education for our				
	copies of this checkli	ward we will be making st and placing in the				
		SM #2 then stated, "We				
		ne nurses are complying.				
	-	ard we will be checking on				
	this."					
	On 3/16/22 at 5:25 P	M ASM #1 the				
		2, the director of nursing,				
	ASM #3, the assistar	nt director of nursing, ASM				
		at sister facility and RN #3,				
	staff development co the above concern.	ordinator were informed of				
	According to the facil	litu's "Transfor or Discharge				
		lity's "Transfer or Discharge /: "Facility staff will ensure				
		ded when a resident is				
		arging from the facility. This				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
		495337	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 622	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	622			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		495337	B. WING			C 03/17/2022		
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST I	HEALTHCARE AT LEEW	DOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 622	Continued From page On 3/16/22 at 12:16 F conducted with ASM member) #1, the adm director of nursing. A envelope "compliance transfer/discharge red required documents. recognized that the m of the envelope of wh the residents going to started whole house as nurses and going forv copies of this checklis resident's record." AS need to make sure the From this point forwar this." On 3/16/22 at 5:25 PP administrator, ASM #3 ASM #3, the assistan #4, the administrator a staff development coo the above concern.	A 15 PM, an interview was (administrative staff inistrator and ASM #2 the SM #1 provided a blank e checklist: quirements" which lists ASM #1 then stated, "We urses are not making copies at is sent to the hospital for the hospital. We have staff education for our ward we will be making st and placing in the SM #2 then stated, "We e nurses are complying. rd we will be checking on M, ASM #1, the 2, the director of nursing, t director of nursing, ASM at sister facility and RN #3, ordinator were informed of		622	DEFICIENCY)			
	3. The facility staff fail	was provided prior to exit. led to evidence care plan for Resident #71 to the						
	÷ .	a facility-initiated transfer on						
	significant change as							

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	MENT OF HEALTH AN					FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			LETED
		495337	B. WING				C 17/2022
NAME OF F	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD		
			ID		ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC' REGULATORY OR L	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	E ACTION SHOULD BE COMPLE TO THE APPROPRIATE DAT				
F 622	The progress notes for in part, "1/29/2022 15 observed in bed at be closed and breathing (oxygen) at 2L (two lit (nasal cannula). BS ( Unable to get reading Resident continued of mucus from mouth notified. Order: Trans hospital] ER (emerge (evaluation) and treat notified. Resident pic The clinical record fai documentation of info hospital on 1/29/2022 On 3/16/2022 at 12:0 conducted with LPN ( LPN #5 stated that the containing documents hospital when the res LPN #5 stated that the on it that they follower sent a face sheet, the progress notes, the ca condition form, and la called a report to the they should documen progress notes becau envelope that was set of the nurses were go and some were not. On 3/16/2022 at 12:10	or Resident #71 documented :16 (3:16 p.m.) Resident ginning of shift with eyes through the mouth. O2 ers)/min (per minute) via nc /blood sugar) checked. because BS was high with lip breathing with a lot . MD (medical doctor) sfer resident to [Name of ncy room) for further eval . R/P (responsible party) k up at 9:15 am via 911." led to evidence rmation provided to the 8 p.m., an interview was licensed practical nurse) #5. ey sent an envelope	F	62:			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/02/2022 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		495337	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				7	120 BRADDOCK ROAD		
AUGUST	HEALTHCARE AT LEEW	DOD		A	ANNANDALE, VA 22003		
(X4) ID PREFIX	-	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
F 622	Continued From page	e 17	F	622			
	making copies of the	envelope sent with the al containing the documents.					
	ASM #1 stated that the planned to make copi	at going forward they					
	On 3/16/2022 at 5:20 administrator, ASM #:	p.m., ASM #1, the 2, the director of nursing,					
	ASM #3, the assistan #4, administrator of a	t director of nursing, ASM sister facility and RN					
		-					
	(registered nurse) #3, staff development were notified of the findings. No further information was provided prior to exit.						
	goals were provided f						
	receiving provider for 3/9/2022.	a facility-initiated transfer on					
		IDS (minimum data set), a with an ARD (assessment					
	reference date) of 2/2	3/2022, the resident scored BIMS (brief interview for					
	mental status), indica cognitively intact.	ting the resident is					
	in part, "3/9/2022 17:	or Resident #2 documented 50 (5:50 p.m.) Resident was ] of oxygen via nasal canula					
	[sic] at 8:40 amCirc	a 9 am CNA (certified ing for resident informed me					
	that she was unable t	o eat her breakfast. Upon					
	cyanotic, skin cool to						
		difficulty, with oxygen @ 2L in use was with definite					
		us. Unable to respond					
	-	on observed. [Name of					
		se at the time and informed					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COMF	SURVEY PLETED
		495337	B. WING				C / <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	resident sent out 911. services) was called further documented, " Resident returned from The clinical record fai documentation of infor hospital on 3/9/2022. On 3/16/2022 at 12:00 conducted with LPN ( LPN #5 stated that the containing documents hospital when transfe the envelope had a cl followed. LPN #5 stated the envelope had a cl followed. LPN #5 stated the envelope had a cl followed. LPN #5 stated to the hospital. LPN # document what was se because they do not of sent. LPN #5 stated the were good about mak were not. On 3/16/2022 at 12:11 staff member) #1, the they did not have evic sent to the hospital ar making copies of the resident to the hospital ASM #1 stated that the planned to make copi On 3/16/2022 at 5:20 administrator, ASM #2	ge in status. He ordered . EMS (emergency medical ." The progress notes '3/9/2022 22:34 (10:34 p.m.) m the hospital at 8:45 pm." led to evidence ormation provided to the 8 p.m., an interview was licensed practical nurse) #5. ey sent an envelope s with residents to the rred out. LPN #5 stated that hecklist on it that they ted that they sent a face 1 physical, the progress the change in condition envelope and called a report #5 stated that they should sent in the progress notes copy the envelope that was that some of the nurses sing the notes and some 6 p.m., ASM (administrative administrator stated that dence of transfer documents and that the nurses were not envelope sent with the al containing the documents. that going forward they es of the envelopes.	F	622	2		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495337	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	<ul> <li>#4, administrator of a (registered nurse) #3, notified of the findings</li> <li>No further information</li> <li>5. The facility staff fai goals were provided t facility initiated transference</li> <li>1/31/2022.</li> <li>Resident #74 was add 1/26/2022. On the model of the day assessment reference</li> <li>resident scored a one interview for mental s resident is severely com aking daily decision</li> <li>The nurse's note date documented, "Patient tachypnea and tachyo not feeding (sic) good very irritable. MD (model given to give ne one time. Patient still fast breathing. Called (emergency room) for treatment. MD made party, son [name of set to [Name of hospital] with med (medication</li> </ul>	sister facility and RN staff development were s. In was provided prior to exit. led to evidence care plan to the receiving facility for a er for Resident #74 on mitted to the facility on ost recent MDS (minimum c, a significant change sessment, with an ARD ce date) of 2/11/2022, the e on the BIMS (brief tatus) score, indicating the ognitively impaired for s. ed 1/31/2022 at 2:42 p.m. c alert and restlessness with cardiaPatient stated, 'I am I,' moving all-around in bed, edical doctor) notified, new ebulizer treatment was given noticed restlessness and d 911 and sent to ER further evaluation and aware and responsible on] notified. Report is given ER nurse. All paper work s) were given to 911 staff." record on 3/15/2022 failed ion that the care plan goals esident # 74 upon transfer to	F	622			

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CENTERS FOR MEDICARE & MEDICAD SERVICES     OME NO. 0938-0391       AND PLN OF CORRECTION     (N) INOVERSIMPLICIPULATION NUMBER.     (P2) MULTIPLE CONSTRUCTION       AND PLN OF CORRECTIONS     (N) INOVERSIMPLICIPULATION NUMBER.     (P2) MULTIPLE CONSTRUCTION       AMB OF PROVIDER OR SUPPLIER     495337     INVIG     (P2) MULTIPLE CONSTRUCTION       AUGUST HEALTHCARE AT LEWOOD     ITTERT ADDRESS CLIVY STATE_201 CODE     (P3) MULTIPLE       AUGUST HEALTHCARE AT LEWOOD     ITTERT ADDRESS CLIVY STATE_201 CODE     (P3) MULTIPLE       Tab     ISUMARY STREMENT OF DEFICIENCIES     (P2) MULTIPLE     (P2) MULTIPLE       Tab     ISUMARY STREMENT OF DEFICIENCIES     (P2) MULTIPLE     (P2) MULTIPLE       Tab     ISUMARY STREMENT OF DEFICIENCIES     (P2) MULTIPLE     (P2) MULTIPLE       Tab     ISUMARY STREMENT OF DEFICIENCIES     (P2) MULTIPLE     (P2) MULTIPLE       Tab     ISUMARY STREMENT OF DEFICIENCIES     (P2) MULTIPLE     (P2) MULTIPLE       Tab     ISUMARY STREMENT OF DEFICIENCIES     (P2) MULTIPLE     (P2) MULTIPLE       Tab     ISUMARY STREMENT OF DEFICIENCIES     (P2) MULTIPLE     (P2) MULTIPLE       Tab     ISUMARY STREMENT OF DEFICIENCIES     (P2) MULTIPLE     (P2) MULTIPLE       Tab     ISUMARY STREMENT OF DEFICIENCIES     (P2) MULTIPLE     (P2) MULTIPLE       F 622     Continued From page 20     F 622			ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391	
AME OF PROVIDER OR SUPPLIER         State of PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZP CODE T/20 BRADDOCK ROAD ANNANDALE, VA 2203         Optimize         Common Pressor         Com Pressor         Common Pressor	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY	
AUGUST HEALTHCARE AT LEEWOOD     T28 BRADDOCK ROAD ANNANDALE, VA 2203       PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FILL RECULATORY OR US: DENTIFYING INFORMATION)     IP     PREFIX TAG     PROVIDER'S PLANOF CORRECTION (EACH OER/CENCY MUST BE PRECEDED BY FILL RECULATORY OR US: DENTIFYING INFORMATION)     IP     IP     PREFIX TAG     PROVIDER'S PLANOF CORRECTION (EACH OER/CENCY MUST BE PRECEDED BY FILL RECULATORY OR US: DENTIFYING INFORMATION)     IP     IP <t< td=""><td></td><td></td><td>495337</td><td>B. WING</td><td></td><td></td><td colspan="3">-</td></t<>			495337	B. WING			-		
AUGUST HEALTHCARE AT LEEVOOD       ANNANDALE, VA 22003         (X) [D] PHEFIX TXG       ISUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST AR ERFORDED BY PLUL, RECOLLTORY OR LSC DENTIFYING INFORMATION)       ID PREFIX TAG       ID PROVIDER SPLANOF CORRECTION (RACH CORRECTIVE ATTER PAROPRIATE DEFICIENCY)       Construction (RACH CORRECTIVE ATTER DEFICIENCY)       Construction (RACH CORRECTIVE ATTER DEFICIENCY)       F 622       F 623       CORRECTIVE ATTER DEFICIENCY)         F 6 021       Notion Fromating Deficience Atter Deficin	NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
Media       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCE TO THE APPROPRIATE DEFICIENCY)       Constraints         F 622       Continued From page 20       F 622         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. LPH #6 stated, "When we transfer a resident to the hospital we send an envelope with them, the care plan, the change in condition form, and labs and we call a report to the hospital. LPH #6 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 administrative staff member) #1, the administrative staff member) #1, the administrative staff members and libe hospital. We have started a whole hospital document this point forward. We will be checking on this." ASM #2, ASM #3, the assistant director of nursing, ASM #4, administrator for an a sister facility, and RN (registerd nurse) #3, the staff development nurse, were made aware of the above concern on 3/16/2022 at 5:30 p.m.       F 623       4/20/22	AUGUST I	HEALTHCARE AT LEEW	OOD						
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 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 or poins 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 concer on 3/16/2022 at 5:30 p.m. No further information was provided prior to exit.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL		COMPLETION				
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         documented, LPN #5 stated, "We hould         stated a whole hospital. We have         stated a whole hospital. We have         started a whole hospital. We have         started a whole hospital education for our nurses         and going forward will be checking on this."         ASM #1, ASM #2, ASM #3, the assistant director         of nursing, ASM #4, administrator from a si	F 622	Continued From page	≥ 20	F	622				
F 623       Notice Requirements Before Transfer/Discharge       F 623       4/20/22		K4) ID REFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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.							
		Notice Requirements	Before Transfer/Discharge	F	623			4/20/22	

Facility ID: VA0142

If continuation sheet Page 21 of 127

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		495337	B. WING			C 03/17/2022		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST	HEALTHCARE AT LEEW	DOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOUL       REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROF       DEFICIENCY)     DEFICIENCY)					(X5) COMPLETION DATE		
F 623	§483.15(c)(3) Notice Before a facility transf resident, the facility m (i) Notify the resident representative(s) of the the reasons for the m language and mannee facility must send a cor representative of the Long-Term Care Omb (ii) Record the reason discharge in the resid accordance with para and (iii) Include in the noti paragraph (c)(5) of th §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, f discharge required un made by the facility a resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indiv be endangered under this section; (C) The resident's hea allow a more immedia under paragraph (c)(f (D) An immediate tran required by the reside under paragraph (c)(f)	before transfer. fers or discharges a nust- and the resident's he transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State budsman. Is for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or ider this section must be t least 30 days before the l or discharged. ade as soon as practicable charge when riduals in the facility would r paragraph (c)(1)(i)(C) of riduals in the facility would r paragraph (c)(1)(i)(D) of alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section;	F	623	3			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/02/2022 MAPPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495337	B. WING		_		C 17/2022
NAME OF P	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
AUCUOT				7120 BRADDOCK ROAD			
AUGUST	HEALTHCARE AT LEEW	000		ANNANDALE, VA 22003	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page days.	22	F 623	3			
	notice specified in par must include the follow (i) The reason for trai (ii) The effective date (iii) The location to wh transferred or dischar (iv) A statement of the including the name, a and telephone number receives such requess to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Omb (vi) For nursing facility and developmental di disabilities, the mailin telephone number of the protection and ad developmental disabi C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facility disorder or related dis email address and tel agency responsible for advocacy of individua established under the for Mentally III Individual §483.15(c)(6) Change	nsfer or discharge; of transfer or discharge; nich the resident is ged; e resident's appeal rights, ddress (mailing and email), er of the entity which ts; and information on how orm and assistance in and submitting the appeal s (mailing and email) and the Office of the State budsman; / residents with intellectual sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and ls with a mental disorder • Protection and Advocacy uals Act.					

Facility ID: VA0142

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 05/02/202 MAPPROVE O. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		495337	B. WING _			03	C 8/17/2022
NAME OF PI	ROVIDER OR SUPPLIER	·	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST I	IEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD NNANDALE, VA 22003		
			ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETION
F 623	Continued From page	e 23	F	623			
. 020				525			
	becomes available.	·					
	§483.15(c)(8) Notice	in advance of facility closure					
	-						
	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495337         IAME OF PROVIDER OR SUPPLIER       495337         IAME OF PROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         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(I).         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.						
	-						
	-	-					
	relocation of the resid	•					
		L is not mot as swideneed					
		Is not met as evidenced					
	-	view, clinical record review			1. No residents were adversely af	fected	
					by this deficient practice. On 3/16/20		
					the facility⊡s Social Services Directo		
	documentation to the	Resident or RP			out to the ombudsman notifications	for	
					residents #101, #85, #71, #2, and #		
		-			3/16/2022. The Facility⊡s Social Wo		
		• •			or Designee will also be sending a v		
	Residents #101, #85	, #/ 1, #2 and #/4.			notification about the hospital transf the representatives of residents #10		
	The findings include:				#35, #71, #2 and #74.		
	1. The facility staff fa	iled to evidence written			<ol> <li>All residents who are transferre the hospital have the potential to be</li> </ol>	u 10	
	documentation to the	Resident or RP and			affected by this deficient practice. T	he	
	•				facility s Director of Social		
	transferred to the hos	spital on 2/19/22.			Services/Designee will be auditing a transfers to the hospital for the mon		
	Resident #101 was a	dmitted to the facility on			February & March 2022 to ensure w		
		I01's diagnoses included but			notification is provided to the Ombud		
		erebral vascular accident,			and resident⊟s representatives.		
		tion and urinary tract			3. The Administrator/designee will		
		101's most recent MDS			educate the Director of Social Service	ces on	
	(minimum data set) a	issessment, a significant			the importance of ensuring written		

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	O. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	· · ·		· · ·	IPLETED	
					С		
		495337	B. WING		0	3/17/2022	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST	HEALTHCARE AT LEEW	OOD		120 BRADDOCK ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 623	Continued From page	e 24	F 623				
	change assessment, reference date of 3/2, scoring 7 out of 15 or for mental status) sco was severely cognitiv Review of Resident # dated 2/19/22 at 3:02 "[Resident #101] Out progressing weakness Slow respond to verb Transferred back in b lunch writer attempte unable to open mouth unable to respond to nurse practitioner- se Emergency room (EF to change in mental se to verbal stimuli. RP of and given the change was sent to the ER vir report to hospital." On 3/15/22 at approx was made for the evid documentation to the Ombudsman when R transferred to the hosp On 3/16/22 at 9:32 At conducted with ASM member) #1, the adm have not been sendir ombudsman on hosp	with an assessment /22, coded the resident as in the BIMS (brief interview ore, indicating the resident rely impaired 2011's nursing progress note 2 PM revealed the following, of bed in wheelchair, noted as, unable to sit up straight. al and tactile stimuli. ted due to weakness. At d to feed the resident, n, change in mental status, verbal stimuliNotified and the resident to R) for further evaluation due status and unable to respond (responsible party) notified e of status update. Resident ia 911 at 2:15 pm and given imately 5:00 PM, a request dence of written Resident/RP and resident #101 was spital on 2/19/22. M, an interview was (administrative staff inistrator who stated, "We og notification to the ital transfers. I have talked r and we will start doing that		documentation of hospital transfe Ombudsman and resident s representative. 4. The Director of Social Services/designee will complete audit for all residents who are tra to the hospital to ensure written notification is provided to the Om as well as the resident s repres Findings of the audits will be pre monthly for 3 months to the Qua Assurance Performance Improve (QAPI) Committee to ensure cor 5. April 20, 2022	a weekly ansferred budsman entative. sented lity ement		

Facility ID: VA0142

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/02/2022 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495337	B. WING _					C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZI	P CODE	•	
AUGUST	HEALTHCARE AT LEEW	000		71	120 BRADDOCK ROAD			
				A	NNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD B		(X5) COMPLETION DATE
F 623	Continued From page	25	F6	523				
	Ombudsman dated 3/ Resident #101's name	/16/22 at 8:16 AM, with e listed.						
	No evidence of written provided.	n notification to RP was						
	AM with OSM (other s director of social serv ombudsman notificati to notify the ombudsm She stated she was ju starting it now. "I star November. I will do a ombudsman. I alread the ombudsman and week." On 3/16/22 at 5:25 Pf administrator, ASM #3 ASM #3, the assistan #4, the administrator a staff development coo the above concern.	ices. When asked about on, OSM #5 stated, "We are nan, which is new to me. ust told this week, and are ted at this facility in at weekly notification to the dy have a relationship with he comes in at least once a M, ASM #1, the 2, the director of nursing, t director of nursing, ASM at sister facility and RN #3, ordinator were informed of						
	Notification" policy wh notify resident, or their the Ombudsman of re- discharge. The facilit representative of tran reasons for the move and manner they und send a copy of the no- the Office of the State Ombudsman."	y will notify resident and the sfer or discharge and the in writing and in a language erstand. The facility will tice to a representative of						

Facility ID: VA0142

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COM	E SURVEY PLETED
		495337	B. WING				C / <b>17/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	Continued From page	26	F	623	3		
F 023	2. The facility staff fail documentation to the Ombudsman when Re to the hospital on 2/3/ Resident #85 was add diagnoses including of diabetes mellitus and most recent MDS (mil assessment, a Medic with an assessment re coded the resident as BIMS (brief interview the resident was not of Review of Resident # dated 2/3/22 at 11:23 "About 11 AM residen good. I feel like passin vital signsPhysician given to send the resident	led to evidence written Resident/RP and esident #85 was transferred /22. mitted to the facility with congestive heart failure, bradycardia. Resident #85's nimum data set) are five day assessment, eference date of 1/19/22, a scoring 14 out of 15 on the for mental status), indicating cognitively impaired. 85's nursing progress note AM, revealed the following, at stated that 'I am not doing ing out,' Checked resident's in notified and new order dent to nearest ER r further evaluation and		62:	3		
	On 3/15/22 at approxives was made for the evided ocumentation to the Ombudsman when Rest to the hospital on 2/3/ On 3/16/22 at 9:32 All conducted with ASM member) #1, the admin have not been sendin ombudsman on hospit with the social worker	imately 5:00 PM a request dence of written Resident or RP and esident #85 was transferred /22. M, an interview was (administrative staff inistrator, who stated, "We og notification to the ital transfers. I have talked and we will start doing that of of what we sent to the					

Facility ID: VA0142

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391		
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED		
		495337	B. WING				U /17/2022		
NAME OF PI	ROVIDER OR SUPPLIER	I		5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00			
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003	NDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE		
F 623	Continued From page	∋ 27	F	623	3				
	Resident #85's name written notification to	/16/22 at 8:16 AM, with listed. No evidence of RP was provided.							
	AM with OSM (other a director of social serv ombudsman notificati to notify the ombudsr She stated she was ju starting it now. I start November. I will do a ombudsman. I alread	ices. When asked about ion, OSM #5 stated, "We are nan which is new to me." ust told this week. We are							
	ASM #3, the assistan #4, the administrator	M, ASM #1, the 2, the director of nursing, t director of nursing, ASM at sister facility and RN #3, ordinator were informed of							
	3. The facility staff fai notification of transfer	n was provided prior to exit. led to evidence written r to the resident/RP or budsman for Resident #71's er on 1/29/2022.							
	significant change as								
		or Resident #71 documented 5:16 (3:16 p.m.) Resident							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		495337	B. WING				C / <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		-
AUGUST	HEALTHCARE AT LEEW	OOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	observed in bed at be closed and breathing (oxygen) at 2L (two lif (nasal cannula). BS ( Unable to get reading Resident continued of mucus from mouth notified. Order: Trans hospital] ER (emerge (evaluation) and treat notified. Resident pic The clinical record fai documentation of writ the resident/RP or no for the facility-initiated On 3/16/2022 at 12:0 conducted with LPN ( LPN #5 stated that th clinical records for fac did not send any writt resident or responsibl On 3/16/2022 at 9:32 conducted with ASM member) #1, the adm that they had not bee ombudsman for hosp stated that they had starte On 3/16/2022 at 10:0 conducted with OSM director of social work only spoke with the re phone regarding the b	eginning of shift with eyes through the mouth. O2 ters)/min (per minute) via nc (blood sugar) checked. because BS was high with lip breathing with a lot . MD (medical doctor) sfer resident to [Name of ncy room) for further eval . R/P (responsible party) sk up at 9:15 am via 911." led to evidence ten notification of transfer to tification to the ombudsman d transfer on 1/29/2022. 8 p.m., an interview was licensed practical nurse) #5. ey sent bed hold notice and cility-initiated transfers but en notice of transfer to the le party. a.m., an interview was (administrative staff inistrator. ASM #1 stated n sending notification to the ital transfers. ASM #1	F	623	3		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495337	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.                                    </u>	
				·	7120 BRADDOCK ROAD		
AUGUST	HEALTHCARE AT LEEW	UOD	ANNANDALE, VA 22003				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page that they were to send On 3/16/2022 at 5:20 administrator, ASM # ASM #3, the assistan #4, administrator of a (registered nurse) #3, notified of the findings No further information 4. The facility staff fai notification of transfer notification to the oml facility-initiated transfer notification to the oml facility-initiated transfer On the most recent M quarterly assessment reference date) of 2/2 a 13 out of 15 on the mental status), indica cognitively intact. The progress notes for in part, "3/9/2022 17:3 in bed on 2 iitters [sic [sic] at 8:40 amCirc nursing assistant) car that she was unable t	<ul> <li>SC IDENTIFYING INFORMATION)</li> <li>29</li> <li>29</li> <li>d them weekly starting now.</li> <li>p.m., ASM #1, the</li> <li>2, the director of nursing, the director of nursing, ASM sister facility and RN sister facility and RN sister facility and RN staff development were s.</li> <li>n was provided prior to exit.</li> <li>led to evidence written to the resident/RP or budsman for Resident #2's er on 3/9/2022.</li> <li>IDS (minimum data set), a with an ARD (assessment 32/2022, the resident scored BIMS (brief interview for ting the resident is</li> <li>or Resident #2 documented 50 (5:50 p.m.) Resident was a 9 am CNA (certified ing for resident informed me o eat her breakfast. Upon</li> </ul>	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
	cyanotic, skin cool to breathing without any (liters) nasal cannula change in mental stat verbally, no congestic physician] was in hou him of residents chan resident sent out 911	side, color appeared slightly touch, resident was difficulty, with oxygen @ 2L in use was with definite us. Unable to respond on observed. [Name of se at the time and informed ge in status. He ordered . EMS (emergency medical ." The progress notes					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		495337	B. WING				C 17/2022	
NAME OF PI	ROVIDER OR SUPPLIER		1	:	STREET ADDRESS, CITY, STATE, ZIP CODE		-	
AUGUST I	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 623	Resident returned from The clinical record fail documentation of write the resident/RP or no for the facility-initiated On 3/16/2022 at 12:00 conducted with LPN ( LPN #5 stated that the clinical records for face did not send any write resident or responsible On 3/16/2022 at 9:32 conducted with ASM ( member) #1, the adm that they had not bee ombudsman for hospi stated that they had starte On 3/16/2022 at 10:00 conducted with OSM director of social work only spoke with the re- phone regarding the k that they had not bee of hospital discharges that they were to send On 3/16/2022 at 5:20 administrator, ASM #3, the assistan #4, administrator of a	<ul> <li>'3/9/2022 22:34 (10:34 p.m.) m the hospital at 8:45 pm."</li> <li>led to evidence ten notification of transfer to tification to the ombudsman d transfer on 3/9/2022.</li> <li>8 p.m., an interview was licensed practical nurse) #5.</li> <li>ey sent bed hold notice and cility-initiated transfers but en notice of transfer to the le party.</li> <li>a.m., an interview was (administrative staff inistrator. ASM #1 stated n sending notification to the ital transfers. ASM #1 spoken with the social ed doing this that morning.</li> <li>3 a.m., an interview was (other staff member) #5, the c. OSM #5 stated that they esponsible parties on the bed hold. OSM #5 stated n notifying the ombudsman a and that they were just told d them weekly starting now.</li> <li>p.m., ASM #1, the 2, the director of nursing, t director of nursing, ASM</li> </ul>	F	623				
	notified of the findings 5. The facility staff fail	S.						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/02/2022 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		495337	B. WING			_		C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
AUCUST				7	120 BRADDOCK ROAD			
AUGUSTI	HEALTHCARE AT LEEW	505		Α	NNANDALE, VA 22003	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	party for a facility initia notify the ombudsmar for Resident #74. Resident #74 was add 1/26/2022. On the mod data set) assessment Medicare five day ass (assessment reference resident scored a one interview for mental s resident is severely co making daily decision The nurse's note date documented, "Patient tachypnea and tachyo not feeding (sic) good very irritable. MD (me order given to give ne one time. Patient still fast breathing. Called (emergency room) for treatment. MD made a party, son [name of so to [Name of hospital] with med (medications) Review of the clinical to evidence a written for the transfer to the Resident #74 was pro- responsible party. And revealed there was no ombudsman of the tra- hospital on 1/31/2022	dent and/or responsible ated transfer, and failed to in of a transfer to the hospital mitted to the facility on ost recent MDS (minimum , a significant change bessment, with an ARD be date) of 2/11/2022, the on the BIMS (brief tatus) score, indicating the ognitively impaired for s. d 1/31/2022 at 2:42 p.m. alert and restlessness with cardiaPatient stated, 'I am l,' moving all-around in bed, edical doctor) notified, new obulizer treatment was given noticed restlessness and d 911 and sent to ER further evaluation and aware and responsible on] notified. Report is given ER nurse. All paper work s) were given to 911 staff." record on 3/16/2022 failed notification for the reason hospital on 1/31/2022 for ovided to the resident and/or d further investigation o notification of the ansfer of Resident #74 to the	F	623				
	An interview was con							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495337	B. WING				C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST I	HEALTHCARE AT LEEW	OOD	7120 BRADDOCK ROAD ANNANDALE, VA 22003				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	stated, "We have not the ombudsman on h with the social worker today. Here is the pro- ombudsman this more An interview was con- member) #5, the direct 3/16/2022 at 10:03 a. notifying the ombudsr to the hospital, OSM is ombudsman is new to week about it and am weekly, I already have ombudsman and he of week." Multiple requests wer documentation of the resident and/or respon the hospital. Nothing ASM #1, ASM #2, AS of nursing, ASM #4, a facility, and RN (regis	hember) #1, the 5/2022 at 9:32 a.m. ASM #1 been sending notification to ospital transfers. I've talked r and will start doing that bof of what we sent to the ning." ducted with OSM (other staff ctor of social services on m. When asked about man of a resident's transfer #5 stated "Notifying the orme. I was just told this a starting it now. I will do it e a relationship with the comes in at least once a re made for the written notification to the nsible party upon transfer to was provided prior to exit. SM #3, the assistant director administrator from a sister itered nurse) #3, the staff vere made aware of the	F	623	3		
F 625 SS=E	Notice of Bed Hold Po	n was provided prior to exit. olicy Before/Upon Trnsfr (2)	F	625	5		4/20/22
	§483.15(d)(1) Notice	bed-hold policy and return- before transfer. Before a ers a resident to a hospital or					

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05 FORM AP OMB NO. 09	PROVE	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495337	B. WING		C 03/17/2	022	
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	i		
AUGUST	HEALTHCARE AT LEEW	OOD		120 BRADDOCK ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE CO	(X5) MPLETIOI DATE	
F 625	nursing facility must j the resident or reside specifies- (i) The duration of the any, during which the return and resume re- facility; (ii) The reserve bed p plan, under § 447.40 (iii) The nursing facili bed-hold periods, wh paragraph (e)(1) of th resident to return; an (iv) The information s of this section. §483.15(d)(2) Bed-ho the time of transfer o hospitalization or the facility must provide the resident representation specifies the duration described in paragra This REQUIREMENT by: Based on staff interva and facility document the facility staff failed hold when the reside hospital for four of 47 sample, Residents #	therapeutic leave, the provide written information to ent representative that e state bed-hold policy, if e resident is permitted to esidence in the nursing payment policy in the state of this chapter, if any; ty's policies regarding ich must be consistent with his section, permitting a d specified in paragraph (e)(1) old notice upon transfer. At f a resident for rapeutic leave, a nursing to the resident and the ve written notice which n of the bed-hold policy ph (d)(1) of this section. T is not met as evidenced view, clinical record review t review, it was determined to provide a notice of bed nt was transferred to the residents in the survey 101, #85, #71 and #74.	F 625		deficiency ed for #74 as they irector of e sent out hold policy party who 4/1/2022.		
	was provided when F transferred to the hos	Resident #101 was		affected by this deficient practic facility transfers and discharged will be closely monitored by Dir	ce. All d residents		

Event ID: W82111

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		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	FOR OMB N	D: 05/02/2022 M APPROVED D. 0938-0391 E SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		495337	B. WING				/17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	Resident #101 was a 2/17/22. Resident #1 were not limited to: co bladder neck obstruct infection. Resident #1 (minimum data set) a change assessment, reference date of 3/2/ scoring 7 out of 15 or for mental status) sco was severely cognitiv Review of Resident # dated 2/19/22 at 3:02 "[Resident #101] Out progressing weakness Slow respond to verb Transferred back in b lunch writer attempter unable to open mouth unable to respond to nurse practitioner- se Emergency room (EF to change in mental st to verbal stimuli. RP ( and given the changer was sent to the ER vir report to hospital." On 3/15/22 at approx was made for the evin notification when Resis to the hospital on 2/1? An interview was con AM with OSM (other st director of social serv the bed hold notification	dmitted to the facility on 01's diagnoses included but erebral vascular accident, tion and urinary tract 101's most recent MDS ssessment, a significant with an assessment (22, coded the resident as 0 the BIMS (brief interview ore, indicating the resident rely impaired 201's nursing progress note 201's nursing	F	625	Social Services to ensure facility staff provide resident and/or responsible po- 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 February & March 2022 to ensure wri- notification has been sent. 3. The administrator/designee will educate the Director of Social Services the bed hold policy and importance of ensuring proper documentation of bed hold notices. 4. Director of Social Services/design will monitor resident transfer/discharg 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, we x4 weeks then monthly. Findings of al will be presented monthly for 3 month the Quality Assurance Performance Improvement (QAPI) Committee to ensure compliance. 5. April 20, 2022	of tten s on d nee es ekly udits	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
		495337	B. WING				C 17/2022	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	·		
AUGUST		OOD		7	7120 BRADDOCK ROAD			
					ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 625	talk with admitting about the family. I do not know documented." An interview was composite the family. I do not know documented." An interview was composite the asked if a bed hold nor residents who are transon of bed residents. We do not hold form. We verbal Not sure if it has been On 3/16/22 at 5:25 Pf administrator, ASM #3, the assistan #4, the administrator astaff development coor the above concern. According to the facilit Transfer" policy: "At the administration or there provide to the resident representative written duration of the bed-hold information explaining the next available bed No further information 2. The facility staff fail was provided when R to the hospital on 2/3/ Resident #85 was additional to the facility fail was additional to the facility staff fail was provided when R to the hospital on 2/3/	but it. I communicate with ow if anything is ducted on 3/16/22 at 3:30 admissions director. When otification is provided to insferred to the hospital, re is no evidence of I hold offered to these give them a copy of the bed ly discussed with the RP. In documented." M, ASM #1, the 2, the director of nursing, t director of nursing, ASM at sister facility and RN #3, ordinator were informed of ty's "Bed Hold Notice Upon the time of transfer for the apeutic leave, the facility will and/or the resident notice which specifies the old policy and addresses the return of the resident to a." was provided prior to exit.	F	625				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495337	B. WING				C 17/2022
NAME OF PROVIDER	OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
AUGUST HEALTH	CARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
were r diabet Residu diapet most r assess with ai coded BIMS the res Review dated "Abou good. vital si given (emery treatm On 3/ <sup>2</sup> was m notific: to the An inte AM wi directo the be talk wi admitt I do no	es mellitus and ent #85 was ado oses including of es mellitus and ecent MDS (mi sment, a Medic n assessment r the resident as (brief interview sident was not of w of Resident # 2/3/22 at 11:23 t 11 AM resider I feel like passi gnsPhysiciar to send the resi gency room) for ent. Resident I I5/22 at approx ade for the evid ation when Res hospital on 2/19 erview was con th OSM (other so or of social serv d hold being pr th the family ab ing about it. I of the the family ab	ongestive heart failure, bradycardia. mitted to the facility with congestive heart failure, bradycardia. Resident #85's nimum data set) are five day assessment, eference date of 1/19/22, a scoring 14 out of 15 on the for mental status), indicating cognitively impaired. 85's nursing progress note AM, revealed the following, at stated that 'I am not doing ng out,' Checked resident's n notified and new order dent to nearest ER r further evaluation and eft with ambulance."	F	625			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/02/2022 MAPPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495337	B. WING					C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIF	P CODE	-	
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD B		(X5) COMPLETION DATE
F 625	"There is no evidence hold offered to these them a copy of the be discussed with the RF documented." On 3/16/22 at 5:25 PF administrator, ASM # ASM #3, the assistan #4, the administrator staff development coo the above concern. No further information 3. The facility staff fai notice for Resident #7 on 1/29/2022. On the most recent M significant change as (assessment reference resident was assesse impaired for making of The progress notes for in part, "1/29/2022 15 observed in bed at be closed and breathing (oxygen) at 2L (two lift (nasal cannula). BS of Unable to get reading Resident continued of mucus from mouth notified. Order: Trans hospital] ER (emerge (evaluation) and treat	e of documentation of bed residents. We do not give ed hold form. We verbally P. Not sure if it has been M, ASM #1, the 2, the director of nursing, t director of nursing, ASM at sister facility and RN #3, ordinator were informed of n was provided prior to exit. led to provide bed hold 71's facility-initiated transfer IDS (minimum data set), a sessment with an ARD ce date) of 2/9/2022, the ed as being severely	F	625				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			PLETED
		495337	B. WING				C / <b>17/2022</b>
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD		
					ANNANDALE, VA 22003		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page	e 38	F	625	5		
	The clinical record fai				-		
	documentation of bec facility-initiated transf	I hold notice provided for the er on 1/29/2022.					
	On 3/16/2022 at 12:0	8 p.m., an interview was					
	conducted with LPN (	licensed practical nurse) #5.					
		ey sent an envelope with ents to the hospital with					
		d out. LPN #5 stated that					
	the envelope had a cl	-					
		ted that the documents they cluded a bed hold notice.					
	LPN #5 stated that th	ey should document what					
		ess notes because they do e that was sent. LPN #5					
	stated that some of th	ne nurses were good about					
	making the notes and	l some were not.					
	On 3/16/2022 at 10:0	3 a.m., an interview was					
		(other staff member) #5, the c. OSM #5 stated that they					
		esponsible parties on the					
	phone regarding the l	ped hold.					
	On 3/16/2022 at 3:30	p.m., an interview was					
	conducted with OSM	(other staff member) #8, the					
		OSM #8 stated that they did a bed hold provided to					
		#8 stated that they do not					
	give a copy of the bed	· · ·					
	-	ed hold with the responsible if it was documented.					
	On 3/16/2022 at 5:20	•					
		2, the director of nursing, t director of nursing, ASM					
	#4, administrator of a	sister facility and RN					
	(registered nurse) #3, notified of the findings	, staff development were s.					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495337	B. WING				C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page	39	F	625	5		
	4. The facility staff fail	n was provided prior to exit. led to provide a written copy upon transfer to the hospital ident #74.					
	1/26/2022. On the modulate set) assessment Medicare five day ass (assessment reference resident scored a one interview for mental s	sessment, with an ARD be date) of 2/11/2022, the e on the BIMS (brief tatus) score, indicating the ognitively impaired for					
	documented, "Patient tachypnea and tachyo not feeding (sic) good very irritable. MD (me order given to give ne one time. Patient still fast breathing. Called (emergency room) for treatment. MD made party, son [name of so to [Name of hospital]	ed 1/31/2022 at 2:42 p.m. alert and restlessness with cardiaPatient stated, 'I am I,' moving all-around in bed, edical doctor) notified, new abulizer treatment was given noticed restlessness and d 911 and sent to ER further evaluation and aware and responsible on] notified. Report is given ER nurse. All paper work s) were given to 911 staff."					
	practical nurse) #5 on When asked the proc to the hospital, LPN # a resident to the hosp with them, the envelo send a face sheet, the progress notes, the ca	ducted with LPN (licensed a 3/16/2022 at 12:08 p.m. ess for sending a resident 6 stated, "When we transfer pital we send an envelope pe has a checklist on it. We history and physical, the are plan, the change in bs and we call a report to					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	NG		C	
		495337	B. WING			03/17/2022	
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			20 BRADDOCK ROAD NNANDALE, 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	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	them." When asked w documented, LPN #5 document this in the p make a copy of anyth good about making th A request was made to bed hold provided to b responsible party on 3 03/16/2022 at 3:31 p. admissions stated, "F family did not formally #8 stated she would f On 3/16/2022 at 3:36 do not give them a co verbally discussed wit party). When asked w	e send a bed hold notice with where this should be stated, "We should orogress note, we do not ing. Some of the nurses are ne notes and some are not." for the documentation of the Resident #74 and/or her 3/15/2022 at 5:00 p.m. On m., OSM #8, the director of rom what I understand, the y pay for a bed hold." OSM urther investigate this. p.m. OSM #8 stated, "We py of the bed hold form, it's th the RP (responsible yhere the verbal discussion #8 stated for [Resident	F 6	625			
F 641 SS=D	of nursing, ASM #4, a facility, and RN (regis development nurse, v above concern on 3/1	n was provided prior to exit. ents	F 6	641			4/20/22
	The assessment mus resident's status. This REQUIREMENT by:	t accurately reflect the is not met as evidenced n, resident interview, staff			1. Resident #83 had their most recen	t	

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			PRINTED: 05/0 FORM APPI OMB NO, 093	ROVED	
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
495337	B. WING		C 03/17/20	22	
		STREET ADDRESS, CITY, STATE, ZIP CODE			
		7120 BRADDOCK ROAD			
		ANNANDALE, VA 22003			
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE COMP	(X5) PLETION PATE	
and review and facility ras determined that the nsure a complete and sment for 2 of 47 residents Residents #83 and #2. The 2/7/22 quarterly MDS ed incorrectly for weight, ht gain. The resident was ficant weight loss and h, based on a weight ely one year prior to the ad no weights obtained in mitted to the facility on diagnoses of but not limited isease, high blood pressure ase. On the most recent Set), a quarterly IRD (Assessment 7/22, the resident scored a dS (brief interview for mental resident was severely or making daily decisions. If record revealed the he last weight obtained was ads. MDS dated 2/7/22 wing in Section K itional Status:"	F 64	<ul> <li>MDS assessment modified to accicode section K to reflect the resident weight or lack thereof.</li> <li>Resident #2 had their most recent assessment modified to accurately section O to reflect the use of oxy 2. All residents in the facility have potential to be affected by this definition practice. The MDS</li> <li>Coordinators/Designee will audit a current residents MDS records to all residents have a complete and accurate MDS assessment.</li> <li>The Director of Nursing/Designe ducate the MDS Coordinators or MDS coding as defined in the RAI manual.</li> <li>The MDS Coordinators/Designee form weekly audits of quarterly on coding accuracy. Findings of tweekly audits will be presented m for three months to the Quality Asternative action of the section of</li></ul>	ent I s MDS y code gen. /e the icient all ensure gnee will n proper mee will MDS he onthly surance		
	IDENTIFICATION NUMBER:	MEDICAID SERVICES       (X2) MULTIF         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIF         A BUILDING       495337         B. WING       B. WING         COD	MEDICAID SERVICES         (x1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:         495337         B. WING         495337         B. WING         STREET ADDRESS. CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNADALE, VA 22003         NEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL sci LIDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDERS PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-RETENCED TO THE APPR DEFICIENCY)         e41       F 641         brdr erview and facility ras determined that the nsure a complete and sment for 2 of 47 residents Residents #83 and #2.       F 641         brdr eview and facility ras determined that the nsure a complete and sment for 2 of 47 residents Resident base and no use of 47 resident was fficant weight loss and no based on a weight the 2/7/22 quarterly MDS ad incorrectly for weight, th tgain. The resident was fficant weight loss and no based on a weight tag one set of but not limited isease, high blood pressure use. On the most recent set), a quarterly sci), a quarterly sci), a quarterly sci), a quarterly sci), a quarterly sci), a quarterly sci), a quarterly or making daily decisions.       1 record revealed the he last weight obtained was rds.       4. The MDS Coordinators/Desig perform weekly audits of quarterly on coding accuracy. Findings of the weekly audits will be presented m for three months to the Quality As Improvement Committee (QAPI) t ensure compliance.         11 record revealed the he last weight obtained was rds.       5. April 20, 2022         12 tand Weight	D HUMAN SERVICES COMB APP MEDICAID SERVICES ON APP MEDICAID SERVICES ON APP MEDICAID SERVICES ON APP 48 100 ME NO. 032 496337 B WING (2) MULTIPLE CONSTRUCTION A BUILDING 496337 B WING (2) MULTIPLE CONSTRUCTION A BUILDING 496337 B WING (2) MULTIPLE CONSTRUCTION A BUILDING 496337 B WING (2) MULTIPLE CONSTRUCTION A BUILDING TYPE FADDRESS, CITY, STATE, 2IP CODE 7728 BRADOCK ROAD ANNANDALE, VA 22003 XTEMENT OF DEFICIENCIES WING (2) CALC CORRECTION CORRECTION MUST BE PRECEDED BY FULL WINS THE PRECEDED BY FULL SCIENTIFYING INFORMATION) 411 F641 F641 WDS assessment modified to accurately code section K to reflect the resident (2) weight or lack thereof. Residents #83 and #2. 41 F641 WDS assessment modified to accurately code section K to reflect the resident (2) weight or lack thereof. Resident #2 And their most recent MDS assessment modified to accurately code section K to reflect the resident (2) Weight loss and ht agin. The resident was ficant weight loss and ht agin. The resident was ficant weight loss and ht using the resident was ficant weight loss and ht agon weight by one year prior to the ad no weights obtained in mitted to the facility on fisageneses of but not limited isease, high blood pressure sec. On the most recent Set, a quarterly RD (Assessment T/22, the resident was fit interview for mental resident was severely or making daily decisions. I record revealed the he last weight obtained was dds. MDS dated 2/7/22 wing in Section K titonal Status." tand WeightB. Weight (in to most recent measure in MDS colorinators (MD Pissure to most recent measure in MDS colorinators (MD Pissure to most recent measure in MDS colorinators (MD Pissure to most recent measure in MDS condinators (MD Pissure to most recent measure in M	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	D. 0938-0391 E SURVEY PLETED
		495337	B. WING				C / <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<b>.</b>	
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	pounds. This weight should no as this weight was ob prior to the above ME parameters of "base" measure in last 30 da	ot have been documented, stained approximately a year OS, and did not meet the weight on most recent ays."	F	641			
	in the last month or lo months. 0. No or unknown. 1. Yes, on physician-p regimen.	nt Loss: Loss of 5% or more oss of 10% or more in last 6 prescribed weight-loss an-prescribed weight-loss					
		ked with a "2" in the box, t had a significant weight above documented					
	in the last month or g months. 0. No or unknown. 1. Yes, on physician- regimen.	nt Gain: Gain of 5% or more ain of 10% or more in last 6 prescribed weight-gain an-prescribed weight-gain					
		ked with a "2" in the box, t had a significant weight above documented					
	approximately a year	had any weights obtained in , hence the above loss or gain "of 5% or more					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391			
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
		495337	B. WING _				C 17/2022			
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE					
AUGUST I	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD NNANDALE, VA 22003					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE			
F 641	has not had any weig should be coded regat She stated she would asked what resource MDS, she stated the I Assessment Instrume On 3/16/22 04:25 PM conducted with LPN # has not been any wei had been a weight loss be coded as a 0 (for " significant weight loss know." On 3/16/22 at 5:06 PM interview was conduct stated the MDS was r weight from a year ag used. On 3/16/22 at 5:19 PM Staff Member) the Ad Director of Nursing, A sister facility, and RN Development, were re No further information the survey. According to the RAI	0% or more in last 6 oply. M an interview was #3 (Licensed Practical e. When asked if a resident hts obtained, how the MDS arding weight loss / gain. I follow up on that. When is used to complete the RAI manual (Resident ent). I a follow up interview was #3. She stated that if there ghts to determine if there ss or gain, the MDS should 'No or Unknown" for s or gain) "because you don't M another follow up tted with LPN #3. She miscoded. She stated the go should not have been M, ASM #1 (Administrative ministrator, ASM #2 the	F	541						
	2019:									

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/02/2022 MAPPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495337	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				7	7120 BRADDOCK ROAD		
AUGUST		UUD		4	ANNANDALE, VA 22003		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI	Х	(EACH CORRECTIVE ACTION SHOULD B		COMPLETION
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE .	DATE
					DEFICIENCE)		
F 641	Continued From page	2 44	F	641			
	Steps for Assessmen						
	-	e most recent measure in the					
	last 30 days.	naistantly over time in					
	-	nsistently over time in ity policy and procedure,					
		current standards of practice					
	(shoes off, etc.).	arrent standards of practice					
		sessments, check the					
		nter the weight taken within					
	30 days of the ARD o	-					
		weight was taken more					
		the ARD of this assessment					
		not available, weigh the					
	resident again.						
	5. If the resident's we	ight was taken more than					
	once during the prece	eding month, record the					
	most recent weight.						
		not be weighed, for example					
		pain, immobility, or risk of					
	pathological fractures						
		-) and document rationale					
	on the resident's med	lical record.					
	K0300 Woight Loss						
	K0300 Weight Loss Coding Instructions:						
	-	vn: if the resident has not					
		oss of 5% or more in the					
		or more in the last 180 days					
	or if information about						
	available.						
		physician-prescribed					
	weight-loss regimen:						
		loss of 5% or more in the					
		or more in the last 180 days,					
		as planned and pursuant to					
	-	In cases where a resident					
		5% or more in 30 days or					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495337	B. WING				_ 17/2022	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST	HEALTHCARE AT LEEW	DOD			120 BRADDOCK ROAD NNNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 641	loss due to loss of flui diuretics, K0300 can l Code 2, yes, not on p weight-loss regimen: experienced a weight past 30 days or 10% and the weight loss w prescribed by a physi K0310 Weight Gain Coding Instructions: Code 0, no or unknow experienced weight g past 30 days or 10% or or if information about available. Code 1, yes on weight-gain regimen: experienced a weight past 30 days or 10% and the weight gain of 10% or more in 180 d physician ordered die as 1. Code 2, yes, no weight-gain regimen: experienced a weight past 30 days or 10% and the weight gain w physician ordered die as 1. Code 2, yes, no weight-gain regimen: experienced a weight past 30 days or 10% and the weight gain w prescribed by a physi 2. The facility staff fa	ays as a result of any t plan or expected weight d with physician orders for be coded as 1. hysician-prescribed if the resident has loss of 5% or more in the or more in the last 180 days, ras not planned and cian. wh: if the resident has not ain of 5% or more in the or more in the last 180 days t prior weight is not physician-prescribed if the resident has gain of 5% or more in the or more in the last 180 days, vas planned and pursuant to In cases where a resident 5% or more in 30 days or ays as a result of any t plan, K0310 can be coded it on physician-prescribed if the resident has gain of 5% or more in the or more in the last 180 days, vas planned and pursuant to In cases where a resident of or more in 30 days or ays as a result of any t plan, K0310 can be coded it on physician-prescribed if the resident has gain of 5% or more in the or more in the last 180 days, vas not planned and	F	641				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE	
				_			C
		495337	B. WING			03/	17/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 641	Resident #2 was adm diagnoses that include acute respiratory failu failure. On the most re assessment with an A date) of 2/23/2022, th of 15 on the BIMS (br status), indicating the intact. Section O of th evidence the use of o On 3/15/2022 at 12:19 made of Resident #2 was observed receivin cannula attached to a this time an interview Resident #2, who stat oxygen all the time ar long time." The physician orders documented in part, " (minute) via nasal car (saturations) above 99 8/16/2021." The comprehensive of documentation for the The eTAR (electronic record) for Resident # and 3/1/2022-3/31/20 receiving oxygen at 1 cannula every shift. On 3/16/2022 at appr- interview was conduct	<ul> <li>witted to the facility with</li> <li>ed but were not limited to</li> <li>re with hypoxia and heart</li> <li>ecent MDS, a quarterly</li> <li>KD (assessment reference</li> <li>e resident scored a 13 out</li> <li>ief interview for mental</li> <li>resident is cognitively</li> <li>ne assessment failed to</li> <li>xygen while a resident.</li> <li>9 p.m., an observation was</li> <li>in their room. Resident #2</li> <li>ng oxygen via a nasal</li> <li>n oxygen concentrator. At</li> <li>was conducted with</li> <li>ted that they wore the</li> <li>nd had used oxygen for "a</li> </ul> for Resident #2 Oxygen at 1 liter per min mula to maintain sats 2%. Order Date: are plan failed to evidence e use of oxygen. treatment administration t2 dated 2/1/2022-2/28/2022 22 documented Resident #2 liter per minute via nasal oximately 2:20 p.m., an ted with LPN (licensed IDS coordinator. LPN #3	F	641			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/02/2022 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		495337	B. WING		_		C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	DOD		120 BRADDOCK ROAD	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	MDS assessments. On 3/17/2022 at 9:00 conducted with LPN # reviewed the physicia administration record) administration record) LPN #3 stated that the #2's quarterly MDS w see if oxygen was coor On 3/17/2022 at appri- stated that they had re- look back period. LPI not coded on the quar 2/23/2022, and it shou According to the RAI Special Treatments, F it documented in part, therapy, Code continu- administered via mas a resident to relieve h The facility policy "Clin Documentation/Accur Coding" documented record facilitatesAcc	nt) when completing the a.m., an interview was 43. LPN #3 stated that they n orders, MARs (medication ) and TARs (treatment ) when completing the MDS. ey would look at Resident ith the ARD of 2/23/2022 to ded. oximately 9:15 a.m., LPN #3 eviewed Resident #2's eceive oxygen during the N #3 stated that oxygen was rterly MDS with the ARD of uld have been on there. manual, Section O0100: Procedures, and Programs, "O0100C, Oxygen uous or intermittent oxygen k, cannula, etc., delivered to ypoxia in this item"	F 641		DEFICIENCY)		
	staff member) #1, the director of nursing, AS	-					

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		MEDICAID SERVICES				NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		· · · ·	ATE SURVEY DMPLETED
		495337	B. WING		C 03/17/2022	
NAME OF PI	ROVIDER OR SUPPLIER	•	STF	REET ADDRESS, CITY, STATE, ZIP COD	E	
AUGUST I	HEALTHCARE AT LEEW	OOD		0 BRADDOCK ROAD NANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	Continued From pag	e 48	F 641			
	PASARR Screening		F 645			4/20/22
SS=D	CFR(s): 483.20(k)(1)	-(3)				
	§483.20(k) Preadmis individuals with a me with intellectual disab	ntal disorder and individuals				
	or after January 1, 19	ing facility must not admit, on 989, any new residents with:				
		s defined in paragraph (k)(3) ess the State mental health ined, based on an				
	performed by a perso State mental health a	l and mental evaluation on or entity other than the authority, prior to admission,				
	condition of the indiv	the physical and mental idual, the individual requires provided by a nursing facility;				
	(B) If the individual reservices, whether the specialized services;	individual requires				
	(ii) Intellectual disabil (k)(3)(ii) of this section	ity, as defined in paragraph				
	(A) That, because of	ined prior to admission- the physical and mental idual, the individual requires				
	the level of services and (B) If the individual re	provided by a nursing facility;				
	services, whether the	•				
	section-	tions. For purposes of this				
	(i)The preadmission					

Facility ID: VA0142

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/02/2022 // APPROVED ). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION		LETED
		495337	B. WING				C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ALIQUAT				71	20 BRADDOCK ROAD		
AUGUST	HEALTHCARE AT LEEW			A	NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 645	paragraph(k)(1) of this for determinations in t to a nursing facility of being admitted to the transferred for care in (ii) The State may cho preadmission screeni paragraph (k)(1) of th to a nursing facility of (A) Who is admitted to hospital after receiving hospital, (B) Who requires nurs condition for which the the hospital, and (C) Whose attending before admission to th is likely to require less facility services. §483.20(k)(3) Definitions section- (i) An individual is cor disorder defined in 48 (ii) An individual is cor intellectual disability at or is a person with a r described in 435.1010 This REQUIREMENT by: Based on clinical rec interview it was detern failed to evidence com (preadmission screen 1 of 47 residents in th #30. The facility staff	s section need not provide the case of the readmission an individual who, after nursing facility, was a hospital. bose not to apply the ng program under is section to the admission an individual- o the facility directly from a g acute inpatient care at the sing facility services for the e individual received care in physician has certified, he facility that the individual s than 30 days of nursing on. For purposes of this hsidered to have a mental ual has a serious mental (3.102(b)(1). hsidered to have an f the individual has an as defined in §483.102(b)(3) related condition as 0 of this chapter.	F	645	<ol> <li>Resident #30 had a PASARR (Preadmission Screening and Residen Review) completed on 3/16/22 by Soci Service Director/Designee.</li> <li>All residents in the facility have a potential to be affected by this deficient practice. The Social Service Director has a service director director has a service director di</li></ol>	al	

Facility ID: VA0142

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495337	B. WING				C / <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				71	120 BRADDOCK ROAD		
AUGUST	HEALTHCARE AT LEEW	UOD		Α	NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 645	facility on 4/24/2021. The findings include: Resident #30 was add 4/24/21 with diagnose disorders, hallucinatic dementia with behavio most recent MDS (min assessment with an A date) of 12/26/2021, t 15 on the BIMS (brief indicating the residen making daily decision Review of Resident # evidence a level 1 PA On 3/16/2022 at appr request was made to member) #1, the adm PASRR for Resident # On 3/16/2022 at appr #1 provided a Level 1 with a completion date On 3/17/2022 at 8:00 conducted with OSM director of social serv the level 1 PASRR no admission documents stated that when they their expectation was the facility at that time PASRR. OSM #5 sta that Resident #30 did	mitted to the facility on es that included delusional ons and unspecified oral disturbance. On the nimum data set), a quarterly ARD (assessment reference the resident scored 10 out of interview for mental status), t is moderately impaired for s. 30's clinical record failed to SRR. 30's clinical record failed to SRR. 45's clinical record failed to SRR.	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/Designe will perform weekly audits on all new admission charts to ensure completion the PASARR Level 1. Findings of wea audits will be presented monthly for the months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance. 5. April 20, 2022	ee n of ekly	
PRÉFIX TAG	(EACH DEFICIENC REGULATORY OR L Continued From page facility on 4/24/2021. The findings include: Resident #30 was add 4/24/21 with diagnose disorders, hallucinatio dementia with behavio most recent MDS (min assessment with an A date) of 12/26/2021, t 15 on the BIMS (brief indicating the residen making daily decision Review of Resident # evidence a level 1 PA On 3/16/2022 at appr request was made to member) #1, the adm PASRR for Resident # 0n 3/16/2022 at appr #1 provided a Level 1 with a completion data On 3/17/2022 at 8:00 conducted with OSM director of social serv the level 1 PASRR no admission documents stated that when they their expectation was the facility at that time PASRR. OSM #5 sta that Resident #30 did until the request was	when the staff member) #5, the ices. OSM #5 stated that or safe that included the staff member) #5, the ices. OSM #5 stated that or safe that included the safe that included the safe that included delusional ons and unspecified or safe the state of the safe the sa	PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) 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 the PASARR Level 1. Findings of wea audits will be presented monthly for the months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance.	ee n of ekly	COM

Facility ID: VA0142

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		ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 05/02/2022 DRM APPROVED NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495337	B. WING				C 03/17/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
AUCUST	HEALTHCARE AT LEEW	000		712	20 BRADDOCK ROAD		
7000311				AN	INANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 645	PASRR on 3/16/2022 been done prior to the The facility policy, "Pr Annual Resident Rev documented in part, " preadmission process the Preadmission Scr Review (PASRR) scr all new and readmiss determine if the indiv mental disorder (SMI (ID) or related conditi screen, the facility wi a mental disorder or i Level II screening pro and the recommendar facility admission and provide the specialize the Level II screen. If the facility is approve process, the facility w PASRR representativ needs of the resident The document, "COV Declaration Waivers" documented in part o Pre-Admission Scree Review (PASARR). C and Medicaid Service 483.20(k), allowing m residents who have m	2 and that one should have is date. readmission Screening and iew (PASRR) Policy" 'As part of the s, the facility participates in reening and Resident eening process (Level I) for ions per requirement to idual meets the criterion for /SMD), intellectual disability on. Based upon the Level I II not admit an individual with intellectual disability until the pocess has been completed itions allow for a nursing I the facility's ability to ed services determined in a provisional admission to d via the Level II screen <i>v</i> ill coordinate with the State re related to the individual as indicated"	F	645	DEFIGIENCY)		
	may be performed po the 30th day of admis to nursing homes with intellectual disability (	ost-admission. On or before ssion, new patients admitted h a mental illness (MI) or (ID) should be referred ng home to State PASARR					

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					FOR	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COM	E SURVEY PLETED
		495337	B. WING			0 /17/2022
	ND PLAN OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING       495337     B. WING       STREET ADDRESS, CITY, STATE, ZIP CODE       7120 BRADDOCK ROAD       AUGUST HEALTHCARE AT LEEWOOD       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTIVE ACTION SH       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SH				·	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPF	ULD BE	(X5) COMPLETION DATE
F 655	program for Level 2 F information was obtain https://www.cms.gov/ ergency-declaration-w On 3/17/2022 at 9:30 staff member) #1, the director of nursing, AS of nursing, ASM #4, th facility and RN (registe development were mather Baseline Care Plan CFR(s): 483.21(a)(1)- §483.21 Comprehense Planning §483.21(a) Baseline (C §483.21(a) (1) The fact implement a baseline that includes the instr effective and person- that meet professional The baseline care plan (i) Be developed within admission. (ii) Include the minimum necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (C) Therapy services.	<ul> <li>Resident Review" This ned from the website:</li> <li>files/document/covid-19-em vaivers.pdf</li> <li>a.m., ASM (administrative administrator, ASM #2, the SM #3, the assistant director ne administrator at sister ered nurse) #3, staff ade aware of the findings.</li> <li>a.was provided prior to exit.</li> <li>(3)</li> <li>ive Person-Centered Care</li> <li>Care Plans</li> <li>cility must develop and care plan for each resident uctions needed to provide centered care of the resident at standards of quality care.</li> <li>n must-</li> <li>n 48 hours of a resident's um healthcare information care for a resident and to a resident are a resident and to a resident are a resident and to a resident and to a resident are a resident and to a resident are a resident area resident area resident area resident area resident area resid</li></ul>				4/20/22
	§483.21(a)(2) The fac	ility may develop a				

Facility ID: VA0142

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	MENT OF HEALTH AN S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM	0: 05/02/2022 1 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495337	B. WING			( 03/ <sup>-</sup>	C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
				7120 BRADDOCK ROAD			
AUGUST	HEALTHCARE AT LEEW	DOD		ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 655	comprehensive care p care plan if the compr (i) Is developed within admission. (ii) Meets the requirer (b) of this section (exc this section). §483.21(a)(3) The far resident and their rep of the baseline care p limited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the fa on behalf of the facilit (iv) Any updated infor of the comprehensive This REQUIREMENT by: Based on observation interview, facility docu record review, it was staff failed to develop plan for 1 of 47 reside Resident #315. The facility staff failed baseline care plan to incentive spirometer. The findings include: Resident #315 was ad 3/7/22. Resident #31 was not limited to a ho	blan in place of the baseline rehensive care plan- in 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary lan that includes but is not if the resident. resident's medications and treatments to be acility and personnel acting y. mation based on the details e care plan, as necessary. if is not met as evidenced in, resident interview, staff ument review and clinical determined that the facility a complete baseline care ents in the survey sample, it to develop Resident #315's	F	<ol> <li>Resident #315 suffer effects related to this define Facility nurse reached our on 3/16/22 with a request incentive spirometer but r denied; MD stated that re need this device. Care Pla updated.</li> <li>All residents with a n spirometer have the poter affected by this deficient p Unit Manager/Designee w audit of all current resider person-centered, complet information.</li> <li>Education completed staff and Department Hea</li> </ol>	cient practice. t to the physici for an order for request was sident did not an was not eed for incenti ntial to be practice. The vill complete an the Care Plans for te, and accura	ian or ive n for te	

Event ID: W82111

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3	· · ·	OMPLETED
						С
		495337	B. WING			03/17/2022
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
AUGUST I	EALTHCARE AT LEEW	OOD		7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE
F 655	Continued From page	e 54	F 65	55		
	An admission assess	ment dated 3/7/22		Plan/Care Plan Meetings/	Baseline Care	
	documented Residen			Plan policy and identifying		
	oriented to person, pl	ace, time and situation.		admitting with the need fo spirometer.	r incentive	
	A review of Resident	#315's March 2022		4. The Unit Manager/De	signee will	
		led to reveal a physician's		perform weekly audits of a		
order for an incentive spiromete Resident #315's baseline care	•		hospital records, hospital			
			summary and resident inv incentive spirometer need	•		
	3/7/22 failed to reveal documentation regarding an incentive spirometer.			include monitoring for a co		
				accurate baseline/compre		
		m. and 3/16/22 at 8:34 a.m., bserved sitting in a chair in		plan. Weekly audit reports presented to the Quality A		
		entive spirometer was on the		Improvement Committee (		
	resident's over bed ta			for three months to ensure		
	interview was conduc			5. April 20, 2022		
		l, "They told me to inhale 10 did not specify who "they"				
	were.					
	On 3/16/22 at 2:20 p.	m an interview was				
		(licensed practical nurse) #3				
	(the minimum data se	et coordinator). LPN #3				
	stated the purpose of					
		are and work out a plan of . LPN #3 stated an incentive				
		atory device used for the				
	lungs and has to be c staff can monitor it.	on the baseline care plan so				
	On 3/16/22 at approx (administrative staff n	imately 5:50 p.m., ASM				
		SM #2 (the director of				
		aware of the above concern.				
		d, "Care Plan/Care Plan				
		re Plan" documented, "The and implement a baseline				
		e plan within 48 hours for				

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		495337	B. WING		C 03/17/2022		
NAME OF P	ROVIDER OR SUPPLIER	•	STRE	EET ADDRESS, CITY, STATE, ZIP CO	DDE		
AUGUST	HEALTHCARE AT LEEW	OOD	-	BRADDOCK ROAD			
				ANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLET IE APPROPRIATE DATE		
F 655	Continued From page	<del>2</del> 55	F 655				
		udes the instructions needed					
	to provide effective a	nd person-centered care that andards of quality of care."					
	No further information	n was presented prior to exit.					
F 656 SS=E	Develop/Implement C	Comprehensive Care Plan	F 656		4/20/22		
	implement a compreh care plan for each res- resident rights set for §483.10(c)(3), that im- objectives and timefra- medical, nursing, and needs that are identif assessment. The com- describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483. provided due to the re- under §483.10, include treatment under §483. (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside (iv)In consultation wit resident's representa	cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's if mental and psychosocial ied in the comprehensive mprehensive care plan must <i>Q</i> - are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	05/02/2022 APPROVED 0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		CONSTRUCTION		LETED
		495337	B. WING _			( 03/ <sup>-</sup>	; 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUQUAT				7'	120 BRADDOCK ROAD		
AUGUSTI	HEALTHCARE AT LEEW			Α	NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	<ul> <li>(B) The resident's prefuture discharge. Faci whether the resident's community was assess local contact agencies entities, for this purpoo (C) Discharge plans in plan, as appropriate, if requirements set forth section.</li> <li>This REQUIREMENT by: Based on observation record review and face determined that the face and implement the co six of 47 residents in the Residents #56, #28, # The findings include:</li> <li>The facility staff face comprehensive care p 56's pain.</li> <li>Resident # 56 was ad diagnosis that include pain. On the most recorset), a quarterly assess (assessment reference resident scored 13 out interview for mental si resident is cognitively decisions. Section Jo having any pain in the The physician's order dated February 2022</li> </ul>	ference and potential for lities must document a desire to return to the seed and any referrals to a and/or other appropriate se. In the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced ity document review, it was icility staff failed to develop mprehensive care plan for the survey sample, t39, #11, #71 and #2 . Ided to develop a blan to address Resident # mitted to the facility with a d by not limited to chronic ent MDS (minimum data assment with an ARD e date) of 02/27/2022, the t of 15 on the BIMS (brief tatus), indicating the intact for making daily coded Resident # 56 as not e past 5 (five) days. sheet for Resident # 35 documented in part:	F	556	<ol> <li>Resident #56□s Comprehensive O Plan updated (developed) to reflect person-centered pain management including both non-pharmacological an- pharmacological interventions. Care pla 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 pain to observe for is also included in th care plan).</li> <li>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 intervention (fall mats) and need to follow plan of ca for resident safety. Fall mat placement now added to CNA charting tasks for al residents with fall mat orders.</li> <li>Resident #39□s Comprehensive Care Plan updated (developed) to reflect</li> </ol>	d an o of ne are II	
	dated February 2022					s to	

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/02/202 A APPROVE ). 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495337	B. WING				C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
		10.00		712	20 BRADDOCK ROAD		
AUGUSTI	HEALTHCARE AT LEEW	000		AN	NANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From pag	o 57	F 6	56			
1 000			FU	000	www.weater headling/deans are visited for fire	at la cu	
		ive one tablet by mouth d. Order Date: 04/23/2021."			promote healing/decrease risks for fur skin breakdown. Wound measuremer		
	twice daily as needed	a. Order Date. 04/23/2021.			and treatment in place. Implementation		
	Resident #56's eMA	R (electronic medication			frequent repositioning, reporting skin		
	administration record				redness/breakdown promptly, changir	ng of	
	documented the adm	inistration of the			incontinence promptly and importance	-	
	Oxycodone-Acetamii	nophen as documented			nutrition/fluids to promote healing in p	lace.	
		ng dates and times, with no			Nursing and CNAs re-educated on		
		rmacological interventions			identifying residents at risk for skin		
		01/2022 at 4:31 p.m.,			breakdown/pressure ulcer formation,		
		.m., 03/03/2022 at 4:54 p.m.,			interventions to decrease skin breakd		
	-	.m., 03/07/2022 at 7:00 p.m., .m., 03/13/2022 at 5:22 a.m.			and pressure ulcer care/documentation Wound nurse to provide wound treatment		
	and on 03/15/2022 a				in TAR and weekly wound measurem		
		p.m.			in PCC Weekly Pressure Wound	01110	
	The comprehensive	care plan for Resident # 56			Observation Tool. Braden Scale		
	-	led to evidence information			assessment completed on all resident	ts to	
	related to pain.				assess for skin risk breakdown. Dietic		
	On 00/47/00 at an m				completes PCC Nutrition assessment		
		oximately 10:52 a.m., an cted with Resident # 56.			all residents upon admission, quarterl and with change of status.	у	
		eceive pain medication as			Resident #11 s Comprehensive Care	<b>`</b>	
		6 stated, "Sometimes."			Plan updated (developed) to reflect	·	
		aff try to alleviate their pain			compression stockings, their cleaning		
		ain medication Resident # 56			care and resident preference to remov		
	stated "Sometimes."				them when taking afternoon rest.		
					Implementation includes CNA daily		
		proximately 2:20 p.m. an			schedule of placing and removing ted		
		cted with LPN [licensed			hose, daily cleaning of these and		
	-	MDS coordinator regarding			interventions to encourage use of weat	-	
		are plan for Resident # 56. ribe the purpose for a care			ted hose per orders. Nurses monitor f	or	
		"To coordinate resident care			compliance in TAR. Resident #71□s Comprehensive Care	<u> </u>	
		of care for the resident."			Plan updated (developed) to reflect		
		comprehensive care plan is			therapeutic bilateral hand splints and		
		lent LPN # 3 stated, "Go with			instructions for use. Implementation		
	-	comprehensive assessment			includes daily schedule to place and		
	and develop the care	plan and we follow the RAI			remove splints, staff encouragement		
	(resident assessmen	t instrument) manual" When			wear splints per orders and skin chec	k	

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		MEDICAID SERVICES				IO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	E SURVEY IPLETED
						С
		495337	B. WING		0	3/17/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
	HEALTHCARE AT LEEW	000		7120 BRADDOCK ROAD		
A00031				ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	e 58	F 65	56		
		care plan to address		schedule to ensure no bre	akdown is	
		LPN # 3 stated, "I'll check		occurring under splint. The		
		proximately 4:18 p.m., LPN		assess for continued need		
		o care plan for [Name of		refusals of resident to wea	•	
	Resident # 56's] pain	and there should be."		Re-education with CNAs a	and nursing staff	
				on following orders for spl		
		Care Plans, Comprehensive		need for skin monitoring u		
		cumented in part, "8. The		reporting to therapy service		
		on-centered care plan will: a. objectives and time frames;		Physician of frequent refuse ordered splints. Education		
		ces that are to be furnished		resident s right to refuse		
	to attain or maintain t			Resident #2 s Comprehe	• •	
		mental, and psychosocial		updated (developed) to re		
	well-being"			oxygen and skin impairme		
				(pressure ulcers resolved	on 3/25/22 by	
		ment Instrument (RAI)		wound nurse practitioner).		
		he RAI and Care Planning		includes nursing to monito		
		As required at 42 CFR		status to ensure effective		
		ehensive care plan is an		oxygen, oxygen in use sig		
	· ·	nunication tool. It must bjectives and time frames		on door of residents using oxygen canisters to be pla		
		e services that are to be		for safety. CNAs and nurs		
		maintain the resident's		on proper flow rates of ox		
	highest practicable pl			of signs of shortness of br		
		ng. The care plan must be		general oxygen use/proto		
	reviewed and revised			Implementation of pressur	re ulcer	
		arranged must be consistent		care/risks include frequen		
		written plan of care. Refer to		keeping skin clean and dr		
		hich notes that a nursing		adequate nutrition/fluids to		
		all resident assessments		wound healing/prevention		
		previous 15 months in the results of the		breakdown. Oxygen use of MAR by nursing. Braden S		
		lop, review, and revise the		assessment completed by		
	resident's compreher	-		determine risk of skin brea	•	
				nurse documents wound of		
	On 03/16/2022 at app	proximately 5:00 p.m., ASM		weekly pressure ulcer ass		
	[administrative staff n	nember] # 1, administrator,		PCC Weekly Pressure Wo		
		nursing, ASM # 3, assistant		Observation Tool. Interdis		
	director of nursing A	SM # 4, administrator from		meets weekly to discuss p	ressure ulcers	

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	red: 05/02/20 0RM APPROVE NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495337	B. WING		C 03/17/2022		
NAME OF PR	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST I	IEALTHCARE AT LEEW	OOD			I20 BRADDOCK ROAD NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 656	made aware of the fir No further information References: (1) Indicated for the fenough to require an which alternative treat This information was https://dailymed.nlm.im m?setid=f2137f1a-b4 4. 2. The facility staff fait 28's comprehensive of mat. Resident # 28 was act diagnosis that include muscle weakness an most recent MDS (mis significant change as (assessment reference resident scored 4 (for (brief interview for me resident is severely in making daily decision On the following date observed to bed, with floor next to the bed: 03/15/22 at 4:55 p.m. 03/16/22 at 12:00 p.m	# 4, staff development, were ndings. In was provided prior to exit. management of pain severe opioid analgesic and for atments are inadequate. obtained from the website: nih.gov/dailymed/drugInfo.cf 9a-40bd-97ac-cd6b36e295f illed to implement Resident # care plan for the use of a fall dmitted to the facility with a ed but was not limited to: d a history of falls. On the inimum data set), a sessment with an ARD ce date) of 12/30/2021, the ur) out of 15 on the BIMS ental status), indicating the mpaired of cognition for	F	656	<ul> <li>and healing process.</li> <li>All residents in the facility have t potential to be affected by this deficie practice. The Unit Manager/Designee complete an audit of all current reside Comprehensive Care Plans for person-centered, complete, timely, accurate development and implementation of care plans.</li> <li>Education completed with all nur staff on Care Plan/Care Plan Meetings/Baseline Care Plan policy a development/implementation of resid care plans. Education completed with nursing and CNAs on individual resid listed above as well as all residents v same areas of concern.</li> <li>The Unit Manager/Designee will perform weekly audits of quarterly comprehensive and new admit baseline/comprehensive care plans.</li> <li>Weekly audit reports will be presente the Quality Assurance Improvement Committee (QAPI) monthly for three months to ensure compliance.</li> <li>April 20, 2022</li> </ul>	nt evill ent sing und ent ents <i>i</i> th	
	The facility's fall inves	stigation for Resident # 28					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPI	LE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	·		PLETED
		495337	B. WING				C / <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
AUGUST	HEALTHCARE AT LEEW	000			7120 BRADDOCK ROAD		
A00001			ANNANDALE, VA 22003				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	dated 11/27/2021 doc c/o (complaint of) che (a.m.). Chest pain pri (oxygen), 3 (three) do am (a.m.). Unresolve bed inspite [sic] of be low bed position. No The comprehensive of with a revision date of part, "Focus: The resi related to sudden che shortness of breath. E Revision on: 11/29/20 placefall mats in p 11/27/2021. Revision On 03/16/2022 at app interview was conduc practical nurse] # 2. Y 28 needed a fall mat stated, "No because H informed of the above the comprehensive ca LPN # 2 was asked a needed a fall mat. LF be down next to his b describe the purpose stated, "What kind of resident." When aske followed if the fall mat the resident's bed LPH On 03/16/2022 at app interview was conduc nurse] # 2, unit manag- mat should be on the bed when they are in	cumented in part, "Resident est pain bout 6:30 am. otocol initiated - O2, pages of Nitro, Aspirin given in ed. Resident rolled out of ing placed at the middle and injuries sustained." are plan for Resident # 28 f 11/27/2021 documented in ident has had an actual fall est pains, dizziness, and Date Initiated: 11/27/2021. 021Safety fall protocol in lace Date Initiated: a on: 11/29/2021." proximately 12:20 p.m. an ted with LPN [licensed When asked if Resident # next to their bed LPN # 2 he's not a fall risk." After e observations and reviewing are plan dated 11/27/2021 gain if Resident # 28 PN # 2 stated, "Yes, it should ed." When asked to of a care plan LPN # 2 care to provide to the d if the care plan was being t was not on the floor next to	F	65			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495337	B. WING				C / <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		-
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	stated, "It should have asked to describe the # 2 stated, "Tells how resident." When aske followed if the fall mai the resident's bed RN time." On 03/16/2022 at app [administrative staff m ASM # 2, director of r director of nursing, AS sister facility and RN made aware of the fir No further information 3. The facility staff fai comprehensive care p observe the pressure On the most recent M assessment, a quarte ARD (assessment ref Resident #39 was con and long term memor as being severely con daily decisions. In Se coded as having no u The comprehensive can right inner heelWea documentation to incl are of skin breakdown of tissue and exudate change or observation	<ul> <li>e been in place." When</li> <li>e purpose of a care plan RN</li> <li>to take care of the</li> <li>ed if the care plan was being</li> <li>t was not on the floor next to</li> <li>I # 2 stated, "Not at this</li> </ul> proximately 5:00 p.m., ASM nember] # 1, administrator, nursing, ASM # 3, assistant SM # 4, administrator from # 4, staff development, were ndings. n was provided prior to exit. led to implement the plan to measure and <ul> <li>injury for Resident #39.</li> </ul> IDS (minimum data set) erly assessment, with an ference date) of 1/6/2022, ded as having both short y difficulties and was coded gnitively impaired for making ction M, the resident was inhealed pressure injuries. care plan dated 12/19/2021, 6/2022, documented in part, has non rupture blister on ekly treatment ude measurement of each n's width, length, depth, type and any other notable	F	656	5		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
			(X2) MUU	וחו	LE CONSTRUCTION	(X3) DATE	
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED
			A. BUILD	ing.			с
		495337	B. WING				0 17/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
					7120 BRADDOCK ROAD		
AUGUSTI		OOD			ANNANDALE, VA 22003		
(X4) ID	SUMMARY ST	IMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION				(X5)	
PREFIX	(		PREF		(EACH CORRECTIVE ACTION SHOULD E		COMPLETION DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
	1						
F 656	Continued From page	62		656			
1 000			- F	000			
		Resident has non ruptured					
		(right) inner heel. Measured					
		n pillow. Apply skin prep bid nitor any change. In house					
		gn and symptoms of verbal					
	or non verbal pain or	• • •					
	The "Weekly Non-Pre	essure Wound Observation					
	Tool" dated 12/19/202						
		Type of Wound - Other;					
		he right heel, Describe the					
	wound - non puncture	ed blister, no infectious					
	process. Date wound	noted:					
		nts: Blister not punctured.					
	Drainage: none. Odor						
	-	th: 2 cm (centimeters),					
		lank. Describe wound					
		ell defined. Treatment:					
		ied, heels were floated.					
		ervation. Comments: Wound					
	care to treat and eval	view" dated 12/27/2022					
	•	Skin Condition: Open area -					
	pre-existing - no site	-					
		view" dated 12/30/2021					
	-	Skin Condition: Open area					
	- pre-existing - no site						
	The "Weekly Skin Re						
	documented in part, "	Skin Condition: Open area					
	- pre-existing - no site	e documented."					
	The "Weekly Skin Re						
	-	Skin Condition: Open area -					
	pre-existing - no site						
	•	view" dated 1/10/2022					
	-	Skin Condition: Open area					
	- pre-existing - no site						
		view" dated 1/17/2022					
		Skin Condition: Open area -					
	pre-existing - RT (righ	it) neel remains."					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495337	B. WING				C 17/2022
NAME OF PF	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUQUOT		000		7	120 BRADDOCK ROAD		
AUGUSTI		UOD		A	NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	documented in part, " - pre-existing - Tx (tre- remains." The "Weekly Skin Re- documented in part, " - pre-existing - Tx cor The "Weekly Skin Re- documented in part, " pre-existing - tx contin The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- the "Weekly Skin Re- documented in part, " pre-existing- Tx in pro- prep." The "Weekly Skin Re- documented in part, " Pre-existing- no site of The "Weekly Skin Re- documented in part, " pre-existing - Tx contin prep." The "Weekly Skin Re- documented in part, " pre-existing - Tx contin prep." The "Weekly Skin Re- documented in part, " pre-existing - Tx contin prep." The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- the "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- the "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- the "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- the "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- the "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- the "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- the "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- the "Weekly Skin Re- documented in p	view" dated 1/20/2022 Skin Condition: Open area eatment) to right heel view" dated 1/24/2022 Skin Condition: Open area ntinues to right heel." view" dated 1/27/2022 Skin Condition: Open area - nues to right heel." view" dated 1/31/2022 Skin Condition: Open area - ogress to right heel." view" dated 2/7/2022 Skin Condition: Open area - ogress to right heel with skin view" dated 2/14/2022 Skin Condition: Open area - focumented." view" dated 2/21/2022 Skin Condition: Open area - documented." view" dated 2/28/2022 Skin Condition: Open area - inues to right heel with skin view" dated 2/28/2022 Skin Condition: Open area - el - tx in progress." view" dated 3/7/2022 Skin Condition: Open area - ogress to right heel." view" dated 3/14/2022 Skin Condition: Open area - ogress to right heel." view" dated 3/14/2022 Skin Condition: Open area - ogress to right heel." view" dated 3/14/2022 Skin Condition: Open area - ogress to right heel." view" dated 3/14/2022 Skin Condition: Open area - ogress to right heel." view" dated 3/14/2022 Skin Condition: Open area - ogress to right heel." view dated 3/14/2022 Skin Condition: Open area - ogress to right heel." view dated 3/14/2022 Skin Condition: Open area - ogress to right heel."	F	656			
	measurements of the Review of the nurse's	heel wound. note from 1/1/2022 through documentation of the right					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495337	A. BUILD	ING _			c
	ROVIDER OR SUPPLIER	400001		9	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	17/2022
					7120 BRADDOCK ROAD		
AUGUST	HEALTHCARE AT LEEW	OOD			ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From page	9 64	F	656	5		
	documented in part, " injury), now devolved pressure wound. Mea (centimeters), width - An interview was con MDS nurse, on 3/16/2 asked the purpose of stated it was the plan resident. When aske LPN #3 stated, "Yes." An interview was con 3/16/2022 at 2:25 p.m aware of the wound of heel, LPN #1 stated, " asked when it was de tissue injury and no lo stated, "In late Janua were any measureme 3/2/2022, LPN #1 stat there were no measu LPN #1 stated, "I don stated the normal pro her about an area is f look at the area of con also goes with them t treatment in place. ASM #1, the administ of nursing, ASM #3, tf #4, the administrator #3, the staff developm aware of the above co 5:30 p.m.	asurements: length - 0.95 cm 1.13 cm, depth - 0.2 cm." ducted with LPN #3, the 2022 at 2:22 p.m. When the care plan, LPN #3 of how to care for the d if it should be followed,					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/02/2022 MAPPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING		CONSTRUCTION	(X3) DATE				
		495337	B. WING _				C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUCUST				7	120 BRADDOCK ROAD		
AUGUST	HEALTHCARE AT LEEW			Α	NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	9 65	F	656			
	4. The facility staff fai comprehensive care p compression stocking	plan for the use of					
	diagnoses including c and chronic obstructi the most recent MDS admission assessmer Reference Date) of 12 5 out of 15 on the BIM status), indicating the cognitively impaired for A review of the physic following order dated Hose/Compression S (morning) as resident On 3/16/22 at 1:00 PM in bed without the stor	tockings (1) in the AM tolerates." If the resident was observed ckings on.					
	Nurse). She stated th this morning when she wants them off when a A review of the compre- revealed no information compression stocking On 3/16/22 at 2:20 PM conducted with LPN # stated that the purpose	<ul> <li>#10 (Licensed Practical hat the resident had them on e was up, but that she she is in bed.</li> <li>rehensive care plan on regarding the use of us.</li> <li>M an interview was</li> <li>#3, the MDS nurse. She se of the care plan was, "To nt care, work out a plan of "When asked if</li> </ul>					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495337	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	included in the care p the time of admission should have been. W responsible to develo plan, she stated, "MD development of the ca A review of the facility Comprehensive Perse This policy document person-centered care services that are to be maintain the resident" physical, mental, and Describe services that provided for the abov to the resident exercisi including the right to r On 3/16/22 at 5:19 PI Staff Member) the Ad Director of Nursing, A Director of Nursing, A sister facility, and RN Development, were m No further information the survey. References: (1) Compression stocking the veins of your legs gently squeeze your I legs. This helps preve- lesser extent, blood c veins, spider veins, of health care provider r	lan if there was an order at for them, she stated it /hen asked who is p the comprehensive care S is responsible for the are plan." policy, "Care Plans, on-Centered" was reviewed. ed, "8. The comprehensive, plan will:b. Describe the e furnished to attain or s highest practicable psychosocial well-being; c. t would otherwise be e, but are not provided due sing his or her rights, refuse treatment" M, ASM #1 (Administrative ministrator, ASM #2 the SM #3 the Assistant SM #4 Administrator of #3 (Registered Nurse) Staff nade aware of the findings.	F	656			

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	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495337	B. WING				C 17/2022
NAME OF F	ROVIDER OR SUPPLIER	-		3	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	and heavy feeling in le Preventing blood clots injury when you are le complications of blood post-phlebitic syndror leg)" Information obtained th https://medlineplus.go 00597.htm 5. The facility staff fa for use of a hand splin On the most recent M significant change ass (assessment reference resident was assesse impaired for making of documented Residen dependent on two or transfers, dressing an Section O documente splint or brace. On 3/15/2022 at appr observation of Resider room. Resident #71 wearing a hand splint The ADL (activities of survey report for 3/1/2 in part, "Restorative: S hand resting splint x 2 at 1pm or as tolerated	egs; Swelling in legs; s, primarily after surgery or ess active; Preventing d clots in the legs, such as me (pain and swelling in the from ov/ency/patientinstructions/0 iled to develop a care plan nt for Resident #71. IDS (minimum data set), a sessment with an ARD ce date) of 2/9/2022, the ed as being severely laily decisions. Section G t #71 as being totally more staff for bed mobility, ad personal hygiene. ed Resident #71 using a oximately 12:45 p.m., an ent #71 was made in their was observed in bed on the right hand. d aily living) documentation 2022-3/31/2022 documented Splint- Apply Bilateral upper 2 hrs a day on at 11am, off d."	F	656			

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ES			OMB NC	0938-0391
	ULTIPI	PLE CONSTRUCTION	(X3) DATE	SURVEY
MBER: A. BUIL	LDING	3		
B. WIN	IG			C 17/2022
		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
		7120 BRADDOCK ROAD		
		ANNANDALE, VA 22003		
FULL PRE	EFIX			(X5) COMPLETION DATE
was was was was staff, are plan guide splints as LPN n was to lan of they go ed the condition hey ee if the that as an ners but hould be sing, ASM vere	F 65			
	MBER: A. BUI B. WIN B. WIN B. WIN B. WIN B. WIN TAL ATION)	MBER: A. BUILDING B. WING B. WING B. WING PREFIX ATION) F 65 was urse) #5. e S staff, are plan guide splints A. BUILDING PREFIX TAG F 65 was urse) #5. e S staff, are plan guide splints as . LPN n was to lan of they go ed the condition hey ee if the I that as an ners but nould be sing, ASM Vere to exit.	MBER: A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003 S PROVIDERS PLAN OF CORRECTION (EACH CORRECTVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIU DEFICIENCY) F 656 Was rrse) #5. e S staff, are plan guide splints as . LPN h was to lan of they go ad the condition hey ee if the lthat as an ners but hould be sing, ASM N vere to exit.	MBER:     A. BUILDING

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		495337	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		-
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	develop a care plan for and for skin integrity of On the most recent M quarterly assessment reference date) of 2/2 a 13 out of 15 on the mental status), indica cognitively intact. Se Resident #2 having 1 Section O failed to ev oxygen use. A. Resident #2 was adm diagnoses that includ acute respiratory failu failure. On 3/15/2022 at 12:1 made of Resident #2 was observed receivin cannula attached to a this time an interview Resident #2 who state all the time and had u time." The physician orders documented in part, " (minute) via nasal car (saturations) above 9 8/16/2021."	or the use of oxygen (A), concerns (B). IDS (minimum data set), a with an ARD (assessment 23/2022, the resident scored BIMS (brief interview for ting the resident is ction M documented Stage 3 pressure ulcer. idence documentation of hitted to the facility with ed but were not limited to are with hypoxia and heart 9 p.m., an observation was in their room. Resident #2 ng oxygen via a nasal an oxygen concentrator. At was conducted with ed that they wore the oxygen used oxygen for "a long for Resident #2 Oxygen at 1 liter per min mula to maintain sats 2%. Order Date:	F	656			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495337	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
AUGUST		OOD			120 BRADDOCK ROAD NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	conducted with LPN ( LPN #5 stated that the responsibility of the u and the nurses. LPN was to show a progree them in patient care. plan was to be update treatment, infection of #5 stated that oxygen the care plan. On 3/16/2022 at 2:19 conducted with LPN # #3 stated that the pur coordinate resident ca care for the resident. over the triggers after comprehensive asses care plan. LPN #3 st completed the care pl or specific incidents. would review Resider oxygen was addresses On 3/16/2022 at 4:18 she had reviewed the on the care plan. LPI be a care plan for oxy On 3/16/2022 at 5:20 staff member) #1, the director of nursing, ASM #4, a facility and RN (regist development were no B.	licensed practical nurse) #5. e care plans were the nit manager, the MDS staff, #5 stated that the care plan ssion of care and to guide LPN #5 stated that the care ed when there was any new r change in condition. LPN a should be documented on p.m., an interview was #3, MDS coordinator. LPN pose of the care plan was to are and work out a plan of LPN #3 stated that they go completing the ssment and completed the ated that the nurses lans for changes in condition LPN #3 stated that they nt #2's record and see if the ed on the care plan. p.m., LPN #3 stated that record and oxygen was not N #3 stated that there should ygen for Resident #2. p.m., ASM (administrative administrator, ASM #2, the SM #3, the assistant director administrator of a sister yered nurse) #3, staff	F	656			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		495337	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	DOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 656	documented in part, " 1.36cm (centimeter), 0.00cmDate Wound Nonblanchable erythe subcentimeter site of paste to wound and p Wound status: New; / Etiology: Pressure Ule The wound evaluation documented in part, " Width: 2.97cm, Depth Acquired: 3/2/22; Rec injury. Barrier cream status: New; Acquired Pressure Ulcer- Stage The comprehensive of failed to evidence a c injuries or skin integrif On 3/16/2022 at 12:12 conducted with LPN ( LPN #5 stated that the responsibility of the u and the nurses. LPN was to show a progre them in patient care. all residents had the p issues and were care stated that Resident # for pressure injuries b of them. On 3/16/2022 at 2:19 conducted with LPN # 3 stated that the pur coordinate resident care	Left lateral leg, Length: Width: 0.80cm, Depth: Acquired: 3/2/22; ema (redness) surrounding a desquamation. Zinc oxide eri-wound Q (every) shift. Acquired in house? Yes; cer- Stage 2" In note dated 3/2/2022 Sacrum, Length: 2.49cm, 0.00cmDate Wound current stage 3 pressure to sacrum q shift. Wound d in house? Yes; Etiology: e 3" eare plan for Resident #2 are plan regarding pressure ty. 5 p.m., an interview was licensed practical nurse) #5.	F	656			

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		D HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		495337	B. WING		03/17/2022		
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST		DOD		7120 BRADDOCK ROAD ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 656 F 657 SS=E	over the triggers after comprehensive asses care plan. LPN #3 st completed the care pl LPN #3 stated that th #2's record and see if integrity was address On 3/16/2022 at 4:18 she had reviewed the not have a care plan have one. On 3/16/2022 at 5:20 staff member) #1, the director of nursing, AS of nursing, ASM #4, a facility and RN (regist development were no No further information Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an inf includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food	<ul> <li>completing the sement and completed the ated that the nurses ans for skin conditions.</li> <li>ey would review Resident pressure injuries/skin ed on the care plan.</li> <li>p.m., LPN #3 stated that record and Resident #2 did for skin integrity and should</li> <li>p.m., ASM (administrative administrator, ASM #2, the SM #3, the assistant director administrator of a sister ered nurse) #3, staff tified of the findings.</li> <li>a was provided prior to exit.</li> <li>I Revision (i)-(iii)</li> <li>ensive Care Plans prehensive care plan must or days after completion of sessment.</li> <li>eredisciplinary team, that ited torisician.</li> <li>e with responsibility for the</li> </ul>	F 65			4/20/22	

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 05/02/2022 MAPPROVED 0. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		E SURVEY IPLETED		
		495337	B. WING		C 03/17/2022		
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
AUGUSTI	HEALTHCARE AT LEEW	100D		7120 BRADDOCK ROAD			
				ANNANDALE, VA 22003		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	Continued From page	e 73	F 657				
		resident's representative(s).	1 001				
		be included in a resident's					
	medical record if the	participation of the resident					
	-	presentative is determined					
	not practicable for the	e development of the					
	resident's care plan.	e staff or professionals in					
		ined by the resident's needs					
	or as requested by th	•					
	(iii)Reviewed and rev	rised by the interdisciplinary					
	team after each assessment, including both the						
	comprehensive and o	quarterly review					
		Γ is not met as evidenced					
	by: Based on observation	on, resident interview, staff		1. Resident #33⊡s comprehe	ensive care		
		ument review and clinical		plan updated to reflect use of b			
	record review, it was	determined the facility staff		grab bars/bed rails to act as en	ablers to		
		or revise the comprehensive		maintain independence with be			
	-	residents in the survey		Orders were obtained for use of bars/bed rails.	of grab		
	#81.	33, #34, #86, #11, #101, and		Resident #34 s comprehensiv	e care nlan		
	<i>m</i> <b>O</b> 1.			updated to reflect use of bilater	•		
	The findings include:			bars/bed rails to act as enabler	-		
	-			maintain independence with be	•		
	2	iled to review and revise		Orders were obtained for use o	of grab		
		rehensive care plan for the		bars/bed rails.	o ooro plan		
	use of grab bar bed r	alls.		Resident #86 s comprehensiv updated with compression stoc			
	Resident #33 was ad	lmitted to the facility on		right hand splint as well as righ			
		st recent MDS (minimum		Therapy services department to			
	data set), a quarterly	assessment with an ARD		continued need for splint.			
	•	ce date) of 12/30/21, the		Resident #11 s comprehensive			
		ut of 15 on the BIMS (brief		updated to reflect risk/actual we			
	interview for mental s	, -		Resident #101 s comprehensi			
	daily decisions.	ively impaired for making		plan updated to reflect use of g bar/bed rail to act as an enable			
	dany de01510115.			maintain independence with be			
	A physical therapy pr	ogress note dated 9/23/21		Orders were obtained for use of			

Facility ID: VA0142

		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 05/02/2022 RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495337	B. WING			C 03/17/2022	
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			I20 BRADDOCK ROAD NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	mobility. A review of comprehensive care reveal documentation rails. A review of Res physician's orders fai order for grab bar bed On 3/15/22 at 1:07 p. observed in bed with the upright position. On 3/16/22 at 2:20 p. conducted with LPN of (the minimum data set stated the purpose of coordinate resident c care for that resident c care for that resident c care for that resident c believed residents' ca and revised to include because grab bars ca to review the care pla need grab bars. On 3/16/22 at approx (administrative staff r administrator) and AS nursing) were made a The facility policy title Meeting/Baseline Car specific information re revising the compreh No further information	At #33 used bed rails for bed Resident #33's plan dated 10/5/21 failed to n regarding grab bar bed sident #33's March 2022 led to reveal a physician's d rails. m., Resident #33 was bilateral grab bar bed rails in m., an interview was (licensed practical nurse) #3 et coordinator). LPN #3 f the care plan is to are and work out a plan of . LPN #3 stated she are plans should be reviewed e the use of grab bars an cause injury so staff has an to see if residents still timately 5:50 p.m., ASM nember) #1 (the SM #2 (the director of aware of the above concern. ed, "Care Plan/Care Plan re Plan" failed to document egarding reviewing and ensive care plan. In was presented prior to exit.	F	857	<ul> <li>bar/bed rail.</li> <li>Resident #81□s comprehensive care updated to reflect use of grab bar/bed to act as an enabler to maintain independence with bed mobility. Orde were obtained for use of grab bar/bed Lumbar support back brace added to comprehensive care plan as well as a breakdown risks associated with brace 2. All residents in the facility have the potential to be affected by this deficie practice. The Unit Managers/Designer complete an audit of all current reside Care Plans for person-centered, complete, timely, and accurate information. Therapy Department will complete an audit of all current reside with grab bars/bed rails to ensure continued need for these devices.</li> <li>3. Education completed with all nur staff and Department Heads on Care Plan/Care Plan Meetings/Baseline Ca Plan Policy and State/Federal regular regarding review/revision of care plar and use of grab bars/bed rails.</li> <li>4. The Unit Manager/Designee will perform weekly audits of quarterly an new admit baseline/comprehensive plans. Weekly audit reports will be presented to the Quality Assurance Improvement Committee (QAPI) more for three months to ensure compliance 5. April 20, 2022</li> </ul>	d rail ers d rail. skin ce. he ent ee will ent ents sing are tions is d care	

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	-	D HUMAN SERVICES				FORM	APPROVED	
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED		
		495337	B. WING			C 03/17/2022		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST HEALTHCARE AT LEEWOOD					120 BRADDOCK ROAD			
				4	ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From page	75	F	657				
	12/29/20. On the model data set), an annual a (assessment reference) resident scored 15 out interview for mental s resident is not cognitine daily decisions. An occupational thera dated 1/12/21 docume grab bars. A review of comprehensive care prevealed documentation rails. A review of Resphysician's orders fail order for grab bar bed On 3/15/22 at 1:36 p. observed in bed with the upright position. On 3/16/22 at 2:20 p. conducted with LPN ((the minimum data set stated the purpose of coordinate resident care for that resident. believed residents' care and revised to include because grab bars care for that care fo	vely impaired for making apy discharge summary ented a recommendation for of Resident #34's blan dated 10/15/2 failed to fon regarding grab bar bed sident #34's March 2022 ed to reveal a physician's d rails. m., Resident #34 was bilateral grab bar bed rails in m., an interview was licensed practical nurse) #3 et coordinator). LPN #3 the care plan is to are and work out a plan of LPN #3 stated she ire plans should be reviewed						
	(administrative staff m administrator) and AS							

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	-	ID HUMAN SERVICES				FORM	): 05/02/2022 MAPPROVED ). 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		(X3) DATE			
		495337	B. WING_				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUCUST	HEALTHCARE AT LEEW	000		7	120 BRADDOCK ROAD		
AUGUST				Α	NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	9 76	F	657			
	No further information	n was presented prior to exit.					
	3. The facility staff fa	iled to revise the					
	comprehensive care	plan for the use of					
	compression stocking Resident #86.	is and a hand splint for					
	quarterly assessment Reference Date) of 2/ scored as having sho memory problems and in cognitive skills for o resident was coded a	d being moderately impaired daily decision making. The s requiring supervision for assistance for all other					
	A review of the clinica physician's order date compression stocking remove at night."						
		al record revealed a ed 12/30/21 for "Apply right morning and remove at					
	observed up in her re	PM, Resident #86 was cliner, dressed. She did not ockings or a hand splint on.					
	with CNA #3 (Certified LPN #10 (Licensed P that the resident frequ or wants them remove while. They stated th	n interview was conducted d Nursing Assistant) and ractical Nurse). They stated uently refuses the stockings ed after they have been on a at she does not like to wear hand splint, they stated that					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1)           IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495337	B. WING			C 03/17/2022		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 657	they will put it on in the resident will remove it wear it. A review of the comparent or hand splint being of On 3/16/22 at 2:20 Pl conducted with LPN as stated that the purpose coordinate the reside care for that resident. comprehensive care prevised to include the should have been. We responsible for review comprehensive care prevised to include the should have been. We responsible for review comprehensive care prevised to include the should have been. We responsible for review comprehensive care prevised to include the should have been. We responsible for review comprehensive care prevised to include the should have been. We responsible for review comprehensive care prevised caring for the residen On 3/16/22 at 5:19 Pl Staff Member) the Ad Director of Nursing, A Director of Nursing, A Director of Nursing, A sister facility, and RN Development, were me No further information the survey. References: (1) Compression stocking the veins of your legs gently squeeze your I legs. This helps prevent lesser extent, blood of veins, spider veins, of	e morning and then the t at some point and won't rehensive care plan failed to of the compression stockings are planned for use. M an interview was 43, the MDS nurse. She se of the care plan was "To nt care, work out a plan of " When asked if the olan should have been se items, she stated it /hen asked who is ving and revising the olan, she stated, "The nurse t." M, ASM #1 (Administrative ministrator, ASM #2 the SM #3 the Assistant SM #4 Administrator of #3 (Registered Nurse) Staff hade aware of the findings.	F	657	7			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C			
		495337	B. WING			03/17/2022			
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•			
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE		
F 657	stockings. Wearing s and heavy feeling in I Preventing blood clots injury when you are le complications of blood post-phlebitic syndror leg)" Information obtained https://medlineplus.go 00597.htm (2) Splint - A splint is maintains in position also used to keep in p part to support healin damagePurpose of Support to promote h supporting during fun for weak muscles; Co contracture & deform of range of motion; Ed Information obtained https://www.physio-pe 4. The facility staff fa comprehensive care p related to weight loss On the most recent M admission assessmen Reference Date) of 12 a 5 out of 15 on the B mental status), indica severely cognitively in decisions. The reside limited assistance for A review of the clinica	tockings helps with: Aching egs; Swelling in legs; s, primarily after surgery or ess active; Preventing d clots in the legs, such as me (pain and swelling in the from bv/ency/patientinstructions/0 a rigid or flexible device that a displaced or movable part, blace and protect an injured g and to prevent further f Splinting: Immobilization; ealing; Positioning or ction; Pain relief; Substitute prection and prevention of ity; Restoring or maintaining dema control" from edia.com/Splint iled to revise the plan for nutritional needs for Resident #11. IDS (Minimum Data Set), an nt with an ARD (Assessment 2/9/21, Resident #11 scored BIMS (brief interview for ting the resident was mpaired for making daily ent was coded as requiring eating.	F	657	7				

Facility ID: VA0142

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/02/2022 MAPPROVED ). 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495337	B. WING _					C 17/2022	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STA	TE, ZIP CODE		-	
AUCUST	HEALTHCARE AT LEEW			71	120 BRADDOCK ROAD				
AUGUST				A	NNANDALE, VA 22003				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 657	<ul> <li>2/3/2022 - 125.9 pour pounds, 12/30/2021 - 129.0 pounds, and 12</li> <li>This reflected a 4.4 po approximately 90 day was admitted and the on 3/3/22.</li> <li>Further review of the dietary note dated 12/ "current weight: 12' weight on admission: index): 19.4, below he regular/regular/no add 7 days 52% average appropriateSuppler with meals to help me not always meeting no resident in room, Ress to eat. Asked if she w meals, Resident state Plan: add ice cream to continue to monitor of A dietary quarterly rev documented, "Reco Percent weight chang weight change in 90 c change in 180 days: r</li> <li>A review of the comprise revealed nutritional reed diabetes, anemia, and However, risk of weig nutritional needs had</li> </ul>	hds, 1/4/2022 - 126.4 127.4 pounds, 12/16/2021 - 12/2/2021 - 129.4 pounds. Dound weight loss in the period since the resident weight that was obtained clinical record revealed a /30/21 that documented, 7.4 lbs (pounds), down from 129.4 lbs. BMI (body mass ealthy range for age. Diet: ded salt. Intake for the past Current diet is ment in place fortified foods eet needs. Intake of meals eeds at this time. Met with ident stated she has enough yould like ice cream with d'yes, she would like that" o lunch and dinner meals, n weekly wts x 4 weeks." view dated 3/15/22 ent changes in Weight: Yes. te in 30 days: 0.0. Percent days: -3.40. Percent weight n/a (not applicable)"	F 6	57					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495337	B. WING			C 03/17/2022		
NAME OF P	IAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST	HEALTHCARE AT LEEW	DOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 657	On 3/16/22 at 2:20 Pt conducted with LPN # stated that the purpose coordinate the resident play should be revised since admission, she When asked who is re- revising the comprehe nutritional and weight dietician should be do On 3/17/22 at 8:15 At conducted with OSM the dietitian. When as related to the resident nutritional needs, she joint effort and nutrition the dietician would be that the resident conse days and 100% on so would not have trigge significant weight loss weight loss. When as 12/30/21 note wherein evidencing a trend of loss, the weight loss as the care plan, she agu On 3/16/22 at 5:19 Pt Staff Member) the Ad Director of Nursing, A sister facility, and RN Development, were m	M an interview was #3, the MDS nurse. She se of the care plan was "To nt care, work out a plan of " When asked if the care d if there was a weight loss stated that it should be. esponsible for reviewing and ensive care plan for needs, she stated the bing that. M an interview was #10 (Other Staff Member) sked about a care plan t's weight loss and related stated that care plans are a on concerns are something e involved in. She stated tumed 50% to 75% most ome days. She stated that it red a care plan for actual or a si t was not a significant sked if, based on the n the resident was mild post admission weight should have been added to reed. M, ASM #1 (Administrative ministrator, ASM #2 the	F	657				

Facility ID: VA0142

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED			
		495337	B. WING			C 03/17/2022		
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-	
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 657	<ul> <li>5. The facility failed to care plan to include b</li> <li>Resident #101's most data set) assessment assessment, with an of 3/2/22, coded the r 15 on the BIMS (brief score, indicating the r cognitively impaired. Trequiring extensive as</li> <li>A review of Resident 2/17/22 revealed no i bars.</li> <li>A review of the physic encounter notes date following, "Bed mobilit to side."</li> <li>The resident was obs quarter grab bars on asked if he used the g stated, "Yes, I use the a little."</li> <li>An interview was con PM with LPN (license MDS coordinate the reside care for that resident. development of the carg plan, LPN #3 stated, "Yes I</li> </ul>	o revise the comprehensive red rails for Resident #101. t recent MDS (minimum t, a significant change assessment reference date resident as scoring 7 out of t interview for mental status) resident was severely The resident was coded as assistance in bed mobility. #101's care plan dated information related to grab	F	657				
	When asked why the	care plan should include the ated, "The care plan should						

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	-	ID HUMAN SERVICES				FORM	): 05/02/2022 // APPROVED ). 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` <i>`</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495337	B. WING	-			C	
		433337	D. 11110		STREET ADDRESS, CITY, STATE, ZIP CODE	03/	17/2022	
NAME OF P	NAME OF PROVIDER OR SUPPLIER							
AUGUST	HEALTHCARE AT LEEW	DOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 657	include the grab bars have injury with the greview the care plan a them." An interview was com PM with LPN #4. Wh should be on the care they should be on the staff development coo the above concern. No further information 6. A. The facility failed comprehensive care p Resident #81. Resident #81's most n set) assessment, a M assessment, with an a of 2/16/22, coded the 15 on the BIMS (brief score, indicating the r cognitively impaired. requiring extensive as A review of Resident is revealed no information A review of the physic	because the resident could rab bar and we need to and check if they still need ducted on 3/16/22 at 3:03 en asked if grab bars e plan, LPN #4 stated, "Yes, care plan. Usually under M, ASM #1, the 2, the director of nursing, t director of nursing, ASM at sister facility and RN #3, ordinator were informed of a was provided prior to exit. d to revise the blan to include bed rails for recent MDS (minimum data edicare five day assessment reference date resident as scoring 9 out of interview for mental status) esident was moderately The resident was coded as assistance in bed mobility. #81's care plan dated 2/9/22 on related to grab bars.	F	657				

		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 05/02/2022 APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495337	B. WING		_	C 03/17/2022		
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-	
AUGUST	HEALTHCARE AT LEEW	DOD		120 BRADDOCK ROAD				
				-				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From page	83	F 657					
	asked if he used the g	erved in bed with one 8/16/22 at 7:53 AM. When grab bars, Resident #81 em to help move and get						
	PM with LPN (license MDS coordinator. Wh the care plan, LPN #3 coordinate the residen care for that resident. development of the ca grab bars should be in LPN #3 stated, "Yes I should be reviewed a When asked why the grab bars, LPN #3 sta include the grab bars have injury with the gr review the care plan a them." An interview was com PM with LPN #4. Wh should be on the care they should be on the falls." On 3/16/22 at 5:25 PM administrator, ASM #2 ASM #3, the assistant #4, the administrator a	plan, LPN #4 stated, "Yes, care plan. Usually under						
	No further information	was provided prior to exit.						

Facility ID: VA0142

If continuation sheet Page 84 of 127

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVE COMPLETED C		
		495337	B. WING				C 17/2022	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 657	<ul> <li>6. B. The facility failed comprehensive care Resident #81.</li> <li>A review of Resident revealed no informatil lumbar supporting brack apply himself when sightf."</li> <li>The resident was obs 3/15/22 at 12:55 PM. wears his brace, Resing the morning and keen helps with my back and An interview was con PM with LPN (licensed MDS coordinates the resident. development of the care plan, LPN #3 coordinate the resident. development of the care plan. "</li> <li>An interview was con PM with LPN (licensed MDS coordinates the resident. development of the care plan, LPN #3 coordinates the resident. development of the care plan. "</li> <li>An interview was con PM with LPN #4. Whe be on the care plan, LPN #4. Whe be on t</li></ul>	d to revise the plan to include brace for #81's care plan dated 2/9/22 on regarding a thoracic ace. cian orders dated 2/9/22, g, "To wear the thoracic when out of bed. Can itting on side of bed every erved wearing his brace on When asked how often he ident #81 stated, "I put it on eep it on till I go to bed. It nd posture." ducted on 3/16/22 at 2:20 ed practical nurse) #3, the hen asked the purpose of 8 stated, "The purpose is to nt care, work out a plan of MDS is responsible for the are plan." When asked if a ded on the care plan, LPN the should be on the care ducted on 3/16/22 at 3:03 ten asked if a brace should LPN #4 stated, "Yes, the he care plan."	F	657	7			

Facility ID: VA0142

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					OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		495337	B. WING		C
		495557		STREET ADDRESS, CITY, STATE, ZIP CODE	03/17/2022
NAME OF PI	ROVIDER OR SUPPLIER				
AUGUST	HEALTHCARE AT LEEV	VOOD		7120 BRADDOCK ROAD ANNANDALE, VA 22003	
	SUMMARYS	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 657	Continued From pag	ne 85	F 657	7	
		r at sister facility and RN #3,	1 007		
		pordinator were informed of			
	the above concern.				
	No further information	on was provided prior to exit.			
F 658		leet Professional Standards	F 658	3	4/20/22
SS=D	CFR(s): 483.21(b)(3				
		,,,,			
		rehensive Care Plans			
	-	ed or arranged by the facility,			
	-	omprehensive care plan,			
	must-				
		l standards of quality.			
		T is not met as evidenced			
	by: Based on observati	on, clinical record review,		1. Resident #71⊡s orders were upda	ted
		acility document review, it was		on $3/15/22$ to include type of enteral	leu
		facility staff failed to meet		feeding to be administered with tube	
		ds of practice in providing		feeding.	
		one of 47 residents in the		2. All residents in the facility have the	•
		ident #71. The facility staff		potential to be affected by this deficient	
		transcribe a physician order		practice. The Unit Managers, MD and/o	
	for Resident #71 to i	nclude the type of enteral		pharmacist will perform a medication	
	feeding to be admin	istered.		reconciliation of all current resident	
				orders.	
	The findings include	:		3. Education completed with all nursi	ng
	On the most recent	MDS (minimum data sat)		staff that pass medications on the	
		MDS (minimum data set), a ssessment with an ARD		Medication Administration Policy and 5 Rights of Medication Administration.	
		nce date) of 2/9/2022, the		4. The Unit Manager/Designee will	
		ed as being severely		perform weekly audits of new medication	on
		daily decisions. Section K		orders to ensure that orders are	
		nt #71 as having a feeding		transcribed accurately and that	
		1% or more of their total		professional standards of practice are	
	calories through tub			met. The Unit Managers will complete	
				medication pass observation two times	
		proximately 12:45 p.m., an		weekly on randomly selected nurses or	n all
		lent #71 was made in their	1	shifts to ensure medications are	1

Facility ID: VA0142

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/02/2022 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		X3) DATE COMP	SURVEY LETED
		495337	B. WING _			C 03/17/2022		
NAME OF PI	ROVIDER OR SUPPLIER		· [	STREET ADDRESS, CITY, STATE, ZIP				
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD			
				Α	NNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	E	(X5) COMPLETION DATE
F 658	Continued From page	∋ 86	F	658				
	<ul> <li>(milliliters per hour) visit</li> <li>The physician orders</li> <li>documented in part, "</li> <li>shift for Nutritional Such via G-tube (gastrospump. Due to dysphator)</li> <li>03/07/2022." The providence the type of eadministered.</li> <li>The comprehensive of documented in part, "</li> <li>feeding r/t (related to)</li> <li>09/03/2020."</li> <li>On 3/16/2022 at 12:1</li> <li>conducted with LPN (LPN #5 stated that with verified the frequency medication, the duration of the feeding that water</li> </ul>	be feeding at 45 ml/hr ia pump. for Resident #71 (Enteral Feed Order every upport Administer 45ml per stomy) continuously via agia. Order Date: ysician orders failed to enteral feeding to be care plan for Resident #71 (The resident requires tube ) dysphagia. Date Initiated: 5 p.m., an interview was (licensed practical nurse) #5. hen transcribing orders they			administered according to the 5 R Medication Administration. Weekly reports will be presented to the Qu Assurance Improvement Committe (QAPI) monthly for three months to ensure compliance. 5. April 20, 2022	/ audit uality ee		
	#5 stated that the rate recently been increas not changed, howeve name of the feeding t The facility policy "Ph Orders/Transcription" Orders for medication and strength of the dr	eed and the feeding type had er the order should reflect the o be administered. Anysician Medication of documented in part, "7. as must include: a. Name rug;" The policy further Resident orders must be						

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(EACH DEFICIENC REGULATORY OR L Continued From page On 3/16/2022 at 5:20 dministrator, ASM #3 SM #3, the assistan 4, administrator of a registered nurse) #3, otified of the findings	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 8 87 p.m., ASM #1, the 2, the director of nursing, t director of nursing, ASM sister facility and RN staff development were	A. BUILDING	STREET ADDRESS, CITY, STATE, ZIP CODE T120 BRADDOCK ROAD ANNANDALE, VA 22003  PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLETI
ALTHCARE AT LEEW SUMMARY STJ (EACH DEFICIENC' REGULATORY OR L Continued From page On 3/16/2022 at 5:20 dministrator, ASM #J SM #3, the assistan 4, administrator of a registered nurse) #3, otified of the findings to further informatior	OOD ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) # 87 p.m., ASM #1, the 2, the director of nursing, t director of nursing, ASM sister facility and RN staff development were	ID PREFIX TAG	7120 BRADDOCK ROAD ANNANDALE, VA 22003 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	03/17/2022 DN (X5) DBE COMPLETIN
ALTHCARE AT LEEW SUMMARY STJ (EACH DEFICIENC' REGULATORY OR L Continued From page On 3/16/2022 at 5:20 dministrator, ASM #J SM #3, the assistan 4, administrator of a registered nurse) #3, otified of the findings to further informatior	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 8 87 p.m., ASM #1, the 2, the director of nursing, t director of nursing, ASM sister facility and RN staff development were	PREFIX TAG	7120 BRADDOCK ROAD ANNANDALE, VA 22003 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DN (X5) DBE COMPLETIN
SUMMARY STJ (EACH DEFICIENC' REGULATORY OR L Continued From page On 3/16/2022 at 5:20 dministrator, ASM #J SM #3, the assistan 4, administrator of a registered nurse) #3, otified of the findings	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 8 87 p.m., ASM #1, the 2, the director of nursing, t director of nursing, ASM sister facility and RN staff development were	PREFIX TAG	ANNANDALE, VA 22003 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLETI
SUMMARY STJ (EACH DEFICIENC' REGULATORY OR L Continued From page On 3/16/2022 at 5:20 dministrator, ASM #J SM #3, the assistan 4, administrator of a registered nurse) #3, otified of the findings	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 8 87 p.m., ASM #1, the 2, the director of nursing, t director of nursing, ASM sister facility and RN staff development were	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLETI
(EACH DEFICIENC REGULATORY OR L Continued From page On 3/16/2022 at 5:20 dministrator, ASM #3 SM #3, the assistan 4, administrator of a registered nurse) #3, otified of the findings	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETI
On 3/16/2022 at 5:20 dministrator, ASM #3 SM #3, the assistan 4, administrator of a registered nurse) #3, otified of the findings lo further information	p.m., ASM #1, the 2, the director of nursing, t director of nursing, ASM sister facility and RN staff development were	F 65	58	
dministrator, ASM #3 SM #3, the assistan 4, administrator of a registered nurse) #3, otified of the findings to further information	2, the director of nursing, t director of nursing, ASM sister facility and RN staff development were			
reatment/Svcs to Pr CFR(s): 483.25(b)(1)(	n was provided prior to exit. event/Heal Pressure Ulcer	F 68	36	4/20/22
esident, the facility m ) A resident receives rofessional standard ressure ulcers and d lcers unless the indi- emonstrates that the i) A resident with pre- ecessary treatment a vith professional stan romote healing, pre- ew ulcers from deve his REQUIREMENT y: Based on observatio ocument review and vas determined the fa	re ulcers. hensive assessment of a bust ensure that- is care, consistent with los of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent dards of practice, to vent infection and prevent loping. is not met as evidenced n, staff interview, facility clinical record review, it acility staff failed to provide		<ol> <li>Resident #39□s right heel woun began treatment on 3/2/22 and is als being monitored by a Wound Nurse</li> </ol>	
	rvey sample, Residents #39		measurements are now in place and being done consistently since 3/2/22. Comprehensive care plan updated w pressure ulcer and interventions to	
leii) ii) iii) iii) iii) iii) iii) iii)	emonstrates that the o A resident with pre- ecessary treatment a th professional star omote healing, pre- we ulcers from deve- his REQUIREMENT ased on observatio occument review and as determined the fa- re and services for ' residents in the su of #2.	ased on observation, staff interview, facility ocument review and clinical record review, it as determined the facility staff failed to provide re and services for a pressure injury for two of residents in the survey sample, Residents #39 of #2.	A resident with pressure ulcers receives excessary treatment and services, consistent th professional standards of practice, to omote healing, prevent infection and prevent ew ulcers from developing. his REQUIREMENT is not met as evidenced : ased on observation, staff interview, facility ocument review and clinical record review, it as determined the facility staff failed to provide re and services for a pressure injury for two of ' residents in the survey sample, Residents #39 ad #2.	<ul> <li>In a resident with pressure ulcers receives seesary treatment and services, consistent th professional standards of practice, to comote healing, prevent infection and prevent we ulcers from developing. Inis REQUIREMENT is not met as evidenced to a seed on observation, staff interview, facility recument review and clinical record review, it as determined the facility staff failed to provide re and services for a pressure injury for two of the survey sample, Residents #39</li> <li>If the survey survey sample, Residents #39</li> <li>If the survey survey</li></ul>

Event ID: W82111

Facility ID: VA0142

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 05/02/2022 RM APPROVED O. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED	
		495337	B. WING			0;	C 3/17/2022	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
AUCUST	HEALTHCARE AT LEEW	000		71	120 BRADDOCK ROAD			
AUGUST				Α	NNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 686	assess and measure January 2022 through On the most recent M assessment, a quarte ARD (assessment ref Resident #39 was cou and long term memor as being severely cou daily decisions. In Se coded as having no u The nurse's note date documented in part, " blister noted to her rt 4x4. Elevated heel o	a pressure injury (1) from n March 2, 2022. IDS (minimum data set) erly assessment, with an ference date) of 1/6/2022, ded as having both short ry difficulties and was coded gnitively impaired for making ction M, the resident was inhealed pressure injuries. ed 12/19/2021 at 3:39 p.m. Resident has non ruptured (right) inner heel. Measured n pillow. Apply skin prep bid	F	686	Resident #2 s wounds have healed. plan updated to reflect skin impairmer risks. 2. All residents with skin impairmer risk for skin impairment have a poten to be affected by this deficient practic The Wound Nurse has completed a s audit of all residents on 3/22/22. Unit Managers/Designee will audit all curr resident s Weekly Skin Review assessments for accuracy. 3. Education completed with nursin staff on Pressure Injury Surveillance Policy and accurate documentation/reporting and care of wounds. 4. Unit Manager/Designee will com	nt tial ce. skin rent		
	wound consultNo si or non verbal pain or The "Weekly Non-Pre Tool" dated 12/19/202 documented in part, " Location - blister on the wound - non puncture process. Date wound 12/19/2021Comme Drainage: none. Odor measurements: Leng Width: 3 cm, Depth: k edges and shape: We placed skin prep appl Evaluation: First obse care to treat and eval The "Weekly Skin Re documented in part, " pre-existing - no site of	<ul> <li>y) and monitor any change. In house sultNo sign and symptoms of verbal pain or discomfort noted."</li> <li>Iy Non-Pressure Wound Observation 12/19/2021 at 12:01 p.m.</li> <li>d in part, "Type of Wound - Other; obister on the right heel, Describe the in punctured blister, no infectious ate wound noted:</li> <li>Comments: Blister not punctured.</li> <li>none. Odor: none. Wound ents: Length: 2 cm (centimeters), n, Depth: blank. Describe wound shape: Well defined. Treatment:</li> <li>prep applied, heels were floated.</li> <li>First observation. Comments: Wound at and evaluate for healing."</li> <li>ly Skin Review" dated 12/27/2022</li> <li>d in part, "Skin Condition: Open area - g - no site documented."</li> </ul>			weekly audits of at least 25% of Wee Skin Review assessments, Weekly Pressure Wound Observation Tool assessment, and Wound Nurse Practitioner□s documentation. Week audit reports will be presented to the monthly Quality Assurance Improven Committee (QAPI) for three months t ensure compliance. 5. April 20, 2022	kly ly nent		

Facility ID: VA0142

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	-	ND HUMAN SERVICES MEDICAID SERVICES					FORM	: 05/02/20 APPROVE . 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495337	B. WING _			C 03/17/2022		
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP COD	E		
	HEALTHCARE AT LEEW			712	20 BRADDOCK ROAD			
A000011				AN	NANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	Ē	(X5) COMPLETIOI DATE
F 686	Continued From nor	- <u>80</u>						
F 000	Continued From page		Ft	686				
		"Skin Condition: Open area						
	- pre-existing - no site	e documented." eview" dated 1/3/2022						
	•	"Skin Condition: Open area						
	- pre-existing - no site							
		eview" dated 1/6/2022						
		"Skin Condition: Open area -						
	pre-existing - no site	documented."						
	The "Weekly Skin Re	eview" dated 1/10/2022						
		"Skin Condition: Open area						
	- pre-existing - no site							
	•	eview" dated 1/17/2022						
	pre-existing - RT (rig	,						
	•	eview" dated 1/20/2022 "Skin Condition: Open area						
		eatment) to right heel						
	remains."							
		eview" dated 1/24/2022						
	-	"Skin Condition: Open area						
	- pre-existing - Tx co	ntinues to right heel."						
	•	eview" dated 1/27/2022						
		"Skin Condition: Open area -						
	pre-existing - tx conti							
	•	eview" dated 1/31/2022						
	-	"Skin Condition: Open area - rogress to right heel."						
		eview" dated 2/7/2022						
	•	"Skin Condition: Open area -						
	-	ogress to right heel with skin						
	prep."							
	-	eview" dated 2/14/2022						
	•	"Skin Condition: Open area -						
	Pre-existing- no site							
	-	eview" dated 2/21/2022						
	-	"Skin Condition: Open area -						
	pre-existing - 1x cont prep."	tinues to right heel with skin						
		eview" dated 2/28/2022						

Facility ID: VA0142

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		E CONSTRUCTION	(X3) DATE	
		495337	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	17/2022
				7	7120 BRADDOCK ROAD		
AUGUST	HEALTHCARE AT LEEW	OOD			ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	documented in part, " pre-existing - right her The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- The "Weekly Skin Re- documented in part, " pre-existing - Tx in pro- On all of the above do measurements of the Review of the nurse's 3/2/2022 revealed no heel wound measurer The physician orders documented, "Skin pr blister bid (twice a da shift." Review of the T Record for December February 2022, docur having been applied t The dietician note dat part, "Is the resident's resident have a press The MD (medical doc documented in part, " clubbing, cyanosis. N The MD note dated 1, part, "Skin: no rashes The MD note dated 2, part, "Skin: No rashes	Skin Condition: Open area - el - tx in progress." view" dated 3/7/2022 Skin Condition: Open area - ogress to right heel." view" dated 3/14/2022 Skin Condition: Open area - ogress to right heel." ocuments, there were no heel wound. a note from 1/1/2022 through documentation of the right ments. dated 12/19/2021 rep apply to right inner heel y) every day and evening Treatment Administration 2021, January 2022, and mented the skin prep as to right inner heel. ted 1/7/2022 documented in a skin intact? Yes. Does the sure ulcer? No." tor) note dated 1/7/2022 Skin: no rashes, lesions, No edema." /24/2022 documented in a, lesions, ulcers."	F	686			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495337	B. WING _				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	heels woundPressu unstageable. Assessi pressure injury." The NP wound specia documented in part, " injury), now devolved pressure wound. Mea (centimeters), width - The comprehensive of and reviewed on 3/16 "Focus: The resident right inner heelWed documentation to incl are of skin breakdown of tissue and exudate change or observatio On 3/16/2022 at 11:0 made of Resident #39 (licensed practical nu nurse. There was a b approximately the siz the area on the right it tissue was pink. An interview was con 3/16/2022 at 2:25 p.n aware of the wound of heel, LPN #1 stated, asked when it was de tissue injury and no lo stated, "In late Janua were any measureme 3/2/2022, LPN #1 stat there were no measu LPN #1 stated, "I don	alist note dated 3/2/2022 Opened DTI (deep tissue into an unstageable asurements: length - 0.95 cm 1.13 cm, depth - 0.2 cm." care plan dated 12/19/2021, b/2022, documented in part, has non rupture blister on ekly treatment ude measurement of each n's width, length, depth, type and any other notable ns." 6 a.m. an observation was D's right heel with LPN rse) #1, the wound care	F	586			

Facility ID: VA0142

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:				COMP	PLETED
							С
		495337	B. WING			03/	17/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW				7120 BRADDOCK ROAD		
A000011					ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
TAG F 686	Continued From page her about an area is f look at the area of cor also goes with them to treatment in place. An interview was com- nurse) #5 on 3/16/202 if she was trained in v "No, but I know a pres- if a blister on the heel injury, RN #1 stated," located." When asked heel wound on which 12/19/2021, RN #1 st that. An interview was com- (administrative staff m practitioner wound ca at 2:53 p.m. When as considered a pressure it's a fluid filled blister stage 2. If it's open it is more than superfici or higher." When asked Resident #39's right h did a full house skin s DTI (deep tissue injur scab." ASM #6 stated an unstageable area a necrotic tissue in the	e 92 or both of them to go in to neem. The unit manager o assess the area and put a ducted with RN (registered 22 at 2:29 p.m. When asked yound care, RN #1 stated, ssure wound." When asked qualifies as a pressure 'It depends on where it is a about Resident #39's right she discovered a blister on ated she could not recall ducted with ASM nember) #6, the nurse re specialist, on 3/16/2022 ked if a blister on a heel is e ulcer, ASM #6 stated "If , it would be considered a would still be a stage 2. If it al, then it could be a stage 3 ed his first observation of neel, ASM #6 stated, "We weep on 3/2/2022. It was a y) on her heel with a small the changed the staging to at that time because of the wound. When asked if d was a pressure wound,		680	DEFICIENCY)	ATE	DATE
	The facility policy, "Pr documented in part, " A system of surveillar identifying, reporting,	essure Injury Surveillance"					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		495337	B. WING				C / <b>17/2022</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	DOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	Explanation and Com Director of Nursing se surveillance activities documentation of inci corrective actions ma surveillance findings t Assessment and Asse and LPNs participate Weekly Skin Review, residents, and report the resident's physicia per protocol for notific in-house reporting of injuries5. Surveillan monitored facility-wide by role or unit, depend observed. A combinat measures will be utiliz will be tracked. A focu completed on pressur worsen in the facility t Risk "Risk" meeting p will be taken immedia be used in the surveil but are not limited to: incident reports, focus Pressure injury/wound Medication and treatm validations for dressir turning/repositioning, assessment data f. Re ASM #1, the administrator #3, the staff developm	pliance Guidelines: 1. The erves as the leader in , maintains/reviews dents, findings, and any de by the facility and reports to the facility's Quality urance Committee. 2. RNs in surveillance through a weekly assessment of ng changes in condition to ans and management staff, cation of changes and new or worsened pressure ce activities will be e, and may be broken down ding on the measure being tion of process and outcome zed7. All pressure injuries used review will be re injuries that develop or through the Residents at rocess. Corrective actions tely, as needed. 8. Data to lance activities may include, a. 24 hour shift reports, sed incident reviews b. d assessments c. nent records d. Skills ag changes,	F	686	6		

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	-					FORM	APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,				LETED
						(	C
		495337	B. WING			03/	17/2022
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD					
					ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 696	Continued From none	04	1 _				
F 686			F	686			
		n was provided prior to exit. iled to implement care and					
		ented pressure injury for					
	Resident #2.						
	On the most recent M	IDS (minimum data set), a					
		with an ARD (assessment					
		3/2022, the resident scored					
	13 out of 15 on the B mental status), indica	IMS (brief interview for ting the resident is					
	-	naking daily decisions.					
	Section M documente	ed Resident #2 having one					
	Stage 3 pressure ulce	er.					
	On 3/15/2022 at 12:1	9 p.m., an observation was					
		in their room. Resident #2					
		with her feel elevated on blankets. Resident #2 was					
	observed to have an						
	The wound evaluation	n note dated 3/2/2022					
		Left lateral leg, Length: 1.36					
		h: 0.80 cm, Depth: 0.00					
	cmDate Wound Acc	quired: 3/2/22; ema (redness) surrounding a					
		desquamation. Zinc oxide					
		peri-wound Q (every) shift.					
		Acquired in house? Yes;					
	Etiology: Pressure Ul	cer- Stage 2"					
		or Resident #2 documented					
		14 (12:14 p.m.) Skin/Wound					
	NoteChief Compla wound evaluationW	int: comprehensive skin and lound plan of care:					
		essure injury to sacrum and					
	stage 2 pressure inju	ry to lateral left lower leg.					
		e analytics) for detailed					
	description and treatr recommendationsV	nent /ound rounds completed					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		495337	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
				71	120 BRADDOCK ROAD		
AUGUST	HEALTHCARE AT LEEW	OOD		A	NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	and reconciled with w		F 6	86			
	record) and eMAR (e administration record 3/1/2022-3/31/2022 fa	) for Resident #2 dated					
		are plan for Resident #2 are plan regarding pressure					
	Resident #2 was mac practical nurse) #1, w	ound care. Resident #2 e no open areas to the left					
	conducted with LPN # wound nurse practition and had conducted a assessment on 3/2/20 process was for them practitioner and enter and notes at the time however the notes we the assessment. LPN should have had the on 3/2/2022, as docu practitioner. She state into place. LPN #1 st have an order entered	022. LPN #1 stated that the to go with the wound nurse any new treatment orders					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO.									
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		495337	B. WING _				17/2022		
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-			
AUGUST	IEALTHCARE AT LEEW	OOD			20 BRADDOCK ROAD NNANDALE, VA 22003				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	E ATE	(X5) COMPLETION DATE			
F 686	that the nursing assis apply barrier cream. #2 was at high risk for being very thin and the pressure injuries. On 3/16/2022 at 12:11 conducted with LPN # Resident #2 received area after receiving in aware of any treatment injury. LPN #5 stated physician order becau LPN #5 stated that the it was ordered and do on the eTAR. The facility policy "Pre- documented in part, " tracked. A focused re- pressure injuries that facility through the Re- meeting process. Co immediately, as need On 3/16/2022 at 5:20 staff member) #1, the director of nursing, AS of nursing, ASM #4, a facility and RN (regist development were no No further information	<ul> <li>bursing staff. LPN #1 stated tants were only allowed to LPN #1 stated that Resident r pressure injury due to be history of recurring</li> <li>5 p.m., an interview was #5. LPN #5 stated that barrier cream to the sacral acontinence care but was not int orders for a pressure 1 that zinc required a use it was a medication.</li> <li>e nurses applied zinc when be unsees applied zinc when be unsees applied zinc when be used the application</li> <li>essure Injury Surveillance"</li> <li>All pressure injuries will be eview will be completed on develop or worsen in the esident at Risk "Risk" rrective actions will be taken ed"</li> <li>p.m., ASM (administrative administrator, ASM #2, the SM #3, the assistant director administrator of a sister tered nurse) #3, staff tified of the findings.</li> <li>n was provided prior to exit.</li> </ul>		586			4/20/22		
F 689 SS=D	CFR(s): 483.25(d)(1)(		F 6	689			4/20/22		
	§483.25(d) Accidents								

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 05/02/2022 RM APPROVED NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		ONSTRUCTION	(X3) DATE SU COMPLET		
		495337	B. WING			C 03/17/2022		
NAME OF PF	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
	IEALTHCARE AT LEEW	σοο		7120	BRADDOCK ROAD			
//000011				ANN	NANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE				
F 689	Continued From page The facility must ensu	ure that -	F 68	39				
		sident environment remains azards as is possible; and						
		esident receives adequate stance devices to prevent						
	This REQUIREMENT by:	is not met as evidenced						
	record review, it was	n, staff interview and clinical determined that the facility			1. Resident # 28 suffered no advers effect related to this deficient practice	e.		
	-	ent interventions to prevent			The resident⊡s fall mat is now place			
		ne of 47 residents in the lent # 28. The facility staff			next to his bed and no longer leaning against the wall at the foot of the res			
		hat on the floor next to			2. All resident at risk for fall have the			
	-	when they are were in bed.			potential to be affected by this deficience. Facility will audit all residen	ent		
	The findings include:				are at risk for fall to ensure intervent to prevent injury is in place. The aud	ions		
		lmitted to the facility with a			include ensuring fall mat orders are			
	•	ed but was not limited to:			implemented including other measur	es		
		d a history of falls. On the			put in place to prevent injury. 3. All Certified Nursing Assistant (C.I	N		
	most recent MDS (mi significant change as	sessment with an ARD			A□s) & Licensed Nurses will be edu			
		ce date) of 12/30/2021, the			by the Director of Staff Development			
	-	ur) out of 15 on the BIMS			Designee on the importance of follow			
	-	ental status), indicating the			the facility□s fall prevention policies			
	•	npaired of cognition for			including implementing fall interventi	on		
	making daily decision	IS.			plan to prevent injury. 4. The facility⊡s unit managers/ Des	ianee		
	On the following date	s a times, Resident #28 was			will complete weekly visual audit on	-		
		no fall mat in place on the			resident who are at risk for fall to ens			
	floor next to the bed:	03/15/22 at 12:40 p.m,			the facility is implementing it fall			
		, 03/16/22 at 8:05 a.m., and			prevention policy. Findings of the			
	-	n. At each observation, a fall			facility s audit of its implementation			
	mat was leaning agai Resident #28's bed.	nst the wall at the foot of			interventions to prevent injury will be presented monthly for three months			
	The facility's fall risk a	assessment titled			Quality Assurance Improvement Committee (QAPI) to ensure complia	ance.		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495337	B. WING			03/17/2022		
NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1		
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD NNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 689	"AHR-MORSE FALL 11/19/2021 for Reside "Low Risk for Falling. The facility's progress Resident # 28 docum	SCALE V2" dated ent # 28 documented in part,	F	689	5. April 20, 2022			
	full body, neuro [neur while resident lie on t	ological] assessment done he fall,[Name of ed, case manager was						
	dated 11/27/2021 doo c/o (complaint of) che (a.m.). Chest pain pr (oxygen), 3 (three) do am (a.m.). Unresolve	oses of Nitro, Aspirin given in ed. Resident rolled out of ing placed at the middle and						
	with a revision date o part, "Focus: The resi related to sudden che shortness of breath. [							
	interview and observa room was conducted assistant] # 1. When needed a fall mat new stated, "Yes. He is a Resident # 28's room fall mat leaning again	proximately 12:10 p.m. an ation of Resident # 28's with CNA [certified nursing asked if Resident # 28 tt to their bed, CNA # 1 fall risk." After entering , CNA # 1 reached for the st the wall at the foot of When asked if the fall mat						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391			
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE				
		495337	B. WING				C / <b>17/2022</b>			
NAME OF PF	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE					
AUGUST I	EALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE				
F 689	stated, "Yes," and planext to the bed. Wheresponsible for placin CNA # 1 stated, "The On 03/16/2022 at apprinterview was conducted practical nurse] # 2. A 28 needed a fall mathestated, "No because H LPN # 2 reviewed the dated 11/27/2021, LP Resident # 28 needed "Yes, it should be dow On 03/16/2022 at apprinterview was conducted nurse] # 2, unit management should be on the bed when they are in When informed of the stated, "It should have The facility's policy "F PREVENTION" document at a state a st	r next to the bed CNA # 1 ced the mat on the floor n asked who was g the fall mat on the floor, CNA or the nurse." proximately 12:20 p.m. an ted with LPN [licensed When asked if Resident # next to their bed LPN # 2 ne's not a fall risk." After e comprehensive care plan N # 2 was asked again if d a fall mat. LPN # 2 stated, wn next to his bed." proximately 12:25 p.m., an ted with RN [registered ger. When asked if a fall floor next to Resident # 28's bed RN # 2 stated, "Yes." e above observations RN # 2 e been in place." FALLS/FALL WITH INJURY mented in part, "POLICY e policy of the facility to ment for our residents. vention initiative will provide to decrease the number of ills with injury. This policy sessment and ential risk for falls, actual d interventions to prevent	F	689						
	(administrative staff m	proximately 5:00 p.m., ASM nember) # 1, administrator, nursing, ASM # 3, assistant								

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		MEDICAID SERVICES					0.0938-039	
STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION ()	(X3) DATE SURVEY COMPLETED		
		495337	B. WING			C 03/17/2022		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
ALICHOT		(00D		71	20 BRADDOCK ROAD			
AUGUST	HEALTHCARE AT LEEW	000		A	NNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	(X5) COMPLETION DATE	
F 689	Continued From pag	o 100		589				
1 009			F	589				
		SM # 4, administrator from # 4, staff development, were ndings.						
	No further informatio	n was provided prior to exit.						
F 695 SS=D	Respiratory/Tracheo CFR(s): 483.25(i)	stomy Care and Suctioning	F	695			4/20/22	
	The facility must ens needs respiratory can care and tracheal suc care, consistent with practice, the compre- care plan, the resider and 483.65 of this suc This REQUIREMENT by: Based on observation interview, clinical rec document review, it w facility staff failed to p	nd tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of hensive person-centered nts' goals and preferences, ubpart. T is not met as evidenced on, resident interview, staff ord review, and facility was determined that the provide respiratory care and residents in the survey 2 and #315.			1. Resident # 2 suffered no adverse effect related to this deficient practice. Resident # 2 oxygen had been provided the prescribed rate while ensuring the flo meter is centered on the line next to the prescribed number. Resident # 315 suffered no adverse effect related to this deficient practice. The	w		
	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				<ul> <li>physician was contacted on 03/16/2022</li> <li>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 sanitary manner.</li> <li>2. All residents who have order for oxyge use are at risk for this deficient practice. The facility will audit all residents who have order for use of oxygen to ensure it</li> </ul>	o a en		

Event ID: W82111

Facility ID: VA0142

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/02/202 MAPPROVE D. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		495337	B. WING			C 03/17/2022		
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
ALIQUATI				71	20 BRADDOCK ROAD			
AUGUSTI	HEALTHCARE AT LEEW	000		Α	NNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 695	Continued From page	e 101		695				
1 000				595		4h a		
	interview for mental s	intact for making daily			is provided at the prescribed rate and flow meter ball is centered on the line			
		) failed to evidence oxygen			to the prescribed number of flow rate.			
	use.				All residents admitted from the hospit			
					have the potential to be affected by th			
	On 3/15/2022 at 12:1	9 p.m., an observation was			deficient practice as well as all reside			
	made of Resident #2	in their room. Resident #2			who use the incentive spirometer hav	e the		
	was observed receivi	ing oxygen via a nasal			potential to have it stored in a manne			
		an oxygen concentrator. At			is not sanitary. The facility will audit a			
	this time an interview				new admissions in the last two weeks			
		ted that they wore the oxygen			ensure they have physician orders for			
		used oxygen for "a long			use of incentive spirometer if deemed			
	time." The top of the	elow the line for 1 lpm (liter			appropriate. The facility will complete audit for all residents using incentive	an		
	per minute).				spirometers to ensure they are stored	lina		
	por minuto).				sanitary manner by providing a bag o			
	Additional observatio	ns of Resident #2 on			another item to cover the month piece			
	3/15/2022 at 2:48 p.n	n., and 4:25 p.m., and on			the incentive spirometer.			
		n. revealed the findings as			3. All licensed / Registered nurses wil	lbe		
	described above.				educated by the Director of Staff			
					Development / Designee on the			
	The physician orders				importance of providing residents oxy	•		
		"Oxygen at 1 liter per min			at the prescribed rate while ensuring			
		nnula to maintain sats			flow meter is centered on the line nex	t to		
	(saturations) above 9 8/16/2021."				the prescribed number. The facility⊡s Director of Staff			
	0/10/2021.				Development/Designee will provide			
	The comprehensive of	care plan for Resident #2			education to all licensed and registere	ed		
	failed to evidence use	•			nurses on the importance of ensuring			
					new admissions who are appropriate			
	On 3/16/2022 at 12:1	5 p.m., an interview was			orders for the use of incentive spirom			
		(licensed practical nurse) #5.			The education will also include the			
		ent #2 received 1 liter of			importance of ensuring incentive			
		ed that the oxygen flow rate			spirometers are stored in a sanitary			
		e top of the flowmeter ball at			manner by providing a bag or another	r		
		bed rate. LPN #5 observed			item to cover the month piece on the			
	Resident #2's oxyger	-			incentive spirometer is provided.			
		low the line for 1 lpm and now they were trained to set			<ol> <li>The facility □s unit managers/ Designation</li> <li>will complete weekly audit on all residness</li> </ol>			

Facility ID: VA0142

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES									
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495337	B. WING			C 03/17/2022			
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-		
				71	120 BRADDOCK ROAD				
AUGUST		OOD		A	NNANDALE, VA 22003				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 695	(registered nurse) #3, (administrative staff m nursing and ASM #3, nursing were asked th flowmeter ball on the #3 stated that the line prescribed oxygen rat flowmeter ball to deliv The manufacturer's in by the facility for Resi documented in part, " make sure that the flo the line next to the pro- flow rate" The facility policy, "O: Utilization" documente administered to the re- On 3/16/2022 at 5:20 staff member) #1, the director of nursing, AS of nursing, ASM #4, a facility and RN (regist development were no No further information 2. The facility staff fail order for Resident #3 spirometer, and failed spirometer in a sanita Resident #315 was an	oximately 5:15 p.m., RN staff development, ASM nember) #2, the director of the assistant director of ne process for setting the oxygen concentrator. RN e corresponding to the te should go through the ver the prescribed rate. Astructions for use provided dent #2's concentrator 2. Check the flow meter to ow meter ball is centered on escribed number of your axygen Concentrator/Oxygen ed in part, "Oxygen will be esident per order" p.m., ASM (administrative administrator, ASM #2, the SM #3, the assistant director administrator of a sister areed nurse) #3, staff atified of the findings. n was provided prior to exit. led to obtain a physician's 15's use of an incentive to store the incentive	F	695	on oxygen to ensuring residents are provided oxygen at the prescribed rate and the flow meter ball is centered on line next to the prescribed number. The facility s unit managers/designee 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 v be completed twice weekly to ensure a residents using incentive spirometer have it stored in a sanitary manner by provid 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	the e will o er vill all ave ding			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OM									
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		495337	B. WING			03/17/2022			
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•			
AUGUST	HEALTHCARE AT LEEW	DOD			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)			x	E ATE	(X5) COMPLETION DATE			
F 695	<ul> <li>#315's admission min completed. An admis 3/7/22 documented R oriented to person, pl</li> <li>Review of Resident # physician's orders fail order for an incentive #315's baseline care failed to reveal docum incentive spirometer.</li> <li>On 3/15/22 at 1:15 p. observed sitting in a concentive spirometer was uncovered and e an interview was come Resident #315 stated times." The resident ware. When asked if provided a bag or and mouth piece on the in resident stated they ha.m., the incentive spirometer spirometer was uncovered and expossover bed table.</li> <li>On 3/16/22 at 2:53 p. conducted with LPN (LPN #4 stated resider physician's order for a control of a control</li></ul>	imum data set was not asion assessment dated esident #315 was alert and ace, time and situation. 315's March 2022 ed to reveal a physician's spirometer. Resident plan initiated on 3/7/22 hentation regarding an m., Resident #315 was chair in the bedroom. An was on the resident's over tive spirometer mouth piece xposed to air. At this time, ducted with the resident. , "They told me to inhale 10 did not specify who "they" the facility staff had other item to cover the centive spirometer, the ad not. On 3/16/22 at 8:34 irometer remained ed to air on Resident #315's m., an interview was licensed practical nurse) #4. hts should have a an incentive spirometer. an incentive spirometer. must have orders from ed nurses can't just guess ders. When asked how an should be stored, LPN #4 ed for a patient with an	F	695					

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	-	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495337	B. WING				C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER	L	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST		OOD			120 BRADDOCK ROAD		
				A	NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 695 F 697 SS=E	RN #1 stated normall dry, then places it in a infection. On 3/16/22 at approx (administrative staff m administrator) and AS nursing) were made a concerns. The facility policy title SPIROMETER" docu physician's order prio clean and kept in a sa No further information Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mana The facility must ensu provided to residents consistent with profes the comprehensive pe and the residents' goa This REQUIREMENT by: Based on resident in clinical record review review, it was determ failed to implement a program by implement interventions prior to (as needed) pain med	m., an interview was egistered nurse) #1, e on an incentive spirometer. y the nurses make sure it is a zip lock bag to prevent imately 5:50 p.m., ASM nember) #1 (the SM #2 (the director of aware of the above d, "USE OF INCENTIVE mented, "1. Get a r to use4. Ensure device is anitary manner." in was presented prior to exit. agement. ure that pain management is who require such services, asional standards of practice, erson-centered care plan, als and preferences. is not met as evidenced terview, staff interview, and facility document ined that the facility staff complete pain management nting non-pharmacological the administration of a prn dications for one of 47		695	<ol> <li>Resident # 56 suffered no adverse effect related to this deficient practice. The facility cannot retroactively correct this deficient practice for resident #56.</li> <li>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 ar</li> </ol>		4/20/22
	interventions prior to (as needed) pain med	the administration of a prn			medications have the potential to be	e	

Event ID: W82111

Facility ID: VA0142

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		ND HUMAN SERVICES MEDICAID SERVICES				F	ITED: 05/02/2022 ORM APPROVED NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	CONSTRUCTION	(X3) [	DATE SURVEY COMPLETED	
		495337	B. WING _				C 03/17/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
AUCUST		000		712	20 BRADDOCK ROAD		
AUGUSTI	IEALTHCARE AT LEEW	000		AN	NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	Continued From page	e 105	F 6	97			
	administration of oxya to Resident #56. Resident #56 was ad diagnosis that include pain. On the most rea set), a quarterly asse (assessment reference resident scored 13 out interview for mental s resident is cognitively decisions. Section J having any pain in the The physician's order dated February 2022 "Oxycodone-Acetamic (milligram) Tablet. G twice daily as needed Resident #56's eMAF administration record documented the adm Oxycodone-Acetamic above on the followin evidence of non-phar being attempted: 03/0 03/02/2022 at 7:23 a	d to implement interventions prior to the codone-acetaminophen (1) dmitted to the facility with a ed by not limited to chronic cent MDS (minimum data assment with an ARD ce date) of 02/27/2022, the ut of 15 on the BIMS (brief status), indicating the <i>v</i> intact for making daily coded Resident # 56 as not e past 5 (five) days. r sheet for Resident # 35 documented in part: inophen 10-325 MG ive one tablet by mouth d. Order Date: 04/23/2021." R (electronic medication ) for March 2022 inistration of the nophen as documented ig dates and times, with no macological interventions 01/2022 at 4:31 p.m., m., 03/03/2022 at 4:54 p.m.,			on pain medications to ensure non-pharmacology intervention are implemented prior to the administration pain medications. 3. All licensed / Registered nurses will educated by the Director of Staff Development / Designee on the importance of implementing and documenting in the clinical record nor -pharmacological interventions prior to administration of as needed pain medication. 4. The facility s unit managers/ Design will complete weekly audit on all resict on pain medications to ensure non-pharmacology intervention are implemented prior to the administration pain medication. Findings of the facilit weekly audit will be presented month three months to the Quality Assurance Improvement Committee (QAPI) to ensure compliance. 5. April 20, 2022	l be o the gnee lents on of ty y for	
	03/04/2022 at 5:42 p. 03/09/2022 at 9:19 p. and on 03/15/2022 at The comprehensive of	.m., 03/07/2022 at 7:00 p.m., .m., 03/13/2022 at 5:22 a.m.					

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	-	ID HUMAN SERVICES				FORM	APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:					LETED
							C
		495337	B. WING			03/	17/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 697	interview was conduct When asked if they re- needed Resident # 56 When asked if the stat before giving them partial stated "Sometimes." On 03/16/2022 at apprinterview was conduct practical nurse) # 2 m administering prn (as and documentation of interventions. LPN # resident's pain, where scale one to ten, with Attempt interventions alleviate their pain, if the pain medication a effectiveness." When non-pharmacological attempted LPN # 2 st medication, every tim where the non-pharm should be documented documented in the nur reviewing the physicia eMAR and the nurse! 03/01/2022 through 0 56, LPN # 2 was aske documentation that no	ximately 10:52 a.m., an ted with Resident # 56. eccive pain medication as 5 stated, "Sometimes." off try to alleviate their pain in medication Resident # 56 proximately 1:55 p.m. an ted with LPN (licensed egarding the procedure for needed) pain medication f non-pharmacological 2 stated, "Assess the e the pain is and using a ten being the worse pain. , like repositioning, to it doesn't work administer nd recheck the resident for n asked how often the interventions should be ated, "Before you give the e." When asked about acological interventions ed, LPN # 2 stated, "It's trse's notes." After an's orders, the March 2022 s progress notes dated 3/15/2022 for Resident # ed if there was on-pharmacological tempted prior to Resident #	F	697	DEFICIENCY)		
	above. LPN # 2 state	one on the dates listed ed, "No." Policy on Pain Management"					

Facility ID: VA0142

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		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
B. WING		COMPLETED	
		C 03/17/2022	
	STREET ADDRESS, CITY, STATE, ZIP CODE		
	7120 BRADDOCK ROAD ANNANDALE, VA 22003		
ID PREFIX TAG	DATE		
	7	4/20/22	
	F 69	F       698         ID       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)         F       697         F       698         I. Resident # 44 suffered no adverse effect related to this deficient practice.	

Event ID: W82111

Facility ID: VA0142

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I				PRINTED: 05/0 FORM APPI OMB NO. 093	ROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	ΞY
	495337	B. WING		C 03/17/20	22
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
AUGUST HEALTHCARE AT LEEW	000		7120 BRADDOCK ROAD		
AUGUST REALTROAKE AT LEEW			ANNANDALE, VA 22003		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COME THE APPROPRIATE D	(X5) PLETION DATE
for one of 47 resident Resident #44. For Refailed to evidence cont the dialysis communic dates in 2022. The findings include: Resident #44 was add with a diagnosis of en requiring hemodialysis (minimum data set) as assessment, with an / date) of 1/11/2022, th the BIMS (brief intervi indicating the resident for making daily deciss #74 was coded as recor- resident at the facility. The physician order of documented, "Dialysis dialysis center] on Mo Friday at 11:00 a.m." An interview was cont 3/15/2022 at 2:08 p.m anything with her to d she takes a book with the book is kept at the On 3/16/2022 at 8:15 book was reviewed. T the book; the page wa clinical record was rev- January 2022 through	ently with the dialysis center s in the survey sample, sident #44, the facility staff hisistent communication via cation book on multiple mit to the facility on 4/5/2019 hd stage renal failure s. On the most recent MDS ssessment, a quarterly ARD (assessment reference e resident scored a 15 on iew for mental status) score, t is not cognitively impaired sions. In Section O, Resident ceiving dialysis while a dated 10/3/2020 s Services [address of onday, Wednesday and ducted with Resident #44 on h. When asked if she takes lialysis, Resident #44 stated h her to dialysis. She stated e nurse's station. a.m. Resident #44's dialysis There was only one page in as dated 3/11/2022. The viewed for the months of h March 15, 2022. The not located in the clinical	F	<ul> <li>cannot be retroactively corr dialysis dates in question h The facility cannot create d communication for the mult communication days.</li> <li>2. All residents on dialysis I potential to be affected by t practice. The facility will con to ensure all dialysis resided dialysis communication bod ensure consistent commun dialysis center.</li> <li>3. All licensed / Registered educated by the Director of Development / Designee on importance of ensuring con communication with the Dia via the dialysis communication will complete weekly audit o on dialysis to ensure dialys have dialysis communication place and dialysis log form consistently for communication place and dialysis residen communication book and c form with the dialysis center presented monthly for three Quality Assurance Improve Committee (QAPI) to ensur 5. April 20, 2022</li> </ul>	ave pasted. ialysis tiple missed have the this deficient mplete an audit ents have bk in place to ication with the nurses will be f Staff in the alysis Centre tion form. gers/ Designee on all residents is residents is residents on book in completed tion with the the weekly to sommunication er will be e months to the ment	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495337	B. WING				C 17/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 698	2/1/2022, 2/7/2022, a A request was made of for the missing dates On 3/17/2022 at 8:00 documentation of com facility was provided: 1/21/2022, 1/24/2022 Still missing were the 1/28/2022, 1/31/2022 The nurse's notes dat documented in part, " dialysis." The nurse's 10:49 p.m. documenter returned from dialysis 1/31/2022 at 10:14 p. "Resident returned from note dated 2/1/2022 at part, "Resident return nurse's note dated, 2/ documented in part, " dialysis." The comprehensive of and revised on 3/15/2 "Focus: [Resident #74 (related to) End Stage dialysis center] 3 time Mondays/Wednesday An interview was com- practical nurse) #5 on When asked the proc	, 1/28/2022, 1/31/2022, nd 2/21/2022. on 3/16/2022 at 3:29 p.m. above. a.m. the following dates of nmunication with the dialysis 1/17/2022, 1/19/2022, and 2/21/2022. following dates: 1/26/2022, , 2/1/2022, and 2/7/2022. ted 1/26/2022 at 8:37 p.m. Resident returned from note dated 1/28/2022 at ed in part, "Resident a." The nurse's note dated m. documented in part, om dialysis." The nurse's at 5:11 p.m. documented in ed from dialysis." The 7/2022 at 4:59 p.m. Resident returned from exare plan dated, 9/28/2020 2022, documented in part, 4] has renal failure r/t e Renal Disease/need for bes to Dialysis [name of es a week on rs and Fridays." ducted with LPN (licensed a 3/16/2022 at 12:58 p.m. ess for when a resident is	F	698			
	-	ess for when a resident is #5 stated, "When we come					

Facility ID: VA0142

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		ID HUMAN SERVICES MEDICAID SERVICES				_	FORM	: 05/02/2022 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		X3) DATE : COMPI	SURVEY _ETED
		495337	B. WING				03/1	; 17/2022
NAME OF P	ROVIDER OR SUPPLIER	·		STR	REET ADDRESS, CITY, STATE, ZIP CODE			
		0.05		712	20 BRADDOCK ROAD			
AUGUST	HEALTHCARE AT LEEW	OOD		AN	INANDALE, VA 22003			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	E	(X5) COMPLETION DATE
F 698	in the morning that [F dialysis, we fill in the the book with her." W completed each time dialysis center, LPN # she goes to dialysis." the resident returns, f book on a daily basis center will write recor- that sometimes the re- the book at dialysis, s to use, just in case. I book and there were it. The facility policy, "C Services" documenter requiring an outside F services coordinated communication betwee ESRD facility regardin will establish a Dialys if there are any reside Services. The agreen residents care is to be The Dialysis Communi- by the facility for any center for hemodialys and complete the infor resident to send to th ESRD facility is to rev Communication form OR b. Provide treatm 4. Upon the resident's nursing will review the form and information center OR the information	Resident #44] goes to paper in the book and send (hen asked if a new sheet is the resident goes to the #5 stated, "Yes, every time LPN #5 further stated when the nurse has to check the as sometimes the dialysis mmendations. LPN #5 stated esident accidentally leaves so they have a second book LPN #5 checked the second no communication papers in oordination of Hemodialysis ed, "Policy: Residents ESRD facility will have by the facility and the ng the resident. The facility sis Agreement/Arrangement ents requiring Dialysis nent shall include how the e managed. Procedure: 1. nication form will be initiated resident going to an ESRD sis. 2. Nursing will collect ormation regarding the e ESRD Center. 3. The view the Dialysis and either: a. Complete the and return with the resident ent information to the facility	F	698				

Facility ID: VA0142

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		D HUMAN SERVICES MEDICAID SERVICES			FOR	M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495337	B. WING _			C / <b>17/2022</b>
NAME OF PF	ROVIDER OR SUPPLIER		-1	STREET ADDRESS, CITY, STATE, ZIP CODE		-
AUGUST I	HEALTHCARE AT LEEW	DOD		7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
F 698 F 814 SS=F	implement intervention Nursing will complete on the Dialysis Commission completed form in the ASM (administrative as administrator, ASM #2, ASM #3, the assistand #4, administrator from (registered nurse) #3, nurse, were made aw 3/17/2022 at 9:29 a.m No further information Dispose Garbage and CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose properly. This REQUIREMENT by: Based on observation document review, it w facility staff failed to n facility dumpsters in a A trash bag approxim hanging on the outsid approximately twelve and numerous pieces on the ground around dumpster. The findings include: On 03/15/22 at approx	partments as needed, ns as appropriate. 5. the post dialysis information nunication form and file the Resident's Clinical record." staff member) #1, the 2, the director of nursing, ASM a sister facility and RN the staff development are of the above concern on n. was provided prior to exit. d Refuse Properly e of garbage and refuse f is not met as evidenced n, staff interview and facility vas determined that the naintain one of three of the a sanitary manner. ately half full of trash was e of the dumpster and pairs of used plastic gloves of debris were found lying and behind the facility's	F	<ol> <li>No resident was affected by this deficient practice. However, on 3/16/after the facility was notified of this deficient practice the facility s Department of Environmental Service ensured the affected dumpster was maintained in a sanitary manner.</li> <li>All three of the facility s dumps and its surroundings have the potent be affected by this deficient practice. 3/16/22, the Department of Environm Services ensured all three dumpsters were maintained in a sanitary mannet.</li> <li>The Director of Environmental Services ensured and the services ensured and the services ensured and three dumpsters were maintained in a sanitary mannet.</li> </ol>	er ial to On iental	4/20/22
	On 03/15/22 at appro observation of the fac	-				

Facility ID: VA0142

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		MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE S	0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3	COMPL	
				·	с	
		495337	B. WING			7/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		
				7120 BRADDOCK ROAD		
AUGUST	HEALTHCARE AT LEEW	OOD		ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 814	Continued From page	e 112	F 81	Λ		
1 011		(other staff member) # 1,		importance of ensuring t	hat the dumpster	
	dietary manager, OS			areas are maintained in	-	
		# 3, director of housekeeping		manner. This education	•	
	and OSM # 4, house			the importance of followi		
				policy on External Enviro	-	
		ealed that the facility had two		by ensuring facility⊡s er		
		one cardboard recycling		maintained in a safe and	•	
		Impster for trash, next to		4. The Director of Envi		
	each other located be	area between and behind the		Services/Designee will p random audit two times		
	-	led a broken mop handle		weeks of the facility a d	-	
	-	npsters, approximately 12		before and after garbage	-	
		gloves, and numerous		ensure its surrounding a		
		nd the two dumpsters,		safe and sanitary manne		
	-	top of decaying leaves and		random visual audits cor		
		er observation revealed a		weekly will be presented		
	trash bag, approxima			months to the Quality As		
		de of the dumpster. When		Improvement Committee	e (QAPI) to	
		onsible for ensuring the		ensure compliance.		
	· ·	ept clean, OSM # 2 stated,		5. April 20, 2022.		
		y to come and empty the ekeeping is responsible for				
	cleaning up around the					
		tied this morning." When				
		dumpster area was cleaned				
		3 stated, "Every morning."				
		ne trash observed on the				
	ground around the du	umpsters OSM # 3 stated,				
		is responsible for cleaning				
		ster." OSM # 4 was asked				
		up around the dumpster,				
		ery morning." When asked if				
	they had come out to	vere emptied earlier that				
		ated, "No I was going to				
		oon." When asked why it				
		p the dumpster areas clean				
	-	OSM # 3 stated, "For				
	sanitary purposes, pr		1			

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	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495337	B. WING _				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 814 F 842 SS=E	coming around." The facility's policy "E Cleaning" documenter the buildings (i.e., sid dumpster area, etc.) sin in a safe and orderly for On 03/16/2022 at apprent (administrative staff m ASM # 2, director of r director of nursing, AS sister facility and RN for made aware of the firm No further information Resident Records - Io CFR(s): 483.20(f)(5), §483.20(f)(5) Resider (i) A facility may not re- resident-identifiable to (ii) The facility may re- resident-identifiable to accordance with a co- agrees not to use or of except to the extent the to do so. §483.70(i) Medical re- §483.70(i) (1) In accor- professional standard	External Environmental d in part, "5. Areas around ewalks, patios, gardens, shall be always maintained manner." proximately 5:00 p.m., ASM hember) # 1, administrator, hursing, ASM # 3, assistant SM # 4, administrator from # 4, staff development, were adings. h was provided prior to exit. dentifiable Information 483.70(i)(1)-(5) ht-identifiable information. elease information that is to the public. lease information that is to an agent only in intract under which the agent disclose the information he facility itself is permitted cords. dance with accepted ls and practices, the facility al records on each resident ented; e; and		314			4/20/22

Facility ID: VA0142

If continuation sheet Page 114 of 127

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495337	B. WING				C 17/2022
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	DOD			7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	2 114	F	842	2		
	all information contair regardless of the form records, except when (i) To the individual, o representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research p medical examiners, fu a serious threat to hea by and in compliance §483.70(i)(3) The faci record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 yea legal age under State §483.70(i)(5) The mer (i) Sufficient information (ii) A record of the ress (iii) The comprehensiv provided;	r their resident permitted by applicable law; (ment, or health care teed by and in compliance activities, reporting of abuse, violence, health oversight administrative proceedings, tooses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. lity must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law.					

Facility ID: VA0142

If continuation sheet Page 115 of 127

		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 05/02/20 RM APPROVE IO. 0938-039	
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		TE SURVEY MPLETED	
		495337	B. WING		0	03/17/2022	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
AUGUST	HEALTHCARE AT LEEW	IOOD		7120 BRADDOCK ROAD			
				ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 842	Continued From page	o 115	F 842				
1 012			F 042				
	and resident review e determinations condu						
		e's, and other licensed					
	professional's progre						
	(vi) Laboratory, radio	logy and other diagnostic					
		equired under §483.50.					
		Γ is not met as evidenced					
	by:				с. I		
		view, facility document review view, it was determined the		1. The facility cannot retroad document pressure injury no			
		maintain a complete and		resident #39 from the period			
	-	ord for one of 47 residents in		2022 until March 2. The facil			
		Resident #39. For Resident		Nurse Practitioner (NP) asse	-		
		failed to document any notes		#39 pressure injury on 03/02	/2022. The		
	-	injury from the end of		wound NP or facility wound r			
	January 2022 until M	arch 2, 2022.		continue weekly assessment	t thereafter		
	<b>-</b>			until resolved.			
	The findings include:			2. All residents with pressure potential risk for this deficien			
	Resident #39 was ad	lmitted to the facility on		The facility s wound nurse of			
		ost recent MDS (minimum		will audit all residents with pr	-		
		t, a quarterly assessment,		injuries to ensure the facility			
		ment reference date) of		a complete and accurate clin			
	· ·	nt was coded as having both		with a minimum of weekly do			
	-	nemory difficulties and was		on resident s pressure injur	y status.		
		rely cognitively impaired for		3. The facility s Director of	to the		
		ns. In Section M, the resident		Nursing/Designee will educa facility s wound nurse on the			
	injuries.	no unhealed pressure		of maintaining a complete an			
				clinical record. This educatio			
	The nurse's note date	ed 12/19/2021 at 3:39 p.m.		include ensuring all residents			
		"Resident has non ruptured		pressure injury having at min			
		(right) inner heel. Measured		progress notes on status of t	heir pressure		
		n pillow. Apply skin prep bid		injury.			
		nitor any change. In house		4. The Wound Nurse/Design			
		ign and symptoms of verbal		complete clinical records auc			
	or non verbal pain or			residents with pressure injury weekly progress notes on pro-			
			1				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 05/02/2022 RM APPROVED IO. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495337	B. WING			C 03/17/2022		
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
AUCUST	HEALTHCARE AT LEEW	000		71	120 BRADDOCK ROAD			
A00031				Α	NNANDALE, VA 22003			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 842	Tool" dated 12/19/202 documented in part, " Location - blister on t wound - non puncture process. Date wound 12/19/2021Comme Drainage: none. Odo measurements: Leng Width: 3 cm, Depth: b edges and shape: We placed skin prep appl Evaluation: First obse care to treat and eval Review of the nurse's 3/2/2022 revealed no heel wound measure The "Weekly Skin Re documented in part, " pre-existing - no site The "Weekly Skin Re documented in part, " - pre-existing - no site The "Weekly Skin Re documented in part, " - pre-existing - no site The "Weekly Skin Re documented in part, " - pre-existing - no site The "Weekly Skin Re documented in part, " pre-existing - no site The "Weekly Skin Re documented in part, " pre-existing - no site The "Weekly Skin Re documented in part, " pre-existing - no site The "Weekly Skin Re documented in part, " pre-existing - no site The "Weekly Skin Re documented in part, "	21 at 12:01 p.m. 'Type of Wound - Other; he right heel, Describe the ed blister, no infectious noted: nts: Blister not punctured. r: none. Wound th: 2 cm (centimeters), blank. Describe wound ell defined. Treatment: lied, heels were floated. ervation. Comments: Wound uate for healing." a note from 1/1/2022 through documentation of the right ments. eview" dated 12/27/2022 'Skin Condition: Open area - documented." eview" dated 12/30/2021 'Skin Condition: Open area e documented." eview" dated 1/3/2022 'Skin Condition: Open area e documented." eview" dated 1/6/2022 'Skin Condition: Open area e documented." eview" dated 1/10/2022 'Skin Condition: Open area documented." eview" dated 1/10/2022 'Skin Condition: Open area - documented." eview" dated 1/10/2022 'Skin Condition: Open area - documented." eview" dated 1/10/2022 'Skin Condition: Open area - documented."	F	842	ensure a complete and accurate clin record. Findings of the weekly audits be presented monthly for three mont the Quality Assurance Improvement Committee (QAPI) to ensure complia 5. April 20, 2022	s will hs to		

Facility ID: VA0142

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	-	ID HUMAN SERVICES				FORM	MAPPROVED	
		MEDICAID SERVICES					D. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY	
			A. BUILD	ING.			с	
		495337	B. WING				0 17/2022	
NAME OF PI	ROVIDER OR SUPPLIER	1	<b>I</b>	:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
	HEALTHCARE AT LEEW	000			7120 BRADDOCK ROAD			
AUGUSTI		000			ANNANDALE, VA 22003			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG	· · ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI			
_					DEFICIENCY)			
F 842	Continued From page		F	842	2			
	- pre-existing - Tx (tre	eatment) to right heel						
	remains."	view" dated 1/24/2022						
		Skin Condition: Open area						
	- pre-existing - Tx cor	•						
		view" dated 1/27/2022						
	-	Skin Condition: Open area -						
	pre-existing - tx contin	view" dated 1/31/2022						
	•	Skin Condition: Open area -						
	pre-existing - Tx in pr	-						
	The "Weekly Skin Re							
		Skin Condition: Open area -						
	prep."	ogress to right heel with skin						
		view" dated 2/14/2022						
		Skin Condition: Open area -						
	Pre-existing- no site o							
		view" dated 2/21/2022 'Skin Condition: Open area -						
	· · ·	inues to right heel with skin						
	prep."							
		view" dated 2/28/2022						
	· · ·	Skin Condition: Open area -						
	pre-existing - right he The "Weekly Skin Re							
		Skin Condition: Open area -						
	pre-existing - Tx in pr							
	•	view" dated 3/14/2022						
		Skin Condition: Open area -						
	pre-existing - Tx in pr	ocuments, there were no						
	measurements of the							
		data d 40/40/2004						
	The physician orders	dated 12/19/2021 rep apply to right inner heel						
	-	y) every day and evening						
	· ·	Freatment Administration						

Facility ID: VA0142

If continuation sheet Page 118 of 127

DEPART	MENT OF HEALTH AN	D HUMAN SERVICES					/ APPROVED
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NC	0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDIN	··· _			C
		495337	B. WING			03/	17/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD NNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 842	Record for December February 2022, docur having been applied t The MD (medical doc documented in part, " clubbing, cyanosis. N The MD note dated 1, part, "Skin: no rashes The MD note dated 2, part, "Skin: No rashes The NP (nurse practit note dated, 3/2/2022 heels woundPressu unstageable. Assess pressure injury." The NP wound specia documented in part, " injury), now devolved pressure wound. Mea (centimeters), width - The comprehensive of and reviewed on 3/16 "Focus: The resident right inner heelWee documentation to incl are of skin breakdowr	2021, January 2022, and mented the skin prep as o right inner heel. tor) note dated 1/7/2022 Skin: no rashes, lesions, lo edema." /24/2022 documented in , lesions, ulcers." /17/2022 documented in s, lesions or ulcers." /17/2022 documented in the el, ment and Plan: Patient has a ///////////////////////////////////	F 8	342			
		ducted with LPN #1 on n. When asked if she was					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
AND I LAN OI	CONNECTION	IDENTIFICATION NOMBER.	A. BUILD	ING			C
		495337	B. WING				/17/2022
NAME OF P	ROVIDER OR SUPPLIER		<b>I</b>		STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			7120 BRADDOCK ROAD		
					ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	aware of the wound o heel, LPN #1 stated," asked when it was de tissue injury and no lo stated, "In late Januar were any measureme 3/2/2022, LPN #1 stat there were no measur LPN #1 stated, "I don stated the normal pro her about an area is f look at the area of con also goes with them to treatment in place. An interview was con- (administrative staff m practitioner wound ca at 2:53 p.m. When as considered a pressure it's a fluid filled blister stage 2. If it's open it is more than superfici or higher." When aske Resident #39's right h did a full house skin s DTI (deep tissue injur scab." ASM #6 stated an unstageable area necrotic tissue in the Resident #39's wound ASM #6 stated, "Yes, A second interview wa on 3/16/2022 at 3:16 wrote a note when sh wound, LPN #1 stated	In Resident #39's right inner 'In late January." When termined to be a deep onger a blister, LPN #1 ry." When asked if there ents of this wound prior to ted, "No." When asked why rements prior to 3/2/2022, 't know." LPN #1 further cess when the nurse tells or both of them to go in to ncern. The unit manager o assess the area and put a ducted with ASM nember) #6, the nurse re specialist, on 3/16/2022 ked if a blister on a heel is e ulcer, ASM #6 stated "If , it would be considered a would still be a stage 2. If it al, then it could be a stage 3 ed his first observation of neel, ASM #6 stated, "We weep on 3/2/2022. It was a y) on her heel with a small I he changed the staging to at that time because of the wound. When asked if d was a pressure wound,	F	842			
	tissue injury and no lo stated, "In late Januar were any measureme 3/2/2022, LPN #1 stat there were no measur LPN #1 stated, "I don stated the normal pro- her about an area is f look at the area of con also goes with them to treatment in place. An interview was con- (administrative staff m practitioner wound ca at 2:53 p.m. When as considered a pressure it's a fluid filled blister stage 2. If it's open it is more than superfici or higher." When aske Resident #39's right h did a full house skin s DTI (deep tissue injur scab." ASM #6 stated an unstageable area necrotic tissue in the Resident #39's wound ASM #6 stated, "Yes, A second interview wa on 3/16/2022 at 3:16 wrote a note when sh wound, LPN #1 stated note." When asked w	onger a blister, LPN #1 ry." When asked if there ents of this wound prior to ted, "No." When asked why rements prior to 3/2/2022, "t know." LPN #1 further cess when the nurse tells or both of them to go in to ncern. The unit manager to assess the area and put a ducted with ASM nember) #6, the nurse re specialist, on 3/16/2022 ked if a blister on a heel is e ulcer, ASM #6 stated "If , it would be considered a would still be a stage 2. If it al, then it could be a stage 3 ed his first observation of neel, ASM #6 stated, "We weep on 3/2/2022. It was a y) on her heel with a small he changed the staging to at that time because of the wound. When asked if d was a pressure wound, it's pressure." as conducted with LPN #1 p.m. When asked if she e was made aware of the d, "No I didn't do a wound					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495337	B. WING			C 03/17/2022	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
AUGUSTI		OOD			120 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)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 842	on her foot and offloa record at that time I s order for skin prep in stated, "We use a car wounds." When aske January of the wound (identification) doesn' measured the wound March 2, 2022, LPN # if she saw the wound January through Marc When asked if she sa write a note, LPN #1 asked if she had the a wounds when the car access to the camera stated, "Yes." LPN #1 "Shrinking." A copy of the policy o clinical record was rea 5:30 p.m. No policy w The following quotatio Fundamentals of Nur 237): "The client reco document of the client receivedBecause team members canno assessments or intervy years after the fact, a documentation at the The care may have b documentation must p ASM #1, the administ of nursing, ASM #3, ti	ated, "I requested the boot ding. When I reviewed the aw there was already an place." LPN #1 further mera to measure the d if she took a picture in I, LPN #1 stated, "No, my ID t work." When asked if she from late January until #1 stated, "No." When asked on Resident #39's heel from ch, LPN #1 stated, "Yes." we the wound but did not stated it was correct. When equipment to measure mera is not working, or her is not working, LPN #1 stated the wound was n a complete and accurate quested on 3/16/2022 at was received. on is found in Lippincott's sing 5th edition (2007, page rd serves as a legal t's health status and care nurses and other healthcare of remember specific ventions involving a client ccurate and complete time of care is essential. een excellent, but the prove it."	F	842			
	of nursing, ASM #3, t						

Facility ID: VA0142

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 05/02/2022 ORM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495337				(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY
		495337	B. WING			C 03/17/2022	
NAME OF P	ROVIDER OR SUPPLIER		•	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			BRADDOCK ROAD IANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842	#3, the staff developr aware of the above c 5:30 p.m.	nent nurse, were made oncerns on 3/16/2022 at	F	342			
F 880 SS=D	No further information was provided prior to exit. Infection Prevention & Control		F	380			4/20/22

Facility ID: VA0142

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 05/02/2022 MAPPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495337	B. WING			C 03/17/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				7'	120 BRADDOCK ROAD		
AUGUST	HEALTHCARE AT LEEW	DOD		Α	NNANDALE, VA 22003		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including but (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possific circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syster identified under the fa corrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu- IPCP and update thei This REQUIREMENT by: Based on observation record review and fac determined that the fa	n possible incidents of e or infections should be smission-based precautions ent spread of infections; lation should be used for a t not limited to: at the isolation should be the ble for the resident under the sunder which the facility ees with a communicable in lesions from direct at not limited to a communicable in lesions from direct at not limited to a communicable at lesions from direct at not limited to: at not recording incidents at not recording incidents at not prevent the spread of liew. at an annual review of its at not met as evidenced an, staff interview, clinical ility document review, it was	F	880	<ol> <li>Resident #35 suffered no adverse effect related to this deficient practice. Resident #35 was assessed by a Registered Nurse on 03/30/2021 to</li> </ol>		

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				PRINTED: 05/02/2 FORM APPRO OMB NO. 0938-0	
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
495337		B. WING		C 03/17/2022	
ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP COD		
HEALTHCARE AT LEEW	OOD		7120 BRADDOCK ROAD ANNANDALE, VA 22003		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE COMPLETI	
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.		F 8	identify any possible effects ro been administered a contamin LPN #9 will be educated on th importance of ensuring medic administered in a sanitary ma #9 will also be educated on th	nated pill. ne cations are nner. LPN ne	
			Medication Pass & Administra 2. All residents who LPN # medication to have the potent affected by this deficient prac- will assess all residents on Ca which is the primary assignme 9 to ensure they have no adv any potential unsanitary medi The remaining stock pill bottle B1 which LPN #9 placed the contaminated pill was discard	ation Policy. 9 administers tial to be tice. Facility ardinal 1 Unit ent for LPN # erse effect to cation pass. e of Vitamin other half of led	
physician's order data (Thiamine) (1) 50 mg On 3/16/22 at 8:17 A Practical Nurse) was administer medication the medications prep Vitamin B1 (Thiamine and picked up the un unsanitized stock bot contaminating her glo pill of Vitamin B1 onto used her contaminate the pill on the pill cutt half, she dumped bot into the palm of her co She then picked up of	ed 9/1/20 for "Vitamin B1 (milligrams)" M, LPN #9 (Licensed observed to prepare and ns for Resident #35. One of ared and administered was e). LPN #9 donned gloves, sanitized pill cutter and the the of Vitamin B1, thus oves. She poured a 100 mg o the pill cutter. She then ed, gloved finger to position rer. After cutting the pill in th halves from the pill cutter contaminated, gloved hand. one half of the pill with her		<ul> <li>complete medication pass will educated by the Director of S Development/Designee on the of ensuring medications are at in a sanitary manner to reside Licensed/Registered nurses we educated by the Director of S Development/Designee on the of following the facility s Medication Policy.</li> <li>4. The facility s Unit Managers/Designee will complete medication pass observation weekly on randomly selected shifts to ensure medications at administered in a sanitary matication pass</li> </ul>	I be taff e importance idministered ents. All vill also be taff e importance dication blete two times nurses on all are inner and	
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER HEALTHCARE AT LEEW SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page of 6 residents in the I observation, Residen The facility nurse adr which had been hand to Resident #35. The findings include: Resident #35 was add diagnoses including a related hepatitis. On (Minimum Data Set), an ARD (Assessmen the resident scored a (brief interview for me resident was not cog daily decisions. A review of the clinica physician's order date (Thiamine) (1) 50 mg On 3/16/22 at 8:17 A Practical Nurse) was administer medication the medications prep Vitamin B1 (Thiamine and picked up the un unsanitized stock bot contaminating her glo pill of Vitamin B1 onto used her contaminated the pill on the pill cutt half, she dumped bot into the palm of her co She then picked up co other contaminated, g	CORRECTION       IDENTIFICATION NUMBER:         Identification Ide	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTI A. BUILDIN 495337         ROVIDER OR SUPPLIER FEALTHCARE AT LEEWOOD       B. WING	S FOR MEDICARE & MEDICAID SERVICES         © FDERCENCIES       (x1) PROVIDERSUPPLERCULA IDENTIFICATION NUMBER:       (x2) MULTIPLE CONSTRUCTION         495337       B. WING         200/DEER OR SUPPLIER       5TREETADDRESS, CITY, STATE, ZIP COD 7120 BRADDOCK ROAD ANNANDALE, VA 22003         IEALTHCARE AT LEEWOOD       7120 BRADDOCK ROAD ANNANDALE, VA 22003         SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFIX TAG         Continued From page 123 of 6 residents in the Medication Administration observation, Resident #35.       F 880         Continued From page 123 of 6 resident #35.       F 880         In the findings include:       F 880         The findings include:       X. All resident #35.         The findings include:       X. All resident #35.         The findings include:       X. All resident was bed on 10 fo on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions.       STREET ADDRESS, CITY, STATE, ZIP COD (EACH CORRECTIVE ACTION (RACH CORRECTIVE ACT	

Facility ID: VA0142

CENTERS FOR MEDICARE & MEDICAID SERVICES         TATEMENT OF DEFICIENCIES         ND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         495337			(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		B. WING	B. WING			
NAME OF P	IAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COD	E	
AUGUST HEALTHCARE AT LEEWOOD				120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 880	Continued From page	e 124	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 standard1. 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"			Findings of the sanitary media weekly audits will be presente for three months to the Quality Improvement Committee (QAI ensure compliance. 5. April 20, 2022	ed monthly y Assurance	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495337	B. WING			C 03/17/2022	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	_ <b>-</b>	
AUCUOT				7	7120 BRADDOCK ROAD		
AUGUST		COD			ANNANDALE, VA 22003		
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F 880	ROVIDER OR SUPPLIER HEALTHCARE AT LEEWOOD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	880			

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		ND HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
	CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA         (X2) MULTIPLE CONSTRUCTION						
AND PLAN OF CORRECTION				A. BUILDING			SURVEY LETED
						С	
		495337	B. WING			03/	17/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	HEALTHCARE AT LEEW	OOD			120 BRADDOCK ROAD		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF COR			(X5)
PRÉFIX TAG				PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM			COMPLETION DATE
F 880	Continued From page	e 126	F	880			
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Event ID: W82111

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